2020

ANHP Community Engagement Report on Home Care and Community Services

CA2 GILLIS CONSULTING

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The ANHP Home Care and Community Services Working Group provided oversight and guidance throughout the project and included:

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With gratitude, we thank all the Elders, community members, front-line service workers and participants who shared their insight and expertise for this Project. It is our intent to provide back to you this report so you can validate that your voice is reflected in a respectful way. We encourage you to continue to be involved in making sure home care and community supports transform in a good way for the ANHP region.

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EXECUTIVE SUMMARY

The Home Care Community Services (HCCS) Working Group acknowledges all community engagement and research informing this HCCS Phase 1 Project has taken place within the original lands of Treaty 3, the Anishinaabe and the homeland of the Métis Nation. It is important to shed truth and place importance on the historical context that acknowledges the mistakes of the past. The Project team has dedicated this community-based approach to give voice to the people who will be served by the All Nations Health Partners Ontario Health Team (ANHP OHT) in a spirit of reconciliation and collaboration.

The following report presents a substantial community-driven engagement project to support the All Nations Health Partners (ANHP) in leading solutions that will best fit the unique needs of the region as home and community care functions transfer to the Ontario Health Teams (OHT).

The ANHP's vision, as illustrated in **Figure 1** is to *create a community-based framework for a people-centered approach that results in a fully integrated model of health care*. With this vision in mind, the project summarized in this report focused on gathering insights from local expertise and community experiences. This information will direct an appropriate and evidence-based framework for a regionally specific, locally owned, culturally congruent, and responsive home and community care system.

Results and recommendations from Phase 1 will inform Phase 2 work aimed to develop and implement the design and delivery of effective Home and Community Care Services (HCCS) in compliance with Bill 175 as it applies to the ANHP unique circumstances. This process will be uniquely designed by, and for, the people living within the ANHP OHT catchment.

> *Culturally congruent care refers to the process of establishing trust and effective communications between the care providers and the client [patient]. The idea is ever-evolving to improve the relationship within the context of cultural competence and safety; providers take the time to improve their quality of communication, leading to trusting relationships and improved quality of life*[1].

[1] Marion, L., Douglas, M., Lavin, M., Barr, N., Gazaway, S., Thomas, L., Bickford, C., (November 18, 2016) "Implementing the New ANA Standard 8: Culturally Congruent Practice" *OJIN: The Online Journal of Issues in Nursing* Vol. 22 No. 1.

Figure 1: The Vision for Creating an All Nations Health Care System for the Kenora Region.

Multiple themes emerged and were reinforced throughout the project regarding unique challenges faced by the ANHP in HCCS (figure 2), health priorities faced across all ANHP communities (figure 3) in addition to insights regarding strengths and solutions. Themes and recommendations included in this report focus on the language expressed by community members but ultimately show the need for increased, more efficient services, as the current demand cannot be met to serve the population of the ANHP. As the project progressed, a vision evolved for creating a person-centered model with a seamless coordinated system that is guided by navigational supports for patients to access effective and safe care regardless of where in the region they lived.

Figure 2 Unique challenges faced by ANHP administrators in delivering HCCS

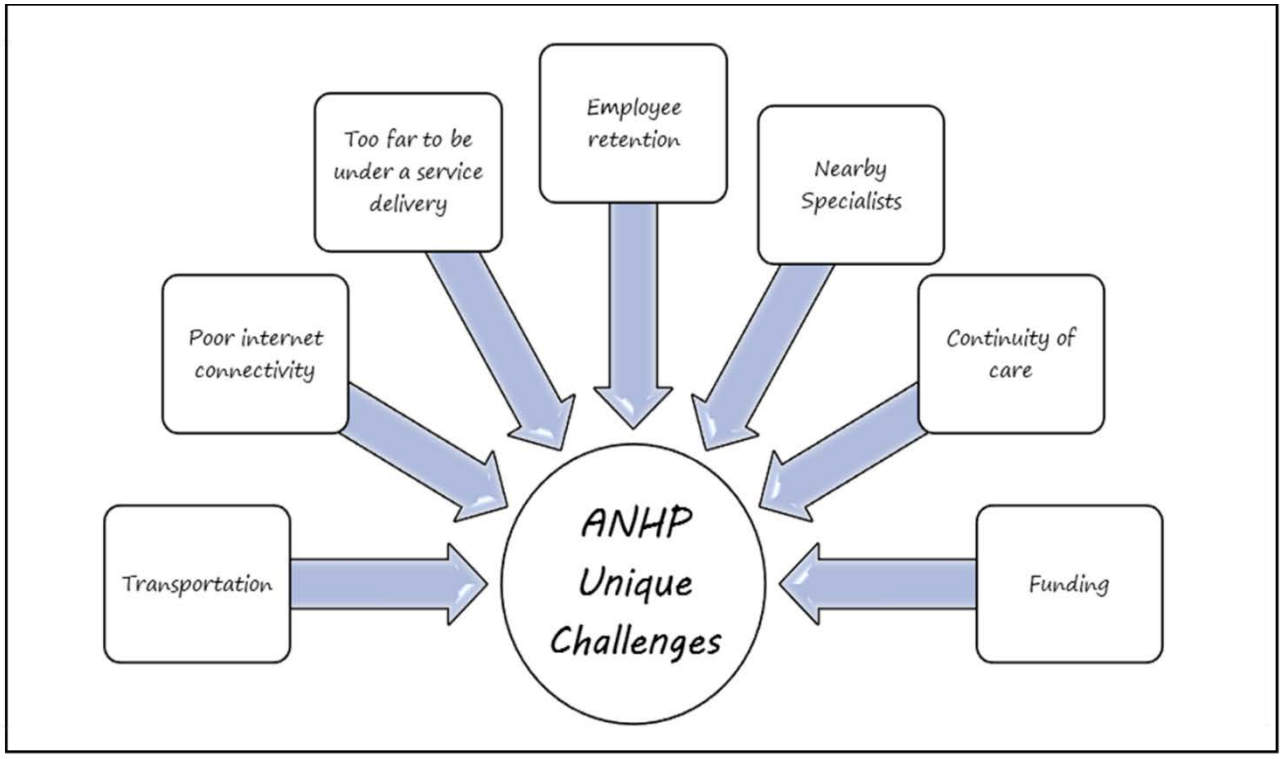
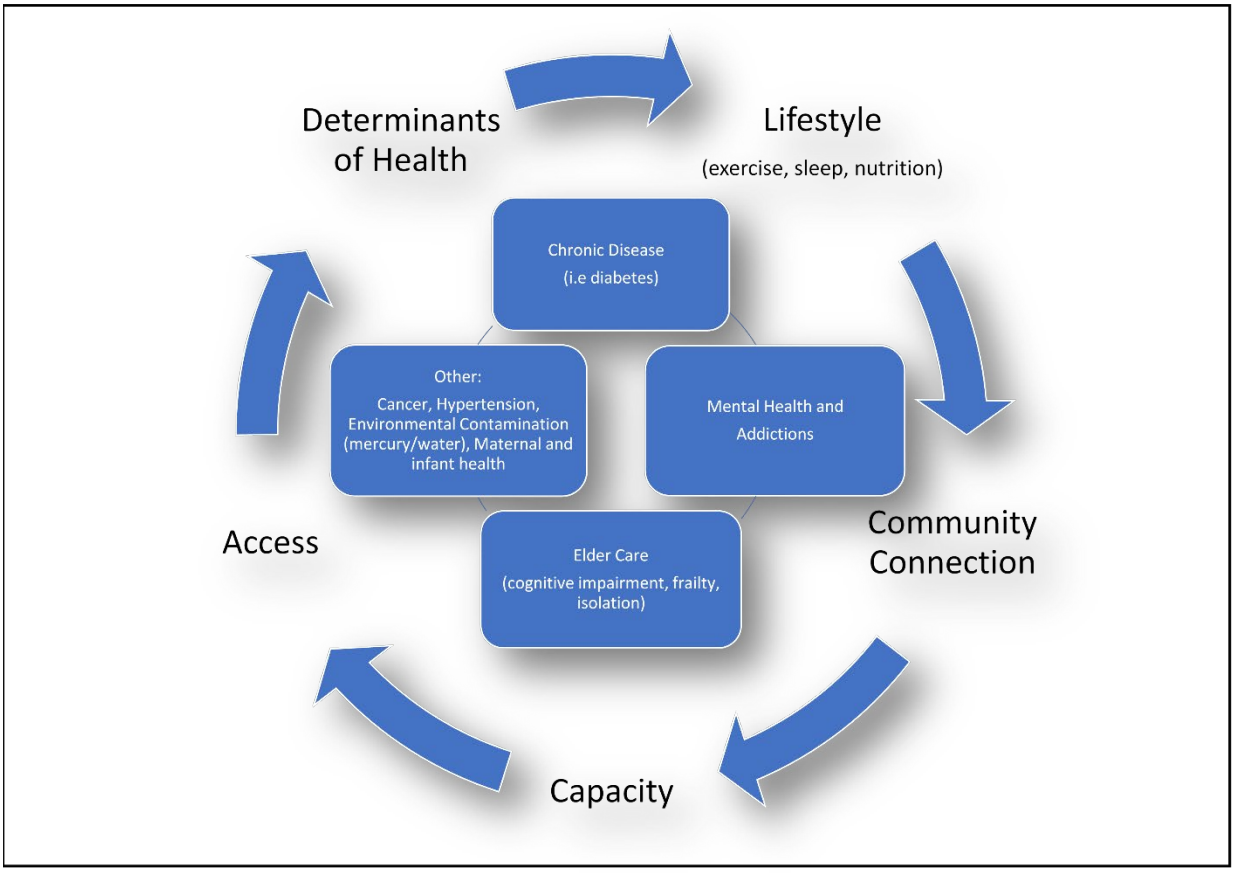


Figure 3 Top Health Priorities from ANHP HCCS Community Engagement 2020



In a co-occurring process to this community engagement work, there were other political and jurisdictional planning processes taking place. This includes the Ontario Health Team formation process, Ontario Health Quadruple Aim to end hallway medicine, launch of Health Quality Ontario's 2020/2021 quality improvement priorities and the planned changes to legislature through Bill 175 – **Connecting People to Home and Community Care Act, 2020**. While being cognizant of the importance and impact of this work, the focus of Phase 1 was on local priorities and solutions and the language and recommendations remaining true to the Voice of the community.

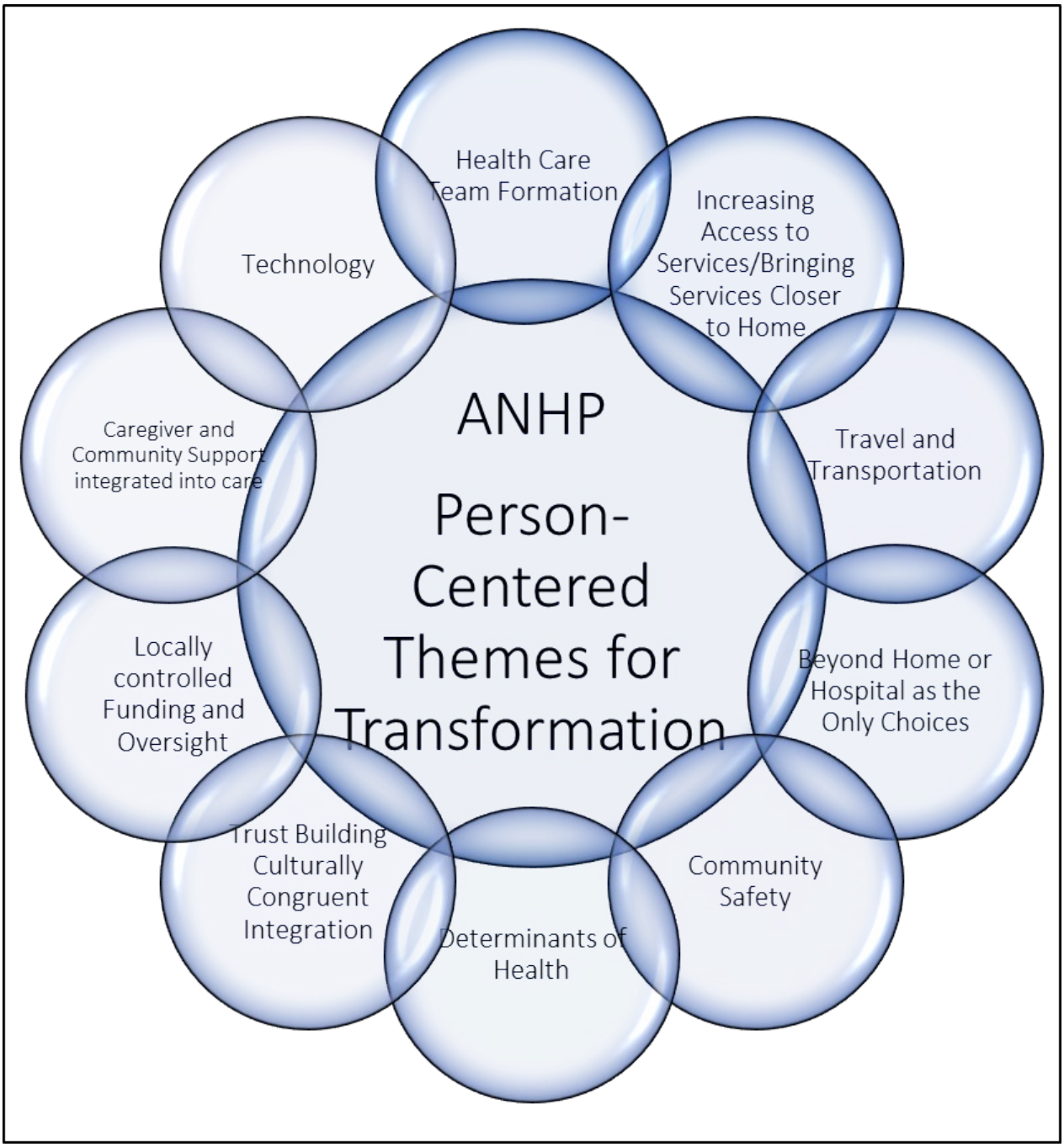
As further work is completed in Phase 2, aligning the Community Voice to ongoing Provincial and other Jurisdictional Priorities will occur, including federally and the ANHP ongoing commitment to remain true to TRC calls to action related to health transformation.

As planning and transformation for a locally operated ANHP HCCS takes place, key health priorities faced by the region should be considered, recognizing that wrap around service delivery focused on the most prevalent health challenges faced by people living in the region will be important in reversing trends and moving toward healthier community outcomes. It is also important to note the unique challenges faced in the region, which must be addressed in order to achieve health equity for the population served.

These challenges are noted in Figure 2. Figure 3 presents the top health priorities as identified by over 140 participants in this study. As highlighted in section 12, there are challenges in validating these priorities with Ontario Health Analytics and other health data sets. At the same time, with data that is available, these are relatively aligned themes with data from Northern Ontario.

Figure 4 highlights the Engagement Themes that evolved when asking where meaningful change was needed.

Figure 4 Engagement themes informing ANHP Home Care and Community services Program



The following were felt to be the top Priorities and recommendations to address the unique needs of the ANHP OHT related to HCCS. Recommendations can be grouped into four practical priority areas:

Communication and Coordination – creating a foundation of trust that front-line teams can work together and ensure all patients will receive the right care at the right time in the right place.

Culturally Congruent System Navigation – creating a simplified, streamlined and informed experience with increased transparency and culturally congruent services.

Transportation Program and Travel Grants – focused on having multi-point access to care with flexible transportation options that are efficient and on-time.

Technology – working toward facilitating improved continuity of care and information sharing that can facilitate bridging remote access challenges and gaps with virtual and digital health opportunities.

Further aligning these priorities to correspond with *key guiding operating principles* that evolved throughout this project. Community-based inputs put emphasis on ensuring design and implementation of the ANHP HCCS System will work collectively in:

- Community-centered and culturally congruent services;
- Health care team formation that values and empowers local recruitment and retention;
- Patients and their families to participate and build capacity to maintain and improve their own health; and
- Building trust and communication amongst all stakeholders, adapting as multidisciplinary teams.

On July 8th 2020, ***Bill 175 Connecting People to Home and Community Care Act*** received Royal Ascent. This legislation looks at removing siloes and removing barriers to home and community care. In order to support the goal of improved community health and well-being and to ensure services meet the unique challenges faced by the ANHP in an equitable manner, community engagement informed the following feedback to the Ministry asking for these aspects of the legislation to be considered:

- *There is an absence of reference to Indigenous communities, Reconciliation, TRC Calls to Action and the reality that OHT's will be creating Home Care and Community Services that are integrated and collaborative with Indigenous partners.*
- *Rigidity of service criteria coupled with lack of collaboration in the past, has resulted in inequitable access and poor health outcomes, especially for rural/remote residents and for First Nation community members (living on and off reserve) – solutions must be contemplated in this Act.*
- *Compliance accountability to meet service standards within the regional context of service delivery needs to be supported locally (Public dollars and regulations need to support local control over services and contracting to local providers who know and understand local geography and client groups is essential over Provincial for-profit organizations).*
- *Equitable Access, Transportation (listed in eligible community support services in 1994 act); and geographic restrictions (Schedule 1 section 4 subsection 23 (2)) – need clear consideration that magnitude of travel, availability of transportation, and geography resulting in inconsistent road/weather conditions is linked to inequitable service delivery for our region (as informed by extensive community engagement).*
- *Technology requires community economic development planning and multi-jurisdictional support/resources in our region if it is to become a corner stone of Ontario Health's changes to legislation.*
- *Mental health and addictions after care is important to add to the list of community support services and integrated delivery system.*
- *Health analytics/evaluation metrics based on local OHT regions need to be supported/resourced to support monitoring, evaluation, enforcement and penalties, and complaints and appeals.*
- *Self-Directed Care: Safeguarding First Nation independence and programs that are working and doing well but build on integrated and connected care to ensure equitable care available across the region*

The full report includes additional details and understanding of the engagement approach with results and community-based recommendations across all themes. It is organized in the following key sections:

- **Recommendations for Improving HCCS in ANHP Region:** This section outlines recommendations and solutions. Solutions are focused on prioritizing changes that were consistently raised and felt by stakeholders to lead to the most impactful transformations toward a community-based integrated HCCS Program.
- **Next Steps:** Includes an understanding of what elements to include for developing and delivering a locally owned HCCS Program. Along with steps on how to better collect and present data for evidence-based prioritization and planning.
- **The ANHP Community:** Providing context for the importance of this project and presenting an overview of the region, its people and other planning processes taking place that are inter-connected to home and community care. This section also describes the methodology and approach to community engagement aimed at gathering meaningful community-based data.
- **Existing Environment:** A substantial effort was made to understand community health priorities, the supply and scope of HCCS services. The intent is to get a full understanding of the current state of service delivery and present a community-based understanding of the health needs and experiences accessing and utilizing available services. Feedback clearly illustrates an understanding of the fundamental connection between determinants of health (often outside the control of the health system but impactful to the community context and outcomes), inequities in service access and challenges in achieving optimal health outcomes (both physical and mental health).
- **Community Voice:** Presenting the themes and key engagement results to provide understanding of lived experiences and insights regarding gaps, barriers, strengths and benefits of existing HCCS service delivery in the region.

It is important to note the Project and its reporting were interrupted by the Covid-19 Global Pandemic. Meaning some stakeholders were unable to participate. Throughout the process adjustment to the approach and methodology were needed due to challenges and multiple pressures on the Working Group and those who were key to engagement. At the same time, the pandemic provided a unique opportunity to experience and see the community-driven strengths of perseverance, flexibility, adaptability and willingness to collaborate and approach things in a different way to make change happen. It's amazing when the locus of control is local, how much can be accomplished through collaboration and partnerships. Many recommendations moving forward has been demonstrated by local community response to Covid-19 putting into action the operating principles of being able to adapt, improvise and overcome the unique geographic and cultural challenges of the region to provide seamless transitions and meet care needs closer to home. While some key stakeholders were unable to participate in the Working Group (Appendix 1 for list of participants), the ANHP is committed to continuing to reach out to them. Providing this report and future reports for their review and input. Emphasizing that this a living, breathing and ongoing process. There is a commitment to ensure the design and delivery of the ANHP HCCS Program and moving forward into future phases of this work,

continuing to reach out to those who may not have had a chance to provide their input during the past months. This is just the beginning.

1 IMPROVING THE PATIENT JOURNEY

The **All Nations Health Partners (ANHP)** created the **Home Care and Community Support Services Working Group (the Working Group)** to identify the needs of the community to improve health and well-being. Through every step during Phase 1 focused on community engagement related to existing **Home Care and Community Services (HCCS)** the Working Group used a co-design approach, working with the communities, administrators, organizational leaders and front-line staff to identify barriers and gaps to promote the health and well-being of the population served by the ANHP.

Insights from Phase 1 show that for the ANHP region, the patient journey to receiving HCCS does not typically meet Provincial standards nor is care consistent.

Validating and testing the themes with Front-line service providers and organizations through a workshop resulted in identifying four key priority areas for locally-drive change. Prioritizing these areas of work in designing local solutions and community-based approaches were identified as having the potential for strongest impact in the creation of an improved, integrated and seamless HCCS program.

Participants shared a vision for creating a person-centered model where referrals may come from a multitude of service providers but all lead to a seamless coordinated system guided by navigational supports for patients to feel they are being listened to and their needs are safely being met. Achieving better integration of federally and provincially funded programs with accountability and oversight locally managed is the primary recommendation to come from this Phase 1 analysis. Figure 5 highlights Key priority areas identified in phase 1, where recommendations for adjusting services to reflect the needs of the community would create meaningful positive change.

What became increasingly evident throughout community engagement was how the ANHP region is unique within the Northwest Ontario region. HCCS should continue to be informed by local expertise at every level of design, delivery and evaluation, including the following key themes for all aspects of ANHP System planning:

- People-centered care with equitable access can only be achieved if the unique living conditions and geography are part of consideration in planning. The movement of people and supplies is challenging on a regular basis (expensive and interrupted due to weather). Approximately 53% of year-round residents' lives in rural areas with a weak link to an urban centre and 20% live in remote regions[2]
- Deficiencies in determinants of health are a large barrier to achieving quality service delivery. Unsafe and crowded housing, road infrastructure, access to adequate nutrition and social support networks of those living remotely directly impact the ability to deliver services.
- Developing dedicated and consistent health care human resources requires a local approach for recruitment and retention to build local capacity and skills (those familiar with the challenges of

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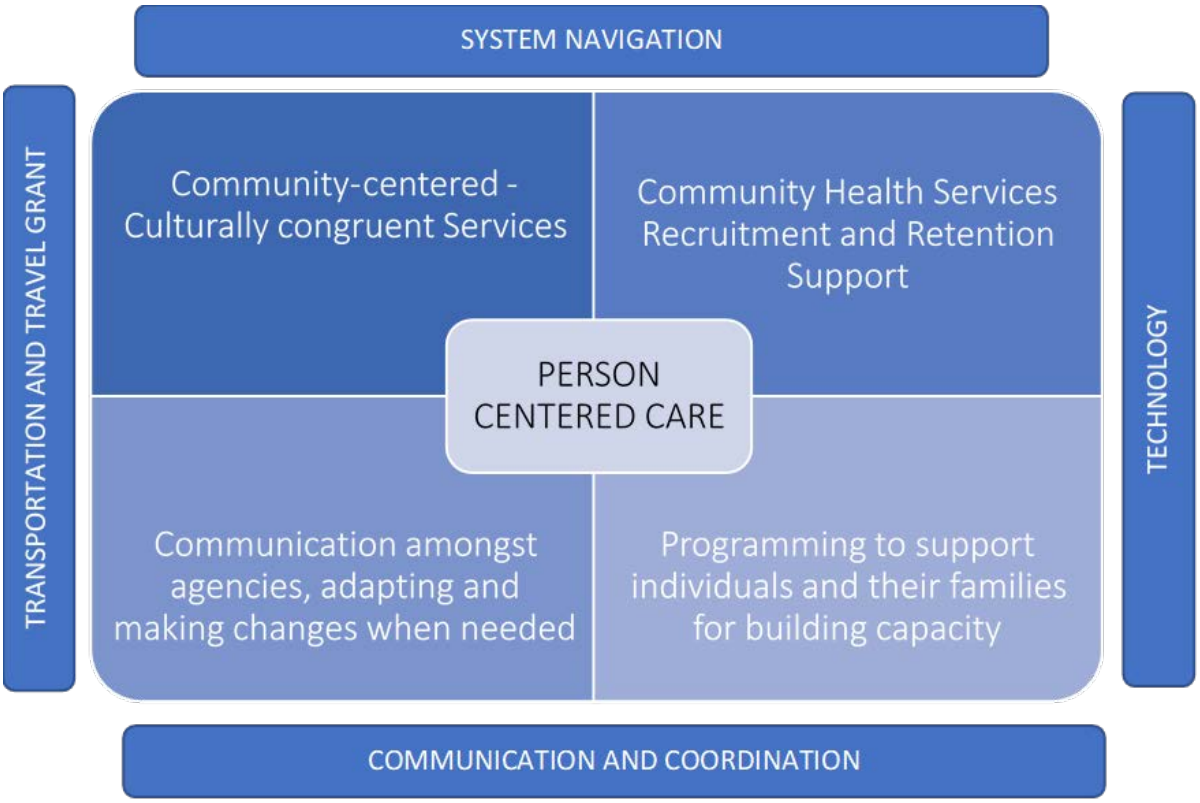
the geography and weather are more likely to want to live and work in the region on an ongoing basis).

- Some of the biggest barriers to expanding choice and options for improving protected and consistent accessibility to service delivery require strong political and community development planning in terms of improved infrastructure in connectivity, roads and housing.
- Evidence-based planning means developing and analysis of population characteristics and health analytics for the ANHP residents to understand the current and future health context of residents living in the service area. It is likely that the analytics showing higher rates of mental health and addictions, chronic disease and premature deaths are even higher within this service area demonstrating need to reconsider what priorities are for developing essential services.

Figure 5 Key Priority Recommendations for Local Home Care and Community Services Delivery



As defined in the Executive Summary, **culturally congruent** care refers to the ever-evolving process of establishing trust and effective communications between the care providers and the client (patient or consumer). Encompassing the concepts of cultural safety and cultural competence within the definition but adds the dimension of on-going reciprocity and building trust to improve quality of communications aimed at person-centered care. This is about encompassing respect for what the patient and family needs and wants for their care (it should include ensuring clients and their family feel spiritually, emotionally, socially and physically safe and encompass respect for both traditional and Christian practices).

The onset of the global Covid-19 Pandemic crisis during this project shed light on specific strengths and notable shortfalls in service delivery. In terms of strengths, the ANHP have demonstrated local response can result in creative, flexible, adaptable and quick responses to urgent needs. Locally driven coordination and integration of services and information sharing advanced considerably during the time of crisis: Multiple providers with overlapping responsibilities and differing mandates, policies and programs pulled together locally driven partnership to achieve flexible and responsive solutions in a timely and effective way. While the state of emergency allowed regulatory and public funding authorities to remove bureaucratic red tape; the ANHP did not disappoint in being able to successfully and quickly open a vulnerable persons Isolation Centre, rapid mobile Covid-19 testing units, adequate response to increase hospital, seniors and long-term care beds across several sites and collaborative digital health information sharing are just a few examples.

During Covid-19 early response and planning for additional waves this fall emphasized the following shortfalls within local delivery of Home Care and Community Supports:

- The loss of Kenora's single hospice care bed to allow for covid-19 capacity and response within the Pinecrest Home for the Aged shed light on the deficiencies within palliative care and hospice care across the region. Choices and coordination continue to be inconsistent and inequitable cross the region and there is a lack of trust for palliative care and end of life care choices to be made consistently available in a timely manner to those who would most benefit from these services. During the Steering Committee review this brought up a renewed interest in emphasizing the importance to have available dedicated and protected resources in the system to make it possible to get extended care needed to make it comfortable for hospice care within community and facilities.
- Mental health and addictions are in crisis within the region. Additional waves of Covid-19 lockdown reverting back to limiting access and providing only virtual care is not sustainable and will place an unprecedented burden on the emergency response system. Creative and community-based solutions need to be prioritized and added to essential services.
- Community Support services for integrated community participation with those experiencing developmental challenges need to be valued as integral part of the health system and a priority for adding to integrated enhanced service delivery.

1.1 KEY RECOMMENDATIONS

Building on the Key Priorities highlighted in Figure 5, recommendations are grouped into four practical priority areas (repeated from Executive Summary):

Communication and Coordination – creating a foundation of trust that front-line teams can work together and ensure all patients will receive the right care at the right time in the right place.

Culturally Congruent System Navigation – creating a simplified, streamlined and informed experience with increased transparency and culturally congruent services.

Transportation Program and Travel Grants – focused on having multi-point access to care with flexible transportation options that are efficient and on-time.

Technology – working toward facilitating improved continuity of care and information sharing that can facilitate bridging remote access challenges and gaps with virtual and digital health opportunities.

Further aligning these priorities to correspond with *key guiding operating principles* ensuring design and implementation of the ANHP HCCS System is working collectively for:

- Community-centered and culturally congruent services;
- Health care team formation that values and empowers local recruitment and retention;
- Patients and their families to participate and build capacity to maintain and improve their own health; and
- Building trust and communication amongst agencies, adapting as integrated and multidisciplinary teams.

In line with Ending Hallway Medicine and the OHT aims, the community engagement from this project provides a strong narrative for the value of locally driven framework development with system governance and implementation of service delivery run by those with intimate knowledge of the local conditions. The geography, weather and way of life associated with living in this region draws a population who live under conditions not often experienced in urban centres, this reality needs to be part of the planning. The following provides further details learned throughout Phase 1 to consider in Phase 2 of implementing these recommendations.

1.1.1 Communication and Coordination

The foundation of this theme is building trust in relationships and coordinating a system to safeguard the care needed by a patient whether they live remotely or within an urban centre. Currently multiple providers (private and public) with overlapping responsibilities and differing mandates and goals and objectives result in a complex, often inefficient system with a degree of overlap as well as gaps in provision of services. A greater local control over services (i.e. contracting with local providers who know and understand the local geography, client group and other organization services available) will support confidence in having dedicated, protected and consistently accessible resources integrated into a seamless delivery model. This will take commitment for ongoing and strengthening communication and coordination amongst local providers.

Regardless of point of entry by a person needing care, anyone involved in HCCS locally should be able to support a coordinated effort to maximize available resources in creating a path of healing at home without restrictions and barriers due to jurisdictional boundaries or organizational silos. This means care team members, regardless of their training and roles within their home organization, are fully familiar with the ANHP regions challenges and resources, able to connect to the correct referrals and are empowered to find patient-centered solutions locally. Communication and Coordination would be locally based to consistently find resources available to patients and their families and to ensure referrals and follow-ups take place for the care needed by the patient, regardless of where they live in the region (on-reserve or off-reserve or in an urban center or remotely). Coordination would also have to transcend federal and provincial jurisdictions in a system that currently does not have resources committed to integrating for patient-centered discharge from hospital or referral from urban organizations back to First Nation communities. The theme could be described as creating a fully integrated system around a culture of sharing information and building coordinated pathways across services.

1.1.2 Culturally Congruent System Navigation

Many themes relate back to fear and inconsistent care which could be reconciled and improved through building relationships with patients and families so they feel respected and safe. This includes recognizing the historical, traditional and cultural story of patients. This theme was unanimous in the need for creating an equitable system that places value on the patient-provider relationship working together to offering cultural support and navigating HCCS services, particularly from Hospital to Home. High value was placed on the roles of system navigators, cultural coordinators, traditional healers, translators and spiritual connections (traditional and Christian) who can support families and community care providers in delivering seamless coordination for culturally safe point of entry, assessment, care, transition and long-term ongoing support.

Throughout the engagement process, both in person and through the Inventory of Services survey the need for policies for integration of Provincial and Federal resources was identified as key to providing and increasing equitable service delivery across the region. It became evident that creating a system that could collaborate and bring together the funding and services provided through Provincial and Federal pathways would increase equity and provide the opportunity to improve conditions of care across the continuum. Providing cultural congruent system navigation (cultural coordinators and system navigators) was particularly relevant to overcoming issues linked to systemic trauma and the high incidence of mental health and addictions in the region. This theme transcends all of health care transformation in order for all residents to confidently move through their journey toward optimal and equitable health outcomes compared to their southern counterparts.

Beyond improving the gaps between Federal and Provincial funded programs and considering Indigenous Cultural safety, the term cultural congruence was utilized because it applies to all community members within the catchment as many non-Indigenous members living rurally (with a weak link to an urban centre) also need to trust they will be supported to navigate and access care dedicated and safeguarded to be delivered consistently to support the best health outcomes available for their situation. Local control with local providers who know and understand the geography and client groups are best suited to build trusting relationships to maximize opportunities in receiving quality care in their home and in community.

1.1.3 Transportation and Travel:

Equitable access is a key theme for all areas of health care system delivery. However, when it relates to HCCS there was a unanimous agreement the most impactful change to create more equitable access may be through reimagining and redesigning of programs around transportation, travel and technology.

At every level of care travel and transportation challenges are perceived as key to inconsistent supports (from health care team recruitment and retention in remote communities, patient safety to maneuver through poor infrastructure/housing conditions to family caregivers and patient's ability to get timely transportation to medical and community care and follow-up appointments). There is a need to reimagine how travel and transport is provided and compensated. Transforming the system to one with depth and alternatives through technology,

when available, for consistent and improved patient-centered care is essential to meet the challenges of the unique geography faced by patients and caregivers without compromising the importance of in-person care. This is true for all who receive care and especially for those living in unorganized territory and on-reserve (remote or rural areas with weak links to Kenora).

One strength to build further is the use of Kenora District Services Board Emergency Response Coordination and Road Ambulance supports. Expanding the EMS as an integrated and valuable tool for wellness checks, Mental Health and Addictions supports and as part of community support services to fill a gap with after hour situations that otherwise put patients at risk for re-admission into hospital and deteriorating their health.

1.1.4 Technology and Digital Health

Interestingly, technology may not have been at forefront of solutions raised through community engagement, likely because the available connectivity in the region is inconsistent and where improvements have been made past experience limits trust in technology and quality of provider care when facilitated virtually. However, with the onset of Covid-19 much work has been done to improve connectivity and build awareness around the utilization of technology and virtual connections to maintain care and planning. There was considerable value placed on improving the use of digital health as a way to augment in-person care and improve interdisciplinary care coordination with an equal amount of caution and concern that technology does not replace in-person care.

Administrators see benefit and value to find ways for digital health opportunities to improve consistency in available care and see innovative, more connected tools for frontline providers as a great safety net and support, especially off-setting gaps related to limited specialized services in geographically distanced communities and when services are interrupted due to bad travel days. Results from the Inventory Survey support the need to invest in IT solutions.

1.2 LEGISLATION AND POLICY

On July 8, 2020, Bill 175 (**An Act to amend and repeal various Acts respecting home care and community services**) received Royal Assent. The short title of this Act is now to be known as, **Connecting People to Home and Community Care Act, 2020**.

This is meant to replace The Home and Community Care Act (1994) where the following deficiencies have been recognized:

- **Rigid care coordination:** Decisions about patient care are often made away from frontline care.
- **Siloed care:** Patients often interact with home care separately from primary and hospital care, which often includes multiple assessments leading to delays in care.
- **Restrictive care plans:** Patients have care plans with a set number of hours or visits with service maximums that can curtail care.

1.2.1 Goals of New Legislation

- **Make it easier for people to access** home and community care in hospital, primary care or community settings. Hospitals and primary care settings and others will be able to arrange home

care directly for patients, instead of referring people to a separate home care organization. Doing so will reduce administration and transitions for patients.

- Help people **connect with their care providers** through secure video conferencing and remote monitoring devices. People with chronic conditions will be monitored at home, with a nurse checking in as needed. Nurses or therapists can use video conferencing to work with a personal support worker in the home to provide more specialized care.
- **Provide more choice** for people with high care needs to get care in new community settings. People will be discharged from hospital into a transitional care setting to gain strength and functionality to return home.
- **Keep people healthier at home** by empowering care teams to work together. Enabling frontline care providers to make more decisions about care, integrating home care into primary care and acute care, and breaking barriers to access to information will create teams that work together to support patients.

1.2.2 ANHP Comments on Proposed Changes

Leadership from the ANHP team has stayed active and engaged in the Ministry of Health process and has provided feedback pertaining to the Act. For the most part the changes to legislation were welcomed and align with ANHP goals and vision.

However, there were some concern as to whether interpretation or wording could create unintended consequences or barriers. This feedback was communicated in and email exchange (May 8 and May 11) to the Ministry of Health with a goal of enhancing opportunities and creating pathways for better integration and equitable access.

It is important the ANHP feels confident that legislation supports and empowers the OHT to take over HCCSS according to their guiding principles and can have oversight and hold accountable any Private service providers who are contracted with the use of public funds under the public legislation and policies in place.

Some of the key points expressed were:

- ***There is an absence of reference to Indigenous communities, Reconciliation, TRC Calls to Action and the reality that OHT's will be creating Home Care and Community Services that are integrated and collaborative with Indigenous partners.***
- ***Rigidity of service criteria coupled with lack of collaboration in the past, has resulted in inequitable access and poor health outcomes, for First Nation community members (living on and off reserve) – solutions must be contemplated in this Act.***
- ***Compliance accountability to meet service standards within the regional context of service delivery needs to be supported locally.***
- ***Equitable Access, Transportation (listed in eligible community support services in 1994 act); and geographic restrictions (Schedule 1 section 4 subsection 23 (2)) – need clear consideration that magnitude of travel, availability of transportation and geographic location is linked to inequitable service delivery for our region (as informed by extensive community engagement).***
- ***Technology requires support/resources in our region if it is to become a corner stone of Ontario Health's changes to legislation.***

- ***Mental health and addictions after care is important to add to the list of community support services and integrated delivery system.***
- ***Health analytics/evaluation metrics based on local OHT regions need to be supported/resourced to support monitoring, evaluation, enforcement and penalties, and complaints and appeals.***
- ***Self-Directed Care: Safeguarding First Nation independence and programs that are working and doing well but build on integrated and connected care to ensure equitable care available across the region***

2 NEXT STEPS: PHASE 2

Ultimately, the recommendations and results from the Inventory of Services Survey (ISS) assess the total health human resources and speaks to the additional funding needs to meet the key priority recommendations. Specifically, results demonstrate the systemic underfunding of the region based on formulas and approaches of service delivery that do not consider the unique challenges of the region and the needed solutions. There was very little evidence that there is a duplication of resources, however, there are multiple providers that result in a complex, often inefficient system with overlap as well as gaps in provision of HCCS. There is an opportunity to coordinate and create more effective and efficient pathways of support to all community members. The ANHP OHT presents an opportunity to create an integrated, locally governed and accountable plan for delivery HCCS to ANHP area residents which uses local expertise to adapt and create flexible solutions in short-time frames to protect consistency and a standard of care available to other Canadians (i.e. adapt to weather conditions, specialists detained/retention challenges, travel restrictions).

The Ministry's use of the Quadruple Aim to Ending Hallway Medicine calls to break down silos and find resource duplications to redistribute resources across the system. This study demonstrates that there is not a duplication of front-line staff, there is a shortage. Add to the pronounced shortage and difficulty in recruitment and retention of essential front-line HCCS service providers due to the unique barriers faced by ANHP region. Although not within the scope of HCCS, shortages in supportive housing and long-term care beds, palliative care/hospice infrastructure should be considered a major barrier and that coordinating with the KDSB and MOHLTC to create better access, improve these gaps and integrated solutions is needed. Assessments and qualifying for Home Care can only happen if there is infrastructure to facilitate along the continuum of care.

There were several areas identified for improved coordination that would lead to better efficiency and use of existing resources to better meet patient needs. What is evident, is the need for additional resources to meet a reasonable standard of care currently not met within existing funding models, for instance the needed infrastructure for dealing with a large remote population (i.e. transportation and technology), fair wages for being trained and retained within this unique geography and additional locally driven recruitment and retention including resources toward system navigation and coordination across Federal and Provincial systems.

2.1 Developing a Service Delivery Plan

While this report focused on community voice, the next phase must bring together community voice, system experts, existing and changing legislation and policy, and funding bodies to create integration framework agreements and enlist support and Partnership commitment to:

- Developing locally based health human resources needed to implement seamless delivery that can reach all boundaries of the region and all priority populations currently experiencing majority of the gaps in service delivery (i.e. elderly population living remotely, those with developmental needs requiring unique services, specialty enhanced services for integrated community living, First Nation members living on and off reserve)
- Build an effective Home and Community Care Program
- Provide services that meet the health priority needs of community members
- Ensure services can be provided in a manner that they make sense to the patient situation and for as long as they are needed
- Establish health analytics and evaluation and review process for making the program better as the ANHP OHT matures
- Allow First Nations to offer their own services on reserve and also be empowered to partner, integrate and access improved services through the ANHP OHT delivery of services. Furthermore, obligations of Canada to Treaty and Aboriginal Rights to be incorporated and maintained.

The following outlines components for planning the development of a new service delivery model and integrate the management of HCCS into the ANHP OHT services they deliver. The components are adapted based on review of Phase 1, Health Canada's Handbook for First nations planning and developing a Home and Community Care Program (2000, Minister of Public Works and Government Services Canada) and the International Health Facility Guidelines for Service Plan Development Process (http://healthfacilityguidelines.com)

2.1.1 Defining Project Partnerships and Development Process:

Establishing organizational roles and responsibilities for development, implementation and evaluation of ANHP OHT HCCS delivery. Define decision-makers, their level of commitment to creating a community-driven process and outlining the decision-making process (perhaps using tools to stage the transfer of authority and programs through MOU, Agreement in Principles and finally Integration Agreements). Include roles and responsibilities:

1. **Decision-making body:** Funding Bodies, Jurisdictional and ANHP leadership (ANHP OHT Leadership, Ministry of Health and Long-Term Care, Indigenous Services Canada, Home and Community Care North West LHIN)
2. **Planning Oversight:** Steering Committee (the Working Group) and Project Planning Team (contracted or formed based on recommendations from the Working Group)
3. **Stakeholder Service Organization and User Groups:** Service organizations, patient care teams, First Nation community coordinators, Metis Nation advisor, local residents

2.1.2 Communicating Results of Phase 1

Present and discuss with Project Partners and decision-making bodies the insights and key recommendations from Phase 1 to inform the next steps in service plan development process:

1. Community-based insights on current and needed scope of services. This includes results relaying health priorities, key gaps and opportunities and reviewing scope of services across the region)
2. Context and Catchment identification. This includes:
    a. review of relevant policies, regulations, guidelines, practice standards and broader stakeholder organizational goals
    b. review of the supply/location of services and the proximity of the population who are to use the HCCS
3. Gaps in available data (especially regarding health analytics and digital health)

2.1.3 Identifying and comparing potential service models

Compare and gain system expert input to Phase 1 insights to review and evaluate options for addressing the gaps and priorities, identify potential service model options and compare and assess best fit for ANHP OHT. Continue with pursuing additional information needs especially as it relates to health data analytic requests for the ANHP Catchment.

2.1.4 Setting Goals and Objectives for the Service Model Plan

Identify, verify and validate the required changes to service capacity and create goals/benchmarks that reflect the program purpose and priorities:

1. Identify the scope of the delivery model, specifically naming the services that will be provided across the continuum of HCCS programming. Consider the following:
    a. The services that will be provided
    b. Other supports, and activities that are connected to other service delivery models
    c. How will barriers be addressed
    d. Strategies used to deliver services
    e. How First Nation communities will be incorporated and integrated into the service delivery model and still maintain autonomy of their ISC components of care
    f. How to connect to regional recruitment and retention
    g. How to engage community on an ongoing basis
    h. The audience for the plan
2. Prioritize the needs in order to plan maximum impact and meaningful change within realistic timeframes.
3. Define the Goals and objectives for how the delivery model will meet the needs and create good outcomes on the health of community members.

2.1.5 Develop an ANHP Service Model Profile

Translate the goals, objectives, partnerships into a preferred service model including a service profile by quantifying the physical, Health Care Team HR needs and system requirements to put into place:

1. Essential Services (to be implemented first and prior to expanding the continuum of care)
    a. Program Management and Supervision
    b. Managed Care: Case Management and referrals and linkages
    c. Client Assessment

d. Home Care Nursing
e. Home Support Services: Personal Care and Home Management
f. In-Home Respite Services
g. Medical Supplies and Equipment
h. Information and Data Collection

Consider adding to essential services: palliative care (hospice facilities), mental health and addictions services (psychiatry, traditional counselling, healing services, medication monitoring) and cultural system navigation services.

2. Enhanced Services and Integrated Care Components:
    a. Rehabilitation and therapy services
    b. Adult day programs for seniors
    c. Community integration services for those with developmental needs
    d. Specialized services to maintain independent living (for examples: special transportation needs, grocery shopping, accessing specialized services, interpretive services, therapeutic bath)
    e. Palliative care services
    f. Social services
    g. Specialized cultural programming, health promotion, wellness and fitness

2.1.6 Identify Needs for Operations and Sustainability

Define the functional requirements for operation of the services. Includes documentation of staffing needs according to hours and type of operation, HR planning and management structure where relevant and collaboration processes. Consider:

1. Locations/physical and virtual infrastructure
2. Hours of operation
3. Legislation and policy
4. Service, Staff and organizational structure (how will the services be integrated/formal lines of authority between managers/staff across the partnering organizations) including:
    a. Training/communications – change management for team formation
    b. Recruitment and retention planning
    c. Connection to other services working within care plans

2.1.7 Partnership and Relationship Diagram

Define and visualize the relationships between each service delivery area and each support area. Define and align to understand the links between aspects of a complex system and what specifically falls within the fiduciary responsibility of HCCS versus the commitment to integrate and collaborate with other responsible authorities to achieve goals and objectives for better outcomes. Special consideration for the linkages to integrate for better services include:

1. Work toward MOUs and partnerships that will start to build the coordinated health human resource pool and administration of seamless delivery. Ultimately these MOU's will lead to some form of the Integrated Framework and transition implementation.
2. With the commitment by the ANHP OHT to demonstrate reconciliation in action consider validating and incorporating cultural/traditional governance models within oversight.
3. With Private sector to hold accountable to the service delivery mandates.

4. With KDSB and MOHLTC for addressing the shortage in assistive and supportive housing and long-term care beds so options along the continuum of care can be provided.
5. With Health Analytics to create a local understanding of population trends and health needs and priorities.

2.1.8 Financial Assessment and Budget

Finance representatives and other persons with authority to affect monetary resources need to be involved in planning to facilitate a budget that will overcome the barriers and empower the solutions. This process must allow for the substantive and incremental changes and prioritization of fiscal decisions. Developing a budget looks at Operations factors (staff, purchasing supplies and equipment, maintenance), new capital needed (planning services, construction or redesign of space, equipment and service delivery goods/equipment/supplies, major delivery infrastructure such as transportation vehicles and IT/Digital implementation). Identifying where savings and additional costs are needed.

2.1.9 Evaluation and Monitoring

Establish the local catchment data needs for performance indicators, evaluation and monitoring structures to be in place. Emphasis on creating evidence-based and community driven improvements on an ongoing basis. Monitor and track indicators to enhance benefits and mitigate negative effects.

2.2 Planning Evaluation Early and Getting the Right Data

It is important to support evidence-based planning for equitable health outcomes in ANHP community members. On July 24, 2020, the following statement was publicly released:

> *CIHI is releasing a discussion document with proposed standards for collecting race-based and Indigenous identity data in health care. The discussion document also includes considerations to mitigate the risks of harm. This work has been informed by a review of the research, a scan of existing data standards, and engagement with clinicians, researchers, organizations representing Indigenous and other racialized groups, and representatives from governments and health systems.*
>
> *With international evidence that racialized communities have experienced disproportionate morbidity and mortality associated with COVID-19, there has been an increased awareness of the need to report racial health inequalities and understand the impacts of racism.*
>
> *More community engagement is needed to inform a pan-Canadian standard. CIHI is also seeking feedback to better understand perspectives on the collection and use of race-based, ethnic and/or Indigenous identity data in Canada's health systems.*

Phase 1 embarked in understanding what data did exist; the expansive data sets that are available for the north western Ontario region are not reflective of the unique ANHP catchment. Existing data sets do not accurately capture data from the 10 surrounding First Nations and many living in unorganized territories, as a result data from the larger urban centers skew results and true disparities within the ANHP communities are not accurately reflected. It is recommended that Phase 2 include the ANHP to

undertake a Comprehensive Health Assessment which would help inform the Working Group. This assessment would also inform all aspects of health reform being considered.

Key recommendations focus on enhanced data access, capacity and collection, including:

- The model should be developed and supported by ANHP stakeholders and include both enhanced pathways to administrative data sets but investment in community surveys to "reality check" the RHS (on-reserve) survey data as well as the CCHS (off-reserve) survey data as there may be little coverage of the communities within the ANHP catchments area.
- Recommendation to work with Health Analytics Branch to re-run the expansive data set provided to capture as close to possible the actual population of the ANHP catchment area (closer to 45,000 residents).
- Work collectively with the ANHP Digital Health Working Group to work toward a process to disaggregate the First Nations communities' utilization, determinants and outcomes from the non-First Nations. Otherwise the city of Kenora data will continue to skew the results and the averages may not accurately reflect true disparities within ANHP communities.
- Work with cross-border related health appointments and hospital stays data will further enhance a true picture of metrics that offer insight to how HCCS services and care plans are successfully keeping people at home.

3 PROJECT SCOPE AND APPROACH

The All Nations Health Partners is a regional, community-focused group of members established and expanded years before the inception of the Ontario Health Teams. It is based on grassroot/community initiatives to address the critical systemic healthcare needs in the area. The ANHP was pleased to enter the process of becoming an Ontario Health Team, and are hopeful in the Ministry's commitment to empower the ANHP in maintaining their vision to be community-driven. As such, the work in this report reflects the voice and language of the countless people who participated. Recognizing that key themes and recommendations will ultimately feed into a system framework aligning with the priorities set out in other jurisdictional process for transforming Home Care and Community Services such as: the Quadruple Aim and Health Quality Ontario Priorities, legislative changes to Bill 175, *Connecting People to Home and Community Care Act, 2020* as well as the Health Transformation Process of Grand Council Treaty #3. The language and focus for this report will stay true to the voice of the people who contributed.

The ANHP Home Care and Community Support Services Working Group (the 'Working Group') was formed in January 2020 to guide the process of creating a more harmonized and accessible network of health services within Home Care and Community Support Services. The Working Group identified two phases of preliminary work to ensure a community-based approach was maintained as planning for the transfer of Home and Community Care Services takes place from the North West LHIN to the ANHP OHT:

- **Phase 1** focused on gathering information from local expertise and community experiences to understand the current supply, needs and gaps related to HCCS provided in the ANHP catchment area (including and understanding of the Federal, Provincial and Private landscape).
- **Phase 2** will focus on taking information from Phase 1 to develop and recommend a services delivery model along with a proposed transition plan to implement meaningful change.

3.1 The ANHP Region

The ANHP region includes the urban and rural communities of Kenora and Sioux Narrows-Nestor Falls, local First Nations, Kenora Metis and the region has a year-round population of approximately 45,000. This does not include seasonal residents which can add pressures on acute and primary care potentially having indirect effects on HCCS. More than one-third of the population is Indigenous and nearly 17% of the population speak Ojibway, Oji-Cree or Cree as their mother tongue. Over half of the population lives in rural areas or on reserve (ANHP Visioning Brief, 2019).

In the ANHP OHT Submission, the Partners specifically identify the need to do better addressing the great health disparities leading to current poor health outcomes of the Indigenous members of the region.

> *Members of the ANHP recognize the unique healthcare needs of Indigenous communities and complexity of health needs encountered. In these predominately young and rapidly growing populations, the trends point towards a future of dramatically increased chronic disease.* ***From a recent report on KCA communities, 70% of all deaths among community members were noted to occur before the age of retirement (65 years old) compared to rest of Ontario (22%).***
>
> *The partners recognize the impact of colonialism, racism, social exclusion and lack of meaningful engagement that have an effect on the health of Indigenous people (i.e. historical trauma, catchment area had a high concentration of residential schools, socio-economic disparity, and significantly worse health status/outcomes). These factors are responsible for the socio-economic inequities combined with neglect and fragmented services of the historically uncoordinated federal, provincial, and regional health care systems. While recognizing these challenges, these communities have great strength and resilience having faced these challenges throughout time. Indigenous communities have shown the ability to thrive by restoring and promoting Indigenous identity, keeping cultures and languages alive and promoting self-governance. All these factors have positive effects on community health and well-being. The ANHP was formed based on these strengths and through direct engagement and partnership with and for the Indigenous leadership, organizations, and communities. Throughout the course of maturation of the OHT, the partners will be engaging and delivering services with and for Indigenous communities.*

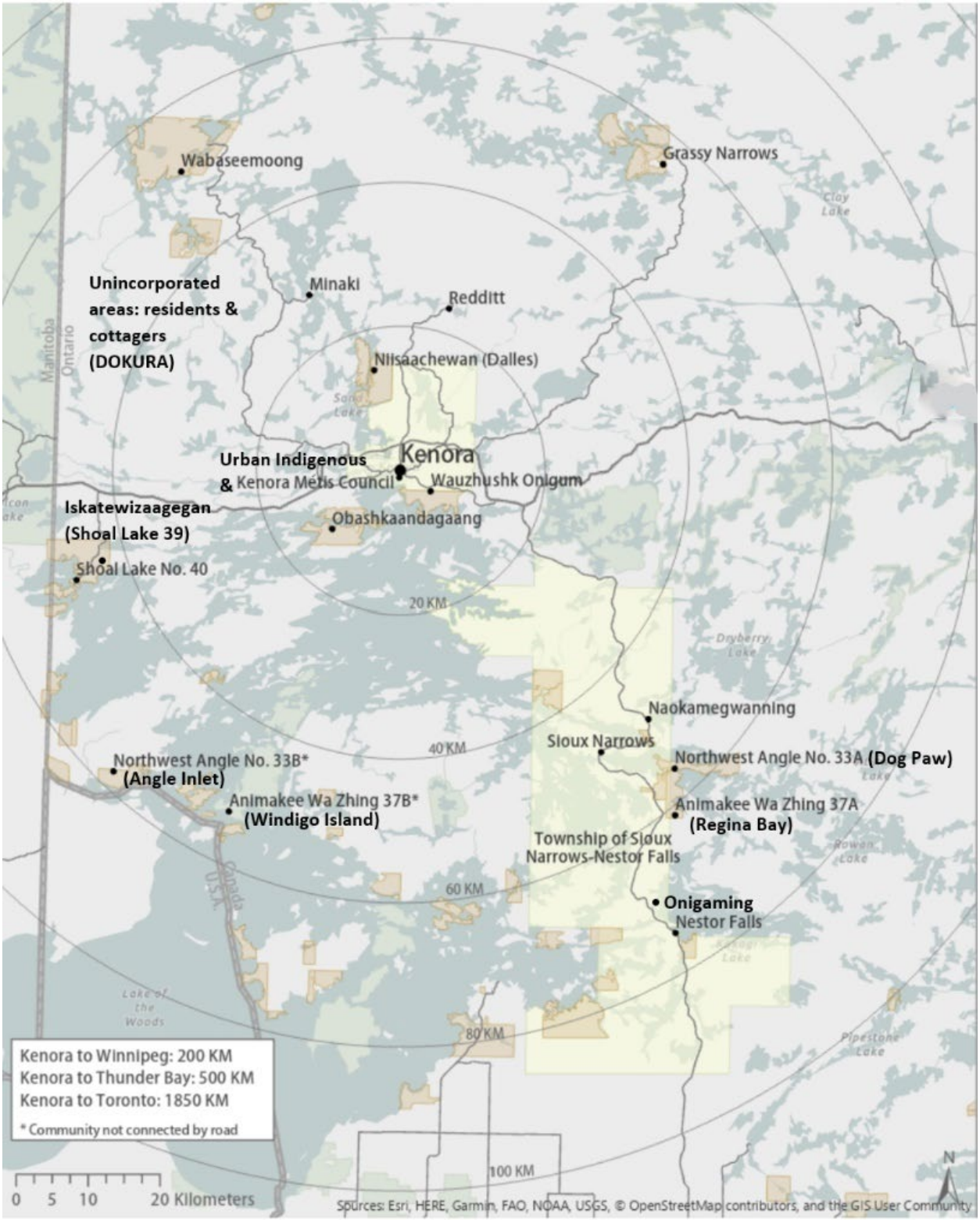
Table 1 provides an overview of the populations of all communities served by Kenora and the driving distance to the Lake of the Woods District Hospital (LWDH). Figure 6 is a map of the ANHP OHT region which illustrates the vast distance and remoteness of some regions with a weak link to an urban center. There are 10 First Nations with a total of 12 Reserve communities. Some communities do not have year-round road access and several communities do not have reliable cell or affordable high-speed internet connectivity.

Table 1 ANHP Community Populations and Driving Distance to Kenora LWDH (Hospital)*

First Nations Communities	Population			
	Total	On reserve	Off reserve	KM (return LWDH)
Wauzhushk Onigum (Rat Portage)	777	383	394	10
Obashkaandagaang (Wash Bay)	329	173	156	25
Niisaachewan (Dalles)	465	185	280	45
Shoal Lake 40	646	302	344	165
Iskatewizaagegan (Shoal Lake 39)	652	361	291	160
Wabaseemoong (Whitedog)	1,985	996	989	225
Asubpeechoseewagong (Grassy Narrows)	1,597	1,018	579	205
Naotkamegwanning (Whitefish Bay)	1,282	781	501	180
Animakee Wa Zhing 37A	592	404	188	180
Animakee Wa Zhing 37B				375
Northwest Angle 33A	556	221	335	192
Northwest Angle 33B				416
Other Communities	Population	Summer Population		KM (return LWDH)
Sioux Narrows	600	Estimated additional 15,000		150
Nestor Falls				240
Minaki	175			110
Reddit	150			60
City of Kenora	15,100			-

*Modified from ANHP Visioning Brief, 2019.

Figure 6 Map of ANHP OHT Region (Year 1)



3.2 The System Context

The Ministry of Ontario Health is planning to end hallway health care. Changing the way home and community care is delivered is essential in their plan. The focus of the Ministry has been on setting Quality Standards (Quadruple Aim) and changing the Home Care Act through ***Bill 175 Connecting People to Home and Community Care Act, 2020.*** Within this context, a new model of health care delivery is set to begin in the Kenora area with the announcement of the Kenora All Nations Health Partners Ontario Health Team (ANHP OHT).

The ultimate goal of the ANHP OHT is to organize health care delivery (including the hospital, primary care providers, mental health and addiction services, home and community care, community support services, palliative care/hospice, clinics and other allied health organizations and services) so that patient care is equitable and as close to home as possible. Focusing on smoothing the transition for patients from different care providers and services. A key priority within this vision is to achieve better coordination of federally and provincially funded health services. For this project understanding the Federal Landscape for First Nation Community members and mapping out the Kenora based supply and gaps in services available Provincially was one step in terms of describing existing services available as they are intended. A second step included listening and learning from community and local system experts in Kenora and on First Nation communities. This was an essential part of gathering the functionality and understanding of gaps in accessing and receiving HCCS care. Understanding how the environment, distances for travelling to services and appointments, the weather and other cultural and historical factors created challenges not considered or supported in the existing systems available.

3.3 Goals and Objectives

The following goals were established by the Working Group to ensure the Kenora ANHP OHT is ready to respond and determine their own solutions. The approach was designed for stakeholders to identify what will work best within the unique needs of the region while aligning with the steps outlined for Ontario Health Team Formation. The results are intended to inform the design and delivery of an effective Home and Community Care Services (HCCS) Framework (Phase 2) uniquely driven by and for the people living within the ANHP OHT catchment. The goals of this Project include:

1. To understand and report the current unique geography and cultural context of the region in terms of defining supply, needs and gaps related to Home Care and Community Support Services in the ANHP Catchment area.
2. Consolidate community-based recommendations for creating a local integrated model of care with specific attention to next steps regarding:
    a. Prioritizing the system components and basket of services in HCCS; and
    b. Suggest metrics and standards which are practical and feasible for the ANHP catchment and will reflect the goals and objectives of the services being provided.

3.4 Approach and Methodology

In early 2020, the Working Group was formed to guide the process of collecting information relevant to creating a more harmonized and accessible network of home and community care services. The Working Group enlisted and provided ongoing oversight and guidance to a Contracted Project Team in the

development and implementation of a full community engagement plan. The resulting report would act as the First Phase to feed into work that would take place within the OHT Process developing and implementing a framework for HCCS delivered locally. The initial kick-off meeting took place January 25, 2020 and the community engagement program began late February and was still underway when the Covid-19 pandemic became a global crisis resulting in a delay. A draft outline of the report and identified gaps in data was provided to the Working Group in April, where final steps and guidance in the engagement were provided to complete a report by end of June. Further to this, adjustments in approach were approved by the Chair and Indigenous advisory sub-group in late May 2020. Adjustments were focused on ensuring integrity of reporting needs would be met but also to alleviate pressures to participate on First Nation Communities responding to Covid-19 and to Provincial and Federal Data Analytics services responsible for running health analytic reports. As a result, the Projects Cultural Advisor took on more of a functional role to research and understand the jurisdictional challenges faced by First Nations.

The initial community engagement program involved the following key activities:

- Completion of an Inventory of Services Survey (ISS), a survey for service mapping and inventory of available supply of HCCS. The ISS was to be distributed and filled in by all senior level administrators identified on the stakeholder list, including all 10 First Nation Communities in the ANHP Catchment area. The survey was detailed and intended to result in a comprehensive inventory report outlining what is in place, how the services currently function and identify any gaps and needs not addressed within the existing supply.
- Comprehensive First Nation and Metis Community Engagement, including facilitation of Focus Groups with each First Nation Community and the Kenora's Metis Nation. Focus groups included elders, care providers and front-line team workers. This Engagement program was led by a Kenora Chiefs Advisory coordination team and the Projects Indigenous Liaison Advisor.
- Questionnaires were provided for front-line workers and for caregivers/patients to fill out and return to Project Team. These questionnaires were in addition to the Focus Groups and offered a chance for those who may not have been able to attend or felt uncomfortable to fully participate in other engagement processes.
- A Front-Line Service Providers Engagement Session was facilitated at the LWDH on March 12, 2020, with representatives across 13 Service Organizations and Communities. This was a full day session dedicated to listening to Front Line service Providers about their thoughts on gaps within the current system and how the ANHP can work to improve the quality of care for the communities they serve.

The majority of the above engagement took place prior to the global Covid-19 Pandemic. However, the completion of the ISS by First Nation Communities and service providers as well as a couple focus groups remained outstanding for a considerable time, as did a pause on the Working Group meetings to guide the process further. By May 2020 it became apparent the response and pressures placed on the health care sector and in particular those working within our First Nation Communities were great and the need to re-evaluate how to proceed meant a change in approach, relying more heavily on an Indigenous Advisor with decades of experience working within the Federal and Provincial jurisdictional landscape of health care in the Treaty #3 region.

Adjustments in the approach were made as follows:

- The Working Group recognized the incredible pressures on communities and service providers and a decision was made that First Nation Health Directors were not going to be pressured to fill in the Inventory of Services Survey and in place. This resulted in the following adjustments to approach and reporting:
    - The Projects Indigenous Advisor conducted system expert phone interviews and worked with the Project team to draft an understanding of the Federal landscape and to describe the First Nations HCCS as intended by Indigenous Services Canada.
    - Local input and insights would be drawn from information gathered during focus groups and interviews/questionnaires to provide a community-based understanding of the functionality of the programs and related opportunities, challenges and gaps.
    - It is important to note that Naotkamegwanning (White Fish Bay) had completed the inventory of services survey prior to this decision, and as a result of the decision to remove First Nations from the Inventory of Services Survey, the detailed information they provided has been incorporated into a case study within the Federal Landscape description.
- Several Service Providers invited to participate in the ISS did not respond to the survey within a reasonable timeframe to include them within the inventory of services report. The Working Group decided to move ahead with the ISS Analysis and report and has made the commitment to continue to communicate results from the Project and continue to open opportunities moving forward for all stakeholders, regardless of their level of participation in Phase 1.
- Lake of the Woods District Hospital Patient Care Team was set to participate in a focus group on March 20, 2020 and although attempts were made to reschedule via zoom, the pressures on individual team members continue to be great. Understanding the transition process from hospital to home, especially related to First Nation Communities, can now only be described through the lens of community members. A gap continues to exist in terms of understanding the role, experience and insights from front-line discharge planning team members.

Table 2 outlines the participation included as part of this report by stakeholder and type of engagement.

Table 2 Summary of Participation by stakeholder group and type of engagement

Stakeholder	Participation
Administrators from Kenora-based Service Providers	
Inventory of Services Survey	14 Completed
First Nation Communities[1,2]	
Animkee WaZhing 37 (Regina Bay)	Focus Group - 6 Participants
Northwest Angle 33 (Dog Paw)	Focus Group - 12 Participants
Naotkamegwanning (Whitefish Bay)	Focus Group - 8 Participants and Inventory of Services Survey
Obashkaandagaang (Wash Bay)	Focus Group - 4 Participants
Grassy Narrows	Interviews - 2 Completed
Niisachewan (Dalles)	Elders Focus Group - 11 Participants
Wauzhushk Onigum	Focus Group - 2 Participants
Wabaseemoong (Whitedog)	1 questionnaire completed *Focus group cancelled due to Covid-19
Shoal Lake #40	*Focus group cancelled due to Covid-19

Stakeholder	Participation
Iskatewizaagegan #39	*no follow-up was pursued due to Covid-19
Front Line Service Providers	15 questionnaires completed
Patients/Caregivers	4 questionnaires completed
Kenora Based ANHP Service Providers and Organizations Engagement:	
Front-Line Services Engagement Session	Workshop - 20 participants across 14 organizations
Front-line service providers	5 questionnaires completed
Northwest Local Health Integration Network	2 questionnaires completed
Lake of the Woods District Hospital	1 Interview, VP Patient Services *Focus group cancelled due to Covid-19
District for Kenora Home for the Aged	Zoom-focus group - 7 participants
All Nations Health Partners – Home Care and Community Services Working Group:	
Sunset Country Family Health Team (Chair) Firefly Kenora Metis Council Naotkamegwanning FN Home Care Coordinator KCA/Community Health Care Professionals Community Support Services (DKHA) Alzheimer Society KRRD NWLHIN KACL LWDH WNHAC Unincorporated Rate Payers/ANHP KDSB	5 Project Working Group Meetings were held
Other:	
Kenora Metis Council	Postponed due to Covid-19
Indigenous Services Canada	Interview

1 Participants were asked for verbal consent and their 'sign in' was acknowledgement of consent to have their input included in report results. In return a commitment was made to provide all reports back to participants, communities and organizations.

2 KCA coordination team attended all First Nation engagement sessions. The team included: Veronica Fobister, Stefanie Bryant, Cathy Cameron, Lucille McKenzie and Kathy Kishiqueb

Every effort was made to include all identified stakeholders and communities. However, not all have been able to provide their insights, and as a result we have drafted this report as a living document. Understanding that this initial report will provide guidance in future phases along with the commitment to continue to reach out to all stakeholders and communities for their involvement. The report will continue to be identified as Draft and updated with new dates as additional input is added. **Appendix 1** provides a comprehensive list of all participants and related engagement activities.

4 Existing Environment

This section describes the existing environment related to regional health priorities, the available supply of Home Care and Community Services in the ANHP region with a separate discussion on the Federal System and First Nations on-reserve experience.

4.1 Home Care and Community Services

Home Care and Community Services support people of all ages who require care in their home, at school or in the community. How you qualify and what this care is can mean different things to different people. The following is provided to help establish a common understanding and context for this Project as we look forward with the All Nations Health Partners. Current publicly funded Home and Community Care Services looks at essential and enhanced services within a limited scope and is based on an assessment and eligibility criteria set provincially (or federally for First Nations). This study allowed for participants to reflect on enhanced services that are limited at this time within the region but would meet the priority needs and outcomes within planning for a new integrated system. The definition goes beyond the limited services available under the current Northwest LHIN's Home and Community Care Services and the Indigenous Services Canada Home and Community Care programs because the community engagement for this Project wanted to tap into reimagining a delivery of services that met the local health priorities of those living with the ANHP OHT region. The definition allows for participants to think beyond limitations of existing programs and to make realistic and practical connections to offering person-centered care that allows people to heal at home in a good way.

The ANHP OHT has used the First Nations Advisory Committee's report on Home and Community Care in First Nations Communities in Ontario (Chiefs of Ontario, 2017) to define and establish priorities. The Report uses the following definitions:

HOME CARE SERVICES are "provided in homes, schools and other community settings and includes nursing, personal support services, homemaking, and other professional services such as rehabilitation therapies"; and

COMMUNITY SUPPORT SERVICES are "additional supports that help people live in the community independently and safely such as meal services, transportation, caregiver supports, social/recreation services and others;" and

PALLIATIVE CARE relates to planning for end of life and **"**is identified as its own suite of services… [referring to an] approach to improve the quality of life of patients and their families facing the problems associated with life limiting illness through the prevention and relief of suffering … palliative care also means "comfort care" and includes end of life planning."

Closely linked and should be considered in future planning are the challenges around supportive housing, assisted living, Long-Term Care beds and community developmental services. The Working Group has emphasized that future planning for HCCSS will be successful if it can become integrated and provide for building capacity of individuals needing support to have the best possible outcomes for the individual (for some this does not mean improving, but maintaining or slowing the rate of deterioration and for others this means supporting the mental health and addictions aspect of day-to-day engagement in community life). The Working Group aims to develop a system where people are supported according to the First Nations Mental Wellness Continuum Framework:

Mental Wellness is a balance of the mental, physical, spiritual and emotional. This balance is enriched as individuals have: PURPOSE in their daily lives whether it is through education, employment, care-giving activities, or cultural ways of being and doing; HOPE for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of BELONGING and connectedness within their families, to community and to culture; and finally a sense of MEANING and an understanding of how their lives and those of their families and communities are part of creation and a rich history."

4.2 Regional Context of Program Delivery

The provincial and federal levels of government each provide funding for home and community care services. The provincial component is being managed by [the Northwest LHIN from Thunder Bay, a center five hours away. The federal component is managed community by community. Even prior to this community engagement, the ANHP OHT Submission stated significant problems with HCCS delivery in the region noting "There is a lack of integration, standardization, and local control together have contributed significantly to poor care in this region" (ANHP OHT Submission September 11, 2019).

Table 2 provides an overview of each of the elements that comprise Home Care and Community Service Elements. Only a portion of these fall within services that are mandatory to provide within the Federal landscape/programming provided through Indigenous Services Canada.

Choice is limited. Provincially funded services in the ANHP region are available as essential services and enhanced services. Enhanced services are more limited than other urban/southern counterparts and trust in a system that has dedicated, protected resources to extend living at home in complex situations currently are limited in options.

Table 3 Description of Home Care and Community Service Elements

Home Care and Community Service Element	Description of basic provisions (and standards) for each element:
Program Management and Supervision	Oversight and accountability structures (policies, procedures and budgetary implementations)
Client Assessment	Assessment to make sure that the health care provided is based on the unique needs of each person (Eligibility and level of care) A care plan put into place to guide the services provided
Managed Care	Transition/discharge planning Coordination with health and social service care providers
Home Nursing	Qualified/teaches 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
Home Support	Personal care (e.g. bathing assistance, etc.) Homemaking In-home meal preparation
Medical Supplies and Equipment	Assistance to acquire equipment to assist with independent living
Information and Data Collection	Electronic Medical Records/reporting
Respite services	In-home temporary relief of primary care provider duties or in-community social recreational programs, adult day programs (seniors), developmental services, integrated community care services (i.e. KACL).
Rehabilitation and Therapy Services	Physiotherapy Occupational Therapy Speech Language Pathology
Emotional Health	Providing for spiritual/emotional support, wellness support, reassurance visits)
Dietitian Support	Special dietary needs requiring diet counseling
Palliative Care	A unique blend of respite, end-of-life comfort care, bereavement/aftercare
Other	Sometimes unique services or other services can be part of provisions if it its within one of the methods of delivery (Traditional Care, Family-Managed Home Care (FMHC) or Bundled Care. Provincially this must fit within the parameters of the Home Care Community Services Act (11994) Federally – based on community-specific model of delivery

Outside of HCCS services funded from the Northwest LHIN are services that build capacity for those with developmental or sever mental health challenges to integrate and live within the community. For KACL clients would qualify through Developmental Services of Ontario which are not currently integrated or coordinated with HCCS, which often results in an 'either/or' situation and limits the effectiveness of fully integrating and supporting an individual from successfully living independently.

4.3 Federal Landscape: First Nation Home and Community Care Program Delivery

Public home care was created in Canada over the last quarter of a century as a result of both the federal and provincial government combining their energies to events occurring in health prior to the 1970's. **Appendix 2** provides a summary of the history, background and program description (including essential service elements, eligibility criteria, funding formula, and recent changes to programming) for the Home and Community Care (HCC) Program provided by Indigenous Services Canada (ISC) for this project.

The First Nations and Inuit Home and Community Care Program (FNIHCC) administered through Indigenous Services Canada is intended to provide a continuum of home and community care services that are comprehensive, culturally sensitive, and accessible, ensuring responses to the unique health and social needs of First Nations and Inuit. The home care program is intended to be a coordinated system of health services, together with the Provincial programs, that enable First Nations and Inuit of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities. Launched in 1999, FNIHCC works with First Nations and Inuit partners to provide core home and community care services. It is provided primarily through contribution agreements with First Nation and Inuit communities and Territorial Governments. FNIHCC strives to be equal to home and community care services offered to other Canadian residents in similar geographical areas. Home and Community Care is delivered primarily by home care registered nurses and trained and certified personal care workers (PSW's). Service delivery is based on assessed need, a funding formula established in the 1990's and follows a case management process.

FNIHCC is a mandatory program. However, the delivery of the federal program is and has been the sole decision of each First Nation Community on how and who they want those services to be directed. The money allocated by the federal government is for the sole use of home care services on reserve, specifically for band members (formula for funding takes into account only band members living on-reserve). The role of the federal home care worker/nurse falls clearly under the supervision of the regional office in Thunder Bay, where the office is responsible for ensuring each home care nurse follows the guidelines within their scope of practice. The federal homecare worker/nurse is different than the one Indigenous Services Canada funds for public health. **Appendix 2** includes a briefing paper from the Projects Indigenous Advisor based on his interviews with key system experts within Indigenous Services Canada.

In general, the Program Objectives are laid out as:

- Build the capacity within First Nations and Inuit communities to plan, develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.
- Assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.
- 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.
- 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.

- Assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.
- Build capacity within First Nations and Inuit communities to deliver home care services through continuing education sessions, evolving technology, along with development and implementation of information systems that enable program monitoring, research, defining best practices and evaluation.

The Programs Essential Service Elements include:

A. Structured Client Assessment: The assessment process utilizes an assessment tool and includes ongoing reassessment to determine client needs and service allocation.
B. Managed Care: This process incorporates case management, referrals and service linkages to existing services provided in the community or elsewhere.
C. Home Care Nursing Services: Home care nursing services include direct service delivery and care planning, as well as supervision and teaching of personnel providing personal care services.
D. Home Support Personal Care: Personal care services could include bathing, grooming, dressing, transferring and turning. This component enhances, but does not duplicate, AANDC in-home adult care services.
E. Provision or Access to In-Home Respite Care: This service is intended to provide family and other informal caregivers with short-term relief from caring for dependent family members.
F. Established Linkages with other Services: The linkages with other services may include other health and social programs available both within the community and outside of the community, such as respite and therapeutic services, gerontology programs and cancer clinics.
G. Access to Medical Equipment and Supplies: This involves the provision of and access to specialized equipment, supplies and specialized pharmaceuticals to provide the care required to maintain patients in homes and communities.
H. A System of Record Keeping and Data Collection: This component develops and maintains a client chart and an information system that enables program monitoring, ongoing planning, reporting and evaluation activities.

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

Unique for First Nations on-reserve assessment, Clients assessment process is different from that set out under the Provincial Home Care Act and LHIN processes. Clients accessing services are First Nations and Inuit people with disabilities, chronic or acute illnesses and the elderly. First Nations and Inuit of any age:

- Who live in a First Nations reserve community (or in a First Nations community North of 60) or Inuit settlement;
- Who have undergone a formal assessment of continuing care service needs and have been assessed a requiring one or more of the essential services; and

- Who have access to services which can be provided with reasonable safety to the client and by the caregiver, within established standards, policies and regulations for service practice.

4.3.1 ANHP On-Reserve Home and Community Care

The First Nation Communities within the ANHP Catchment area continue to retain their dollars and either contract services or hire their own home care nurses. The following ANHP First Nation Health Partners contract a private company, Community Health Care Professionals, to provide nursing and home care service delivery:

- Naotkamegwanning
- Washagmamis bay
- Wauzushk onigum
- Niisaachewan
- Wabaseemoong
- Shoal lake 40

Waasegiizhig Nanaandawe'Iyewigamig provides the services specified as program components of the federally funded HCC program to members of two First Nations. Off-reserve members living in Kenora aare served as well as on-reserve members at the following locations:

- Animakee Wa Zhing 37A (Regina Bay community)
- Animakee Wa Zhing 37B (Windigo Island community)
- North West Angle 33A (Dogpaw Lake community)
- North West Angle 33B (Angle Inlet community)

The following ANHP First Nation Community independently runs their own home care services with a band hired nurse providing oversight of the Program:

- Grassy Narrows

Based on community engagement results it is evident the biggest gaps with meeting basic home and community care standards lie with lack of coordination of federally and provincially funded services. In addition, the Federal funding and service delivery model does not fully take into consideration several unique factors including: the true population of each community; the challenging physical environment, limited resources on reserve (determinants of health and infrastructure and access to goods and services in general), distances for travelling to individual homes and health centers and the weather which is often problematic.

4.3.1.1 Strengths and Opportunities

Despite that most Home Care programs in First Nation communities are small in staffing numbers and employ primarily PSWs and homemakers with nurses attending to community visits a couple times a week, there is a sentiment of strength in the community-based program "we are mighty in the sense that we know our community well and capitalize on the strength of services that are available within our community" (Grassy Narrows, July 2020). Key strengths and opportunities that should be retained include:

- Referral and assessment process are not very stringent, and this leads to a more open-door feeling of welcome. Those needing basic HCC services are provided services without a lot of assessment/eligibility restrictions.
- Follow-up to ensure the patient is receiving/experiencing what they need is a community responsibility. This should be enhanced by including them as part of hospital and specialty interdisciplinary care teams when a patient's managed care transcends federal services into and provincial boundaries.
- Communities where local residents are trained and employed as front-line staff in home care are able to respond more flexibly and consistently. This is often accompanied with a narrative of stronger bonds and relationships with families and a comfort with the environmental conditions that more urban staff travelling into community can find challenging.

Palliative care is not an Anishinaabe concept and may not fit as a specialized program within First Nations. A few key themes emerged when speaking with members and elders living on-reserve. **The most important being that "palliative care" is a westernized concept and there is no word for it in the Anishinaabe language.** However, the need for the health care supports and resources to provide for end of life care as well as hospice facilities are not currently being met.

In a 2016 evaluation of Naotkamegwanning First Nations Pilot Program for improving end-of-life care in First Nation Communities the elders directed the name of their program to be "The Wiisokotaatiwin Program" which translates to "taking care of each other or supporting each other." Community members repeatedly speak of the experience of simply sitting with and providing quiet shared visits with those who are at end of their life and alongside their family and friends. Palliative care services should be available to help support and add to experience and providing the comfort care needed, but within a way that maintains the cultural connection and work of the people to be simply present with those at end of life. The supports are needed in terms of resources to help families keep a peaceful place of passing at home (the needs of people are often complex with a high intensity of care needs and so opportunities for staying home are limited at this time).

4.3.1.2 Gaps and Challenges

While the funding for home and community care is primarily provided through Indigenous Services Canada, there is an envelope of funding that is provided by the Ministry of Health and a referral process to the LHIN for services not under the Federal program. In general, the ISC historical context suggest the Province still holds responsibility to coordinate care plans, however, of the 8 communities engaged through this process there was a theme that LHIN do not share or feel they hold a responsibility to the home care clients of the community and that any referral process is a lengthy battle for assessment and meeting eligibility for support. In most cases, the referral for assessment is related to off-reserve populations or services that are not available federally, such as Occupational Therapists, Physio and Speech Language experts through LHIN programming. These services are seen as valuable to upholding the goals of Home and Community Care Programs to support community clients to live well and optimally in their home communities.

Due to a lack of these services, many stories are shared about elders and individuals having to go to hospital or alternate care outside of the community. Even more worrisome is the stories of rapid decline, accidents and ER visits due to avoidable situations had the services been available within the

community. In instances where specialty services are acquired, the individuals are often unprepared for the circumstances they face on reserve, they are often new to the community and unfamiliar with the conditions they arrive to and this on magnifies the challenges that First Nation communities face in trying to contract and retain specialty service providers (Grassy Narrows interview, 2020).

The biggest federal program challenges and barriers to seamless home and community care include:

- Lack of understanding the experience First Nations members go through to access and receive care (infrastructure, environmental barriers, determinants of health, trauma)
- Inequitable funding (at its most basic level, the Berger formula has not changed funding since 1999) with assessments based on "on-reserve First Nation members" population only. Leaving out spouses and family members from other reserves living in the community and other reserve members living off-reserve. At a more complex level, the current funding:
    - does not account for the infrastructure and environmental challenges as well as current wage and training expectations of recruitment and retention of qualified team members.
    - Provide adequate resources for smaller communities to meet the same level of coordination and care as larger First Nations because funding is not scaled according to need for a full complement of resources regardless of size of community. What this means is that smaller communities are at the mercy of outside service providers to provide limited services and have no in-community capacity to support system navigation by hiring a coordinator to manage case conference and co-development of case plans.
- Lack of integration and coordination with LHIN, and this is most evident with regards to discharge planning/transitional care planning from hospital back to home. Navigating the system that is (or should be) available off-reserve is repeatedly a concern.
- Accountability and compliance to basic standards of care is inconsistent as oversight of programs are run through the regional office in Thunder Bay. Those communities with larger populations speak to being able to provide consistent levels of care because they are able to, with their funding, have a program team in place. This scale of services allows for a Coordinator role and multiple PSW and homemakers who then can support each other and trade off work for vacation/continuing education. Those smaller communities where only one PSW and one Homemaker, often with part-time hours, struggle to maintain a constant level of service simply because they are the only one in their community living and working to provide the care.
- Non-Insured Health Benefits vary from those benefits available through Northwest LHIN HCCS/Provincial system (medications/equipment)

4.3.1.3 Naotkamegwanning: A Case Study of Home Care Delivery On-Reserve

Naotkamegwanning First Nation (Whitefish Bay) is a larger community located approximately 96 km south of Kenora. The community has year-round road access including an ice road in the winter. There are 712 community members living in the community. In a recent Palliative Care study, it was noted that approximately 48% of the population were able to speak Ojibway, which tells a story of the community's ability to retain their Anishinaabe culture. Planning documents and the Inventory of Services Survey speak proudly and loudly about the community's commitment to determine their own service plans and continued reliance on taking direction from their Elders on important decision-making processes that impact the health and wellbeing of their community (Improving End-of-Life Care in First

Nations Communities, An Evaluation of Naotkamegwanning First Nation's Wiisokotaatiwin Pilot Program, 2016).

In 2007, Naotkamegwanning Integrated the First Nations and Inuit Health Branch's Home and Community Care program which provides basic home care services such as nursing, personal support and respite with the provincially funded Long-Term Care Program which provides home support and home maintenance. This integrated model of care, called Naotkamegwanning's Community Care Program, provides a single point of access with customized care plans for those requiring services.

The First Nations and Inuit Health Branch Home and Community Care Program (HCCP) provides basic home and community care services. Essential services in place are case management, nursing, respite and personal care. There are no FNIHB HCCP services funded on evenings or weekends (HCCP hours were Monday to Friday, 8:30 a.m. to 4:30 pm.). People with advanced chronic or terminal illness often access service and supports outside of the community, which really means that many WFB members with progressive chronic or terminal illnesses are in hospital and eventually transferred to LTC.

A key opportunity and gap the community wants to bridge is facilitating the coordination and integration of coordinated health service delivery to keep clients at home longer.

> *"Really, providing 24/7 care in the community still has to be cheaper than having our people in the hospital? Isn't the hospital the most expensive way to care for people?"*
> Home Care Coordinator

Table 8 provides a summary of responses by Naotkamegwanning First Nation to ISS. It is important to remember that every First Nation community manages and delivers the Federal program differently within their community. However, Naotkamegwanning has been perceived throughout community-engagement as a relatively organized and well-structured program because they have a population that is large enough to hire a Home Care Case Coordinator and leadership has worked for years to guide their own community development process to create a Local and culturally driven homecare program through their Agreement with the ***Integrated the First Nations and Inuit Health Branch's Home and Community Care program, 2007.*** Naotkemegwanning also has some key services unique to their community (i.e. not available in the other ANHP First Nation communities) including, EMS services with ambulance providing response 24/7 and after-hours mental health crisis response (and women's shelter).

Based on community-engagement with other First Nation communities, the information in Table 8 is at the upper end of coordinated and available services to First Nations (smaller communities would place more services in the category of not available or does not meet needs)

Table 4 Naotkamegwanning Response to the Inventory of Services Survey (ISS)

INVENTORY OF SERVICES QUESTION CATEGORY	NAOTKAMEGWANNING RESPONSE:
COMMUNITY HEALTH SERVICES MISSION	To provide wholistic care to all members of all ages with both traditional and western medical strategies so that each person can complete their circle of life in a balanced state, mentally, emotionally, physically and spiritually.
TOP HEALTH PRIORITIES AND CONTRIBUTING FACTORS:	Diabetes with related complications (linked to lack of nutritional food sources available and healthy fitness activities) Heart Disease (linked to poor eating and lifestyle habits, with lack of knowledge in heart health) Cancer (poor lifestyle, tobacco and marijuana smoking and delayed screening and early detection)
SERVICES WITHIN COMMUNITY THAT NEED IMPROVEMENT:	• Crisis Response - EMS available and some Mental Health After Hours • Alzheimer's and Dementia Services • Discharge Planning and referrals from services outside of the community • Dietitian and nutrition services • Equipment and aides for independent living • Health information and awareness • Home care nursing services; nursing support • Medication management (especially drug addiction support) • Medical transportation outside community • Personal care (bathing etc.) • Point of care testing for people living with chronic conditions (A1C) • Services such as physiotherapy, occupational therapy, speech language therapy, audiology • Spiritual support • Support and care for persons with chronic conditions • Support to family members of those living with chronic conditions
SERVICES THAT ARE NOT AVAILABLE OR DO NOT MEET NEEDS:	• Crisis Response for Home and Community Care • Drug and alcohol treatment and counselling services • In-home respite for caregivers • Meal preparation support • Medical transportation in community • Mental health services and therapy (including psychiatric and behaviour support) • Palliative Care Services • Rehabilitation services to help people maintain or regain abilities (outpatient) • Rehabilitation services through home care • Services to help persons with disabilities to live independently

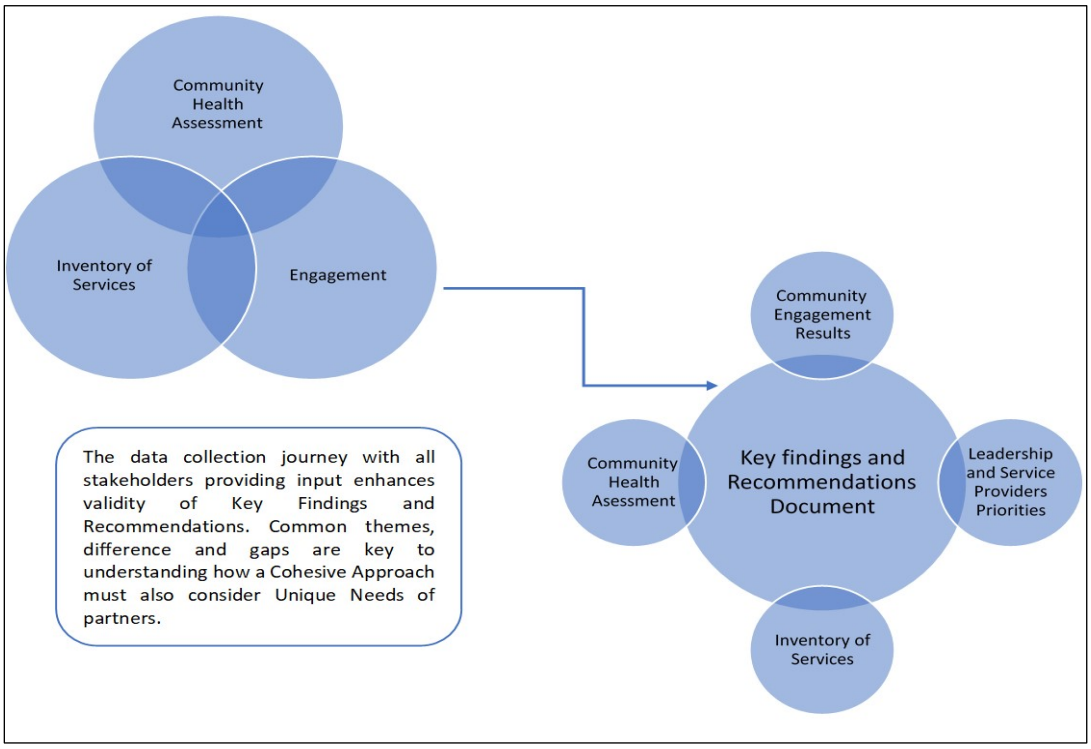
INVENTORY OF SERVICES QUESTION CATEGORY	NAOTKAMEGWANNING RESPONSE:
	• Traditional and/or land-based healing services
UNIQUE CHALLENGES RELATED TO LOCATION	• Winnipeg Health Sciences Center and Lake of the Woods District Hospital are often where community members are referred. These hospitals do not share info immediately in order for HCCP to provide best care for our members. • Thunder Bay or London Ontario are also points of entry (especially LHIN referrals) to HCCP but not often provided with the proper orders to provide the necessary care.
HEALTH SERVICE INTEGRATION WITH OTHER SOCIAL, EDUCATIONAL AND COMMUNITY SERVICES	• It is misunderstood that all elder care falls under the HCCP, limiting coordination and integration to supportive services that could compliment care.
HOW MANY COMMUNITY MEMBERS ARE LIVING OUTSIDE OF THE COMMUNITY IN ORDER TO RECEIVE CARE	• Numbers were not available, but there are HCCP community members who have had to, by no other choice, relocate to LTC facilities or Hospital due to high care needs: blind, dementia, chronically ill, frail elderly, no or lack of family supports.
BARRIERS RELATED TO SERVICE PROVIDERS:	• HCCP clients do not have a dedicated primary care provider but they are referred to visitng nurse practitioners at different locations near the community. • Access to specialists is inconsistent and HCCP does not receive medical history or specialist instructions from any arranged HCCP client visits. • No accessible transportation available for HCCP • No culturally congruent navigation of system leads to lack of understanding and capacity to be involved in self-care.
ESSENTIAL SERVICE DELIVERY IN COMMUNITY:	• Home Care Nursing to all community members of all ages who are in need • Home Care support to elderly (60+) who are community members • Home Maintenance and Assisted Living Support to elderly (60+) who are community members • Medical supplies and equipment for HCCP clients only (more rigid assessment/eligibility criteria)

5 INVENTORY OF SERVICES SURVEY (ISS)

The intention of the ISS was to provide a fundamental link between the engagement process, the review of health status and determinants of health data, and the availability of services. Figure 7 illustrates how the information from the ISS was to be triangulated to provide insight into the current system operations and link to identified needs. Gaps, potential overlap and opportunities were to be highlighted to provide the evidence base for planning within the new ANHP approach.

The ISS was meant to highlight key differences in service availability among the ANHP partners and to highlight the needs for services based on engagement feedback and a review of health status indicators. The comprehensive document is complete and due to length, it is presented as a companion document: ***Home Care and Community Services -Results of Inventory Survey*** (July 28, 2020).

Figure 7 Complementary Processes to Identify Gaps and Overlaps and Inform Key Findings



5.1 ISS METHODOLOGY AND CHALLENGES

The survey was available on-line using Survey Monkey for direct data entry if preferred as well as through submitting answers to the Word document which were then entered into Survey Monkey. Section 3.4 has outlined the intentions and challenges associated with the Inventory of Services Survey so the challenges will not be reiterated in this section.

The full ISS was reviewed and approved by the Working Group and it was recognized that due to the differences among the ANHP stakeholders, many questions would not apply to all respondents so

analysis of response rates were not calculated. The ISS was completed by senior administrators and their team members from the following agencies:

Organizations who Responded to the ISS:

- Alzheimer Society Kenora Rainy River Districts
- Brain Injury Services of Northern Ontario (BISNO)
- Canadian Mental Health Association, Kenora Branch
- Community Support Services - DKHA
- Firefly
- Kenora Association for Community Living (KACL)
    - Children's
    - Mental Health Programs, District Case Management and Supported Independent Living
    - 24 hour supports
- Kenora Chiefs Advisory (KCA)
- Kenora District Services Board - Northwest EMS
- Lake of the Woods District Hospital Mental Health & Addictions
- Naotkamegwanning (Whitefish Bay) – *used as case study*
- North West Local Health Integration Network
- North West Regional Palliative Care Program – St. Joseph's Care Group
- Sunset Country Family Health Team
- Waasegiizhig Nanaandawe'iyewigamig (WNHAC)
- Wesway

Although there were additional organizations and communities invited to participate, the onset of Covid-19 resulted in the Project Teams decision to not pursue follow-up requests and to conduct the analysis based on these organization responses. In addition, since Naotkamegwanning was the only First Nation able to respond within the available timeframe, we pulled their data out of analysis and provided a Case Study using their ISS results (Section 4.3.1.3). The results include the ANHP organizations and Kenora based service providers.

5.2 ISS PRODUCTS

Two companion documents are available under separate cover to meet the expected outcomes of the Inventory of Services Survey.

1. Inventory of Current Services Directory
    a. Intended to be an "evergreen document" to be shared among partners, stakeholders and community members.
    b. This is an attempt to assist with service navigation.
    c. This outlines services offered, locations, times and contact information.
    d. The current guide includes information from the 16 responding agencies. It is recognized that as the process continues, there will be changes to services and the document will need to be continually updated.

2. Inventory of Services Report
    a. This report is an extensive analysis of the Inventory of Services Survey.
    b. Many themes in the survey link to the engagement results priorities stated. Although the number of respondents was lower than anticipated, the information contained is a valuable starting point to build on community requirements and challenges.

As stated earlier, although Whitefish Bay did respond, and this is greatly appreciated, because this was the only response from First Nations Communities, the decision was made not to merge the responses into this report but to develop a separate "Case Study" Report for this community.

5.3 ISS Respondent Key Priorities

This section provides a summary of the linkages between health priorities identified (this can include outcomes, determinants/risk factors and service access), themes of challenges and identified solutions. Further detail is available in the extensive companion document.

Figure 8 highlights operational priorities for the respondent organizations. This shows, regardless of years of experience in the organization or community, there are on-going barriers for operational success and much of it is related to cohesiveness and communication. Clearly, programming must address population needs. Sufficient evidence that truly captures the local trends and outcomes for service delivery to show baseline health status is needed to validated the findings that "one size" does not fit all.

Figure 9 summarizes key themes of "needs" vs "gaps". For example, funding is "need" because although there is funding, it is often not adequate to address true needs. On the other hand, a gap shows that there are components that are integral to optimal health and service operations that do not exist or are minimal or not operating in a way that is sufficient. That is "needs" can have a baseline to build on, while "gaps" either do not exist or do not exist in a way that can be built up – reconfiguration and re-thinking is needed. Covid-19 has clearly illustrated that Information Technology is both a need and gap and that limited connectivity and access to "real time" information and opportunity to connect remotely with clients and caregivers and co-workers leads to poor health and planning outcomes.

Figure 8 Operational priorities of survey respondents

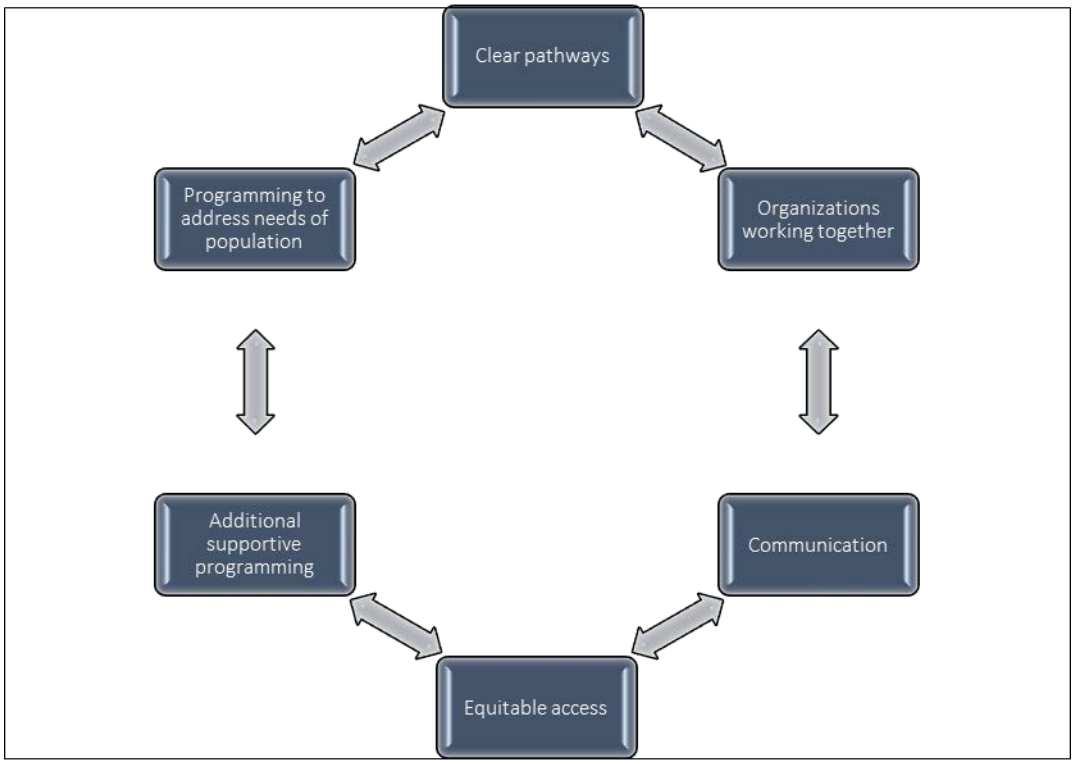


Figure 9 Key themes of needs vs gaps

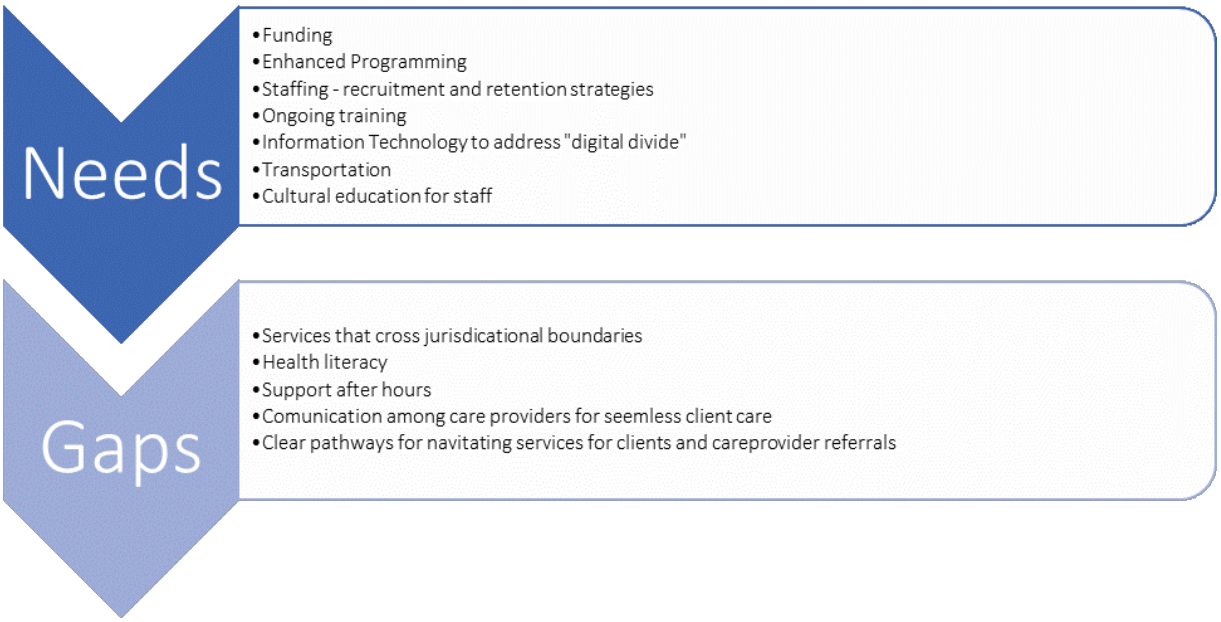


Table 5 provides a summary of some of the linkages between health priorities identified (this can include outcomes, determinants/risk factors and service access), themes of challenges and solutions. Further detail is available in the extensive companion document.

Table 5 Summary of key health priorities, challenges and solutions

Health Priorities	Challenges	Solutions
Pathway, Transitions and Communication	Lack of access to consistent psychiatry, specialized psychiatry, diagnostic services for adults, stabilization and in-patient beds	Multiple community psychiatrists that have specialty in child and adolescent, addictions, dual diagnosis, and geriatric, Increase in community clinics for FASD, Addictions, Mercury poisoning, and genetic testing, Require appropriate setting and number of stabilization beds and in-patient beds to meet the needs of the complexities of the individuals whom have FASD, mental health, poly-substance use, and suicidal ideation.
	Minimal specialists in town, long wait times	More local specialists, along with OTN and telehealth options
	Jurisdictional issues – who is responsible for home care on reserve?	Need dedicated planners to support with patient journey
	Fragmented communication	Communication strategy, transparent partnerships and community vision
Mental Health Services for Adults and Children	Stigma, staff not educated on process or availability, Lack of knowledge of programs and services available	Education for front line workers
	No psychiatrist in the area	Recruit psychiatrist on a permanent basis
	Continued stigma of those needing to access services can be a barrier, Parents may have mental health issues, which relay on to children in the family, Socio-economic status of families and social determinants of health (as above), Issues within the family unit (e.g. divorce, domestic abuse)	Efficient services to support children, inclusive of funding and clinicians, Community campaigns to reduce stigma, Single point of access for services, Innovative service delivery to minimize wait for services, Supporting the health and well-being of front-line staff, to be able to adequately support their clients
	Trauma, Lifestyle, congenital effects of alcohol/drug use by mother, effects of hereditary trauma	Client support through counselling, increase access to specialized support/programs, Support and education for family, Community supports/programs
	Fragmented access to programs and various services	Community strategy and support structure
	Not enough mental health support for dual diagnosis - particularly youth with FASD and Autism	Support for individuals with dual diagnosis and families

Health Priorities	Challenges	Solutions
Pediatric Care	Social Determinants of Health (Poverty, housing, nutrition, education), Access to services is difficult due to barriers (paperwork, travel time), Difficulty navigating services (due to language, educational level, insight into needs, Cultural divide and historical context	Single point of access, system navigation, community engagement, patient and family advocacy groups
	No Pediatrician or pediatric ward in hospital	Offer a pediatrician or pediatric ward in hospital
Access	Remote Communities	Expansion of Home Care and Community Support Services
	Transportation	Medical transportation from a central location
	Availability for outpatient services	Explore new models for services
	Lack of community support services to appropriately serve communities	Need additional funding to offer expansion of supports for home help, meal support etc.
Diabetes Care and Education	Social determinants of health, genetics, lifestyle	Client engagement to improve self-care, person focused education – socially congruent care close to communities
	Poor awareness, prevention, education, lack of nutritional food resources	Education in schools, organizations and one-on-one
Caregiver, assisted living, palliative support	Lack of support in Kenora	Lack of funding and additional coordination and staffing
	Accidents and problems with patients	Offer afterhours and weekend care
	Aging population - systems overwhelmed, not enough doctors	Hire more Nurse practitioners and GP's - Community paramedicine
	Mental Health Diagnoses, Addiction Issues, Un-diagnosed medical issues that are presenting as mental health issues, Assistance with activities of daily living	Offer appropriate housing to support clients close to health locations while being aware of bottleneck services, ensure client centered process
	Not adequate respect and recognition of the caregiving role	Offer higher compensation
	Individuals denied access to care for being too high needs	Further understanding and education around developmental and intellectual disabilities and aging population in hospital and long-term care facilities
	No support for clients with mental health & addictions issues in the home	Revamping the system to make it more client focused - to ensure vulnerable populations receive equitable care

Health Priorities	Challenges	Solutions
Housing	The lack of stable housing for individuals in this community is a crisis. Safe housing is a foundation for well-being and stability. With a lack of housing issues including mental health and addictions are exacerbated.	Safe and affordable housing stock that has wrap around services to aid in success. Services that are actually individualized and will adapt to the needs of the individuals served, If housing stock exists in private market a requirement is funding for repairs of units to maintain landlord, tenant, service provider relationships.
	Poverty, displaced population from the north	
	First Nation communities Elders wants to move into the city but no accommodations for them to access local services. Therefore, they are admitted to LTCH with no programs or services	Housing for Seniors with Social Rec, programs services, friendly visiting that we already do

6 Defining the Health of the Region

Phase 1 has focused on assessing what services are available at this time as well looking at the current state of health and well-being within the region. The ISS and identified needs and gaps of the ANHP region does not tell the full story without the support of adequate data. Reliable data is required to ensure a baseline of needs is true to the population trends of the region and will allow for adequate evaluation in real time of Home and Community Care services as the ANHP progress with the OHT.

6.1 Health Status and Utilization Data Provided

Data for northwestern Ontario is available from various sources (Northwest LHIN, Ontario Health Analytics, LWDH, ICES) and was reviewed by the Project Team epidemiologist. Ultimately regionally specific data that utilizes a methodology to reflect the population of the ANHP catchment area is deficient. If the OHT's are expected to define not only their key populations and also understand the true needs of that population then resources and focused concentration on accessing reliable and regionally specific data is needed within Phase 2 of this work. A community health assessment that includes understanding the importance of linking priorities to data is recommended.

The current ANHP data provided by Ontario Health Analytics Insight Branch was intended to provide a vast set of important indicators. However, the data is based on an "attributable population", not the actual population of ANHP residents, meaning the received data does not accurately describe the true health status or services of the catchments area residents. Further investigation and comparison of running a small number of indicators using different geographic boundaries is recommended as a starting point to assess the degree of differences and importance of re-running all indicators within a new geographic boundary.

Table 6 illustrates the attributable population which was used by Ontario Health Analytics in providing all health indicator data. In this first run of data, over 14 of the included communities do not fall within the ANHP catchment area and "all other communities" would have to include over 10 communities within the ANHP to reflect the actual population. A second run by Ontario Health Analytics was provided

with closer to true geographical boundaries, however, the inclusion of several additional urban centers such as Dryden, Sioux Lookout, Thunder Bay and Kitchener again results in data with a more urban skew and tend to under report the disparities in health within the region.

Table 6 ANHP Attributed population for all health data

Census Subdivision (CSD)	Attributed population	% of total attributed population	Actual CSD population
Kenora 38	14,881	57.9%	16,053
Kenora, Unorganized	4,073	15.9%	8,679
Whitefish Bay 32A	1,322	5.1%	1,926
Wabaseemoong	757	2.9%	800
English River 21	682	2.7%	723
Shoal Lake (Part) 39A	545	2.1%	615
Kitchener	531	2.1%	248,185
Toronto	247	1.0%	2,850,074
Sioux Lookout	238	0.9%	6,295
Thunder Bay	217	0.8%	113,744
Pikangikum 14	169	0.7%	2,195
Rainy River, Unorganized	165	0.6%	2,599
Kitchenuhmaykoosib Aaki 84 (Big Trout Lake)	63	0.6%	1,372
Ottawa	98	0.4%	996,556
Lac Seul 28	91	0.4%	2,312
Waterloo	88	0.3%	107,272
Sandy Lake 88	87	0.3%	1,962
Ignace	85	0.3%	1,271
Fort Frances	81	0.3%	10,224
Mississauga	79	0.3%	775,453
All other communities	1,097	4.3%	9,103,259
Total ANHP Attributed Population	25,696		14,251,569

*First Run Data provided by Ontario Health Analytics.

Challenges were met during the data collection in Phase 1 with support requested from IntelliHealth and CIHI. Unfortunately, due to time pressure and the impact on workload during COVID-19 full data were not able to be obtained. Phase 2 will focus on enhanced understanding and communication regarding data.

During community engagement, several other sources of individual organization data were provided, and again, the biggest disparity and challenges was recognizing a very large underreporting of First Nation utilization. If the ANHP were to utilize only the Health Analytics data they would not accurately reflect the true health status of the community.

Kenora Chiefs Advisory (KCA), had commissioned a report from Mamow Ahyamowen (2019), a Project Partnership with Northwestern Ontario First Nations, ICES and MHLTC to work with First Nation communities to access and report community data in a respectful way. Results within this study showed several areas of statistically significant disparities in health between the communities served by KCA compared to Ontario. Although this does not identify all those served in the region it represents a high proportion and highlights key discrepancies in health for Indigenous communities in the region. **key findings are:**

- **life expectancy is much lower. 69% of deaths among men occurred before age 65 compared to 27% across Ontario, and 70% of deaths among women occurred before age 65 compared to 17% across Ontario.**
- substantially higher rate of chronic disease (e.g., diabetes, cardiovascular disease, asthma, cancer) compared to Ontario.
- Suicides and overdoses among young people in their teens and twenties are high (During Covid-19 response, the increase in mental health and addictions crisis and overdoses has risen)

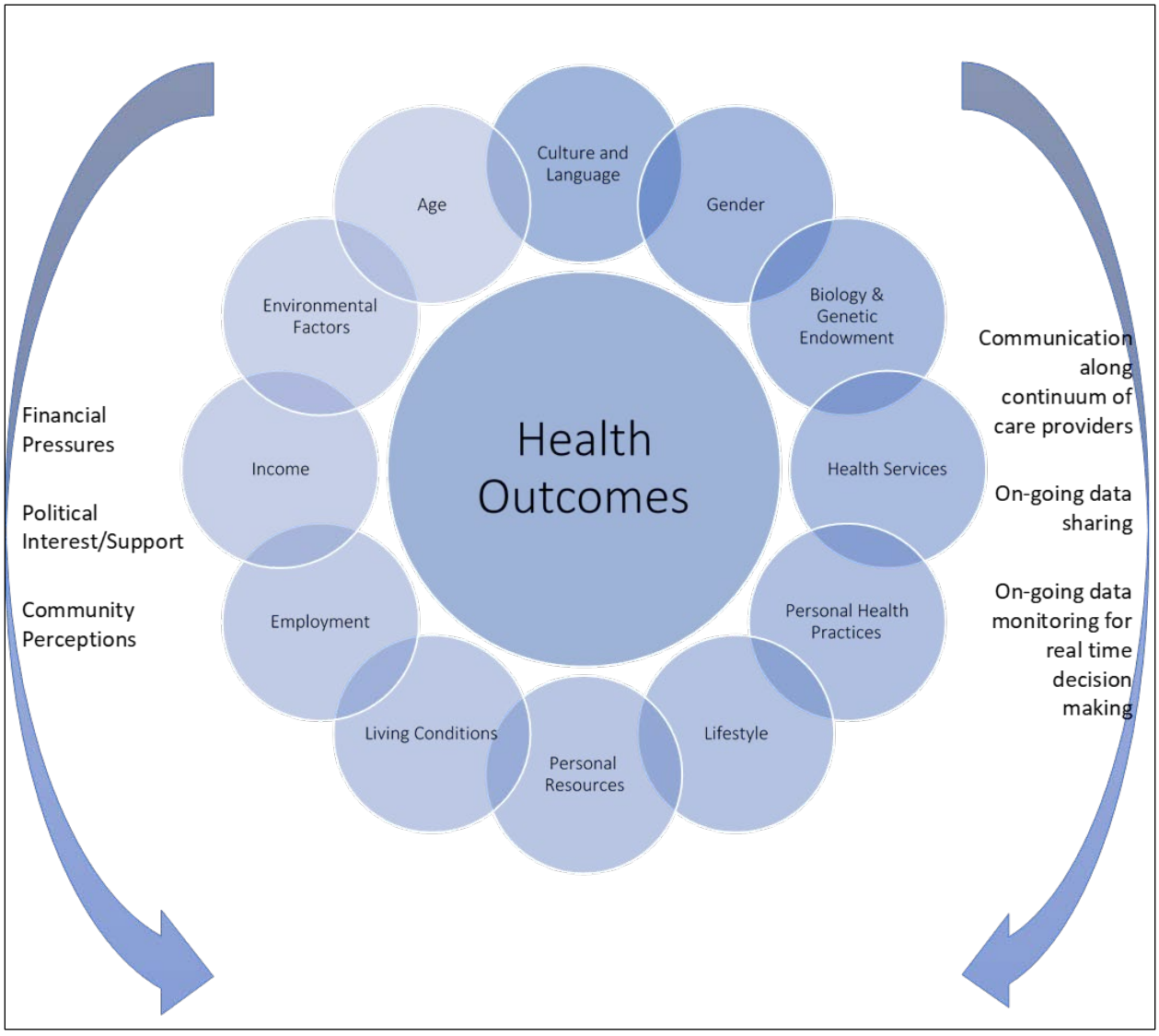
The report also states that KCA communities have more deaths in communities due to injuries, diabetes and infections compared to Ontario overall, all of which can be better managed with improved home and community care.

6.1.1 Linking Health Data to Determinants of Health

Figure 10 illustrates that health outcomes is at the centre of multiple determinants of health and all of which are impacted by factors outside the control of the health system but are the context in which it operates. Further, to continue to monitor and plan services effectively and minimize gaps, ongoing communication is needed. These are also key themes throughout Phase 1 engagement.

It is likely, based on community engagement and ISS that the interlinkage between determinants of health and health outcomes experienced by ANHP residents, in particularly those living on-reserve- that acquiring data which truly reflects the catchment area would provide further evidence that the challenges and disparity is much greater than currently relayed in data utilized to determine Provincial and Federal programming.

Figure 10 Health Outcomes within the context of determinants and system pressures



7 COMMUNITY VOICE: 10 THEMES FROM ENGAGEMENT ANALYSIS

This section focuses on providing more details and narrative from the analysis and results leading to the key recommendations provided in Section 1. The most important focus of Phase 1 was listening to and documenting the ANHP communities' voice. Over 140 people participated in some form of engagement providing their local expertise as patients, families, elders, cultural and traditional navigators and healers, leaders and front-line service providers about their lived-experience. The following provides detailed description of the 10 themes that emerged from the community-based engagement sessions. **Appendix 3** provides the raw notes and analysis from focus groups and interviews and **Appendix 4** provides a report from the March 12 2020 Front-line service engagement session held at LWDH.

7.1 Health Care Team Recruitment, Retention and Training

Across the region recruiting and retaining qualified front-line service providers is a challenge. Finding individuals who have the professional grit to do a little more than is comfortable, especially in terms of northern climate and geographical challenges, is seen as a skill that is more likely to result in job satisfaction and retention. Often this means that investing and training local residents into available health care roles is preferred, however, the model for reimbursement and provision of support appear to be outdated and limit interest of younger generations going into front-line service delivery. This is even more true the more specialized a Health Care Provider is and having specialized care becomes a real challenge.

"they don't understand the experience we have, living on First Nations, when we can't provide someone who comes from outside a safe house to come into, they say they can't provide services. This is the way we live. Our PSW and homemaker live in the community and they come into my house and provide the care I need. I think they do more than they get paid for" [Elder, WFB Focus Group]

Front-line service providers speak of the high turnover rate in Human Resources, providing front-line care and feeling alone in the work they do, especially in situations where there is no oversight (Supervisor or coordination role). Compensation does not reflect the travel time, level of skill and commitment needed to provide safe, effective and culturally congruent care.

"One example is Paramed is the largest provider of home care supports for Provincial clients but their ability to retain team members is low and then our clients get multiple phone calls, multiple points of contact with the same questions which leads them to be confused, very frustrated and then decline assessment or care." [DKHA Focus Group]

A consistent strength in referring to quality front-line service delivery is related to having local residents trained and hired in community. If the home care service providers have grown up and live in the community they serve, their level of satisfaction is greater, and they are more likely to retain the job and build trusting relationships.

Perspectives from front-line service providers shared a common theme that ongoing training and opportunities to connect with others holding the same positions are important for morale and job satisfaction. Conferences, awareness events and continuing education are all incredibly valuable to building service providers confidence and feeling a sense of security in their position (knowing they are not alone and they build a network they can connect to should they need someone to fill in for vacation or support during a particular difficult situation).

A Note about the On-Reserve Experience

Patients, elders and family members speak frequently of front-line service providers who come from outside the community lacking a basic understanding of the lived experiences and environment First Nation members go through. Frequent dropped visits and appointments cancelled are often communicated last minute or after the client had waited all day for the scheduled appointment. Often the reason is the specialist was redeployed to a more urgent matter, or was no longer available to the community (quit and not replaced) or no alternate means of providing the service was available.

Communities with larger populations are able to scale-up services into creating a Home and Community Care Program because the Federal funding model is population based. With greater resources comes the ability to hire a Home Care Coordinator to manage assessments and case coordination as well as hiring multiple PSW and homemakers. When this type of Home Care program can be developed in communities (for example in Whitefish Bay and Grassy Narrows) there is a sense of team with staff retained for long periods of time who speak about building trusting relationships with their clients and each other.

Smaller communities whose funding is far more limiting means they have limited resources and are only able to hire part-time or a single PSW and home-maker position (examples include NWA#33 and AWZ#37). These communities rely on outside nursing services and Community Health Representatives to facilitate Case Management a couple times a week. In these cases, it appears job satisfaction and retention are much lower. It was noted that in small communities these positions are difficult to recruit and retain, mostly due to factors contributing to burn out and being solely responsible 24/7 in community for home care clients.

> *"when you feel like you can't meet the expectations your job description tells you have to meet because you have to do it in 2 hours and get to the next house without transition time and you don't have anyone to turn to for support or situations that you need to check-in on how to deal with, you burn out. You don't want to do the job. We have had an opening for months that we can't fill because the training needed, level of skill required doesn't meet the pay received and those that have tried it give up because they get blamed for providing poor care. You can't do this job part-time and that's all you are compensated for."* NWA33 Focus Group participant

7.2 Geographic Isolation Limits Equitable Access

The further away one lives from Kenora the more limited and inconsistent services are. The issues and problems with technology and unique challenges with weather, especially in winter causing unsafe travel conditions are a huge factor attributed to limited services. The more specialized a service is the less likely that a professional is willing, within available compensation models, to travel long distances for appointments.

Another aspect of geographic distance as a barrier is in the need for 'pre-scheduled' appointments that do not match up with the needs of a patient. The most impactful examples of these situations include:

- Readmittances into hospital increase on weekends and after hours and the severity of condition also increases. Accidents happen, health fails, and issues come up that are exacerbated because in the evenings and weekends clients are left alone. There is a feeling that when left alone too long feeling socially isolated and loneliness or boredom leads leads individuals to push themselves outside of their ability resulting in potential accidents, and on weekends and evenings the response times can be long, often exacerbating the conditions and resulting in admission to the hospital;
- Mental health and addictions, where a mental health worker comes into a community every other Tuesday and is able to follow-up with wellness checks. However, someone cannot predict or pre-schedule a mental health crisis. When individuals are faced with a trigger and their trauma

situation often results in an emergency response without any community tools or supports for offsetting the situation.

- Dementia related incidences, such as falls, fires, accidents and lost elders roaming in the community, dramatically go up after hours and on weekends because their home care is weekday and they are left without activity or care during evenings or weekends.

> *"The ability to keep a person at home with dementia is far more difficult with inadequate home support, causing care partners to seek 24-hour care in hospitals because they have no other options"* DKHA, Focus Group participant

> *"It has to be cheaper to provide 24-hour care on reserve than have our elders in hospital beds in the city?"* WFB, Home Care Coordinator

In Kenora area, there are EMS and some after-hours supports available, however, the more remote one lives the less likely any safety net is in place to provide the check-in or an urgent wellness check/lift from a fall. In addition, remoteness limits access to specialty services and options for community services that add to quality of life and the ability to build capacity for self-healing.

7.3 Travel Grants and Transportation Programs are Needed

The geographical distance for travelling from home to appointments or having service providers visit the home is by far the most unanimous challenge to equitable access and continuity of care. Outdated compensation models and policies with limited medical transport in individual communities and organizations, inconsistency of transport programs/vans from community to community (and day to day), and lack of infrastructure to facilitate accessibility all contribute to challenges in consistent, timely, efficient and safe care. Often travel/transportation has been discussed in conjunction with technology and the use of virtual appointment and telephone calls to coordinate better on-time and efficient connection to follow-up appointments and professionals. The technology on reserves and in remote communities is simply not consistent or of a quality that allows for a solid OTN program but has potential for supporting and providing choices to individuals and their family's that could really improve quality of care for patients and better involve families.

The gaps and challenges are many and include several categories of need.

7.3.1 TRANSPORT VANS AND DRIVERS

- Patients are dependent on the medical transport driver for meeting their appointment times. Many stories of late pickups are because current transport arrangements are limited and dependent on maximizing pick-up and drop off of multiple clients and faced with weather related travel delays. In return, the client is deemed by the organization as having "missed their appointment" and are disqualified from rebooking or receiving further follow up care.
- No wheelchair accessible transport as cabs and transport vehicles often don't have the space for mobility devices along with the patients.
- Lack of well trained and qualified staff or drivers to transport to the function effectively (as those from DKHA note, often clients need help with the last few activities to get ready to leave the house and they need help getting back into their homes and settled).

7.3.2 *COMMUNICATION AND PLANNING*

- Connectivity with limited internet and cell service outside of Kenora's urban region means that making the appropriate call to say your late or your driver hasn't arrived yet, is a regular situation faced by many, especially those on reserve or living in remote camp-like settings.
- There is a disconnect with getting patients home and it is at the responsibility of a patient to be able to navigate the system to find their way back home. While an ambulance or a taxi is arranged by someone to get an individual to the hospital or a specialist appointment. The return trip is often left in the hands of the patient, a coordination task that often feels overwhelming and is based on the assumption the person has access to a phone and the correct contact information to arrange a ride. Often, individuals are at the mercy of medical transport availability, with the potential of stranding a patient in Winnipeg for days until a transport is able to pick up and returning individuals to community.

7.3.3 *TRAVEL GRANTS FOR FAMILY*

> *There is so much focus and worry about 'abusing the system' by people taking travel grants and using them as a 'city visit' that you go through a process of proving you needed and attended the appointment for $.0.28/km! this is nothing considering road conditions and time it takes to fill in and verify the travel grant. In addition, the travel grant allows for $600.00 to be paid to a taxi to go to Winnipeg and back, so it actually deters family members taking on the task of accompanying someone to an appointment.*
> Obashkaandagaang Focus Group participant

- Limited compensation for self-driving or having a caregiver drive to appointments. Complicated travel grant forms and compensation submissions.
- Barriers within our services often disqualified certain situations and leads to feelings like the patient/client has done something 'wrong'.
- On reserve, many Bands pay up front for travel grants because the time it takes to get approval is lengthy. However, the amount of proof and paperwork to get reimbursement often leaves the Band in deficit for their transportation programs.
- Travel grants are time consuming and require the client to pay up front with a process for reimbursement in place. The cost of taxis is too high and reimbursement for personal travel is too low.

7.3.4 *FRONT-LINE WORKERS NOT COMPENSATED FOR TRAVEL TIME*

- HCCS front-line staff working in remote communities are rarely compensated for their travel time from client to client; both in terms of allotted time and in financial reimbursement. Infrastructure is hard on vehicles with poor conditions in local roads and driveways often leading to damage and limiting lifespan of vehicles and many on-reserve PSWs and Homemakers do not have transportation so have to walk from home to work, which often is considerable distances.
- Specialists travelling to remote communities need to feel the distance is worth it. As a result of stressful road/weather conditions, often visiting specialists end up taking on the challenge for a short time. This limits the quality of long-term relationship building and trust in client interactions and care. The insights from front-line team members suggest that if there were safety nets and supports in place so that everyone would feel consistently successful in the quality of service

provision the likelihood of satisfaction and staying long-term in serving a community would increase (for example, everyone has access to telephones so they can call and update clients in a timely matter when delays or weather changes plans). Virtual visits can be used as a back-up and relationships with in-community service providers are strengthened so care plans and wellness checks can ensure continuity of care when interruptions due to travel are experienced).

7.4 Limited Choices other than Home or Hospital

Throughout the region there are limited options for respite beds, supportive housing, day centers and wait lists across all of the Northwest Region for assisted Living and LTC beds. In a North West LHIN study as of January 2020, there were 111 Assisted Living spots available in the ANHP catchment with over 111 individuals remaining on the wait list for placement. With Long-Term Care there was a capacity of 341 Long-Term Care Beds across the entire region with over 100 waiting for a spot.[3] This means for most of the population, especially those living rurally, the options are to stay home or be admitted into hospital. For those with developmental challenges access to coordinated care between integrated community participation and home care essential services is needed. In addition, overcoming the deficiencies in enhanced services such as Physiotherapy, Occupational therapy and Speech language therapy are repeated themes. Insights from community show how limited options are and a fear of being admitted into the Hospital on a long-term basis leads to emergency situations. Patients and caregivers have waited until their situation is so desperate before heading to the hospital that their condition and ability to heal is greatly reduced. A continuum of care options should be a choice available, including:

- Home and Community Care beyond Monday to Friday 9 to 5
- Respite Beds and programs, including Day Centers
- Assisted Living options
- Palliative care programming and Hospice Beds
- Long-term Care Beds

Also key to this discussion is the assessment model; where the Federal Programs jurisdiction provides only for on-reserve situations and are not typically mandated to provide intake and admission services (unless the reserve has managed to secure their own independent assisted living/long-term care facility). Typically, intake and admission services are Provincially coordinated, however the disconnect with the assessment model often leaves on-reserve referrals for assessment and intakes within a grey area. At a time when the demand for services are becoming greater and the cases more complex, it is crucial to ensure every available resource is integrated, a full continuum of care is available closer to home so that they can be provided through equitable assessments and access criteria.

A Note about the On-Reserve Experience

There are no funded programs on-reserve that result in palliative care programming. However, in ongoing engagement with First Nation members, it is evident the cultural systems for end-of-life care have remained strong. Communities consistently speak of being present and sitting with someone when the primary need is comfort care.

[3] Northwest LHIN, January 20202: Informing Care for Seniors in the North West LHIN.

"Families and neighbours just come together and sit with the person. It just happens. Really it feels like the whole community knows and watches out for the family, brings food for family and lets people take time off work to go sit with their family members." Health Director, WON

This is a strength and opportunity where any future palliative care and respite service need to be careful not to interrupt the strength of community response.

7.5 Community and Front-Line Staff Safety

There are two particular areas where community and staff safety challenges have a limited ability to provide adequate home and community care, in most cases, these safety concerns are linked to conditions on-reserve or in very remote areas. These safety challenges include:

- **The infrastructure/equipment to support mobility does not meet the environmental conditions.** The conditions of individuals entry ways (stairs up to the house), driveways and road systems connecting houses to health centers are often in disrepair. The act of getting out of one's home into a vehicle or to use a mobility device is problematic and causes safety concerns. The more remote a patient lives, the more likely that environmental conditions (seasonal freeze thaw, spring flooding, summer droughts, winter deepfreezes and snowstorms) have placed a great amount of strain on outside infrastructure. Equipment like walkers and wheelchairs provided through HCCS do not have the integrity to withhold this kind of wear and tear. The fear of breaking equipment or worse, encountering an accidental fall down a set of stairs, ramps or outside and not having EMS be able to respond for hours. The ability to get outside or support one's own family member through mobility challenges is very limited.
- **Workplace Safety for front-line service providers limits ability to provide services in the home.** Service providers will not enter houses in disrepair, those that are unsanitary and those whose pets are not on owners' command. Living in Northwestern Ontario translates to living conditions that match the environment. Many have woodstoves, non-paved drives and entries, staircases and entries that have premature wear and tear, not to mention holding tanks for limited bathrooms in overcrowded spaces and boil water advisories.

A Note about the On-Reserve Experience

While there were many stories shared about delays in accessing equipment and the infrastructure conditions limiting mobility or leading to accidents. The following is a particularly impactful story that seems to exemplify the on-reserve experience of facing these gaps and barriers on a day-to-day-basis:

…it took a long time for my husband to be assessed and qualify for a wheelchair. At first, when he arrived home, we would roll him onto a sheet and I would drag him to the bathroom and together we would pull him up to go to the bathroom. I don't think that was safe, it was hard and I was scared I would hurt myself. But then we qualified for and received a basic wheelchair from home care. It came time to go for a follow-up, I had help from the PSW and we struggled to get him down a make shift ramp and into the wheelchair and as we hobbled it through the ruts left on our gravel driveway from spring freeze/thaw the wheel fell off. It turns out we do not qualify for another wheelchair for two more years! But the first one didn't last because it wasn't strong enough to get him

through our driveway, never mind being able to take a walk with him outside for fresh air. I feel isolated and we don't go out because it's too hard, and if I fall and can't move, what if I can't reach our phone, we only have a landline, then we will be lying there until someone finds." Elder, WFB

The ability to feel safe and confident within the northern conditions is increased when front-line service providers come from and live in the community they serve. For front-line workers who live within a community and are used to certain levels of disrepair, animal interaction or cleanliness. The willingness to exercise some oversight and continue providing in-home care has been something noted as a strength in hiring local community members for these roles.

7.6 Determinants of Health

Service gaps are compounded by substancial deficiencies in physical and social determinants of health. A recurring theme was how HCCS delivery is impacted by determinants of health and without addressing the root of systemically poor determinants of health in the region, the ability to improve outcomes with changing HCCS delivery was not realistic. For those who participated in this study and struggled to meet their basic needs of shelter, food and clean drinking water and were faced with other poor determinants of health noted these major barriers needed to be overcome before they could provide insights to improving HCCS delivery. This is relevant across the entire region, as Kenora and surrounding First Nations are at the intersection of a growing mental health and addiction crisis, exacerbated by lack of affordable housing and treatment or care options. Up until recently, the poor determinants of health as a barrier to providing HCCS was particularly relevant for on-reserve conditions and remote living as the historical make up of the Kenora ANHP lies in truths of Treaty #3 and its related colonial hurts and traumas as well as in resource development (forestry, pulp and paper milling and mining) all of which have had a lasting legacy of living a hard 'northern' life, often associated with people living geographically distanced from Kenora. Having said that, the increase in homelessness and substance addiction within the City of Kenora makes this a very relevant and urgent conversation for improved coordination and integration across various sectors of ANHP transformation.

A Note about the On-Reserve Experience

Many elders and family members who participated in focus group discussions felt their community's own determinants of health needed to be addressed before they could consider how to make suggestions for better home care services.

it's difficult to provide input to home and community care when we don't have adequate housing or food security. My friend, an elder that is quite frail, has 10 people that live with her in a small house with one bathroom. Some of these people are seen by Home Care as capable of providing her support so she doesn't qualify for much, however, the reality is they are facing addictions and mental health issues themselves. She gets a Meals on Wheels delivery and when I go to open the fridge to bring it to her to eat, it's gone, the younger generations spend on their addictions and then are hungry and have none of their own groceries. We have no way to ensure we can get groceries for just her and have her room and bathroom cleaned. We need our leaders to deal with the housing

and food security issues, addictions due to systemic trauma before I can provide advice on this. Elder, Obashkaandagaang

7.7 Culturally Congruent Services

Family members, patients and elders described their mistrust of a system that provides inconsistent care, promises of follow-up or specialty appointments broken. Reasons often refer back to a revolving door of assessments, long wait periods for assessments, and constant introduction of new care providers which limit the ability to build trusting relationships that places the healing of the patient as a priority.

There was a common thread across all shared experiences in that services were not coordinated or integrated and at the root was a mistrust in the system to truly listen and support the needs of the client in a holistic way. This theme crosses on and off-reserve care and includes:

- Impact of the visiting "parachute professional" a care provider is brought in from out of region for a block of time and the questions and interactions feel like they are starting from scratch each time, often with a different professional filling the role the next visit. Having repeated questioning processes becomes exhausting and limits long-term success seen with trusting relationship formation.

  Within Kenora region, Paramed is the largest provider of home care but there is no retention of team members so clients get multiple phone calls and points of contact with same questions and eventually start to resist care. DKHA Focus Group

- There is a fear of being stigmatized and feeling shame or blame for the issues a patient faces (Mental Health and Addictions, Diabetes, Renal Failure etc.) and a fear of not qualifying for the help needed resulting in being sent away from home for care.
- Mental Health and Addictions is one of the region's top health priorities and currently is not integrated within the HCCS program which limits successful outcomes.
- Spiritual aspects of care are important to respect whether they be traditional or Christian or other belief systems.
- Language barrier and miscommunications. This goes beyond translation into different languages but in providing information that can be heard and understood. Communications should meet capacity of patient to understand (this can be cultural and language barriers or cognitive functioning abilities). The stigma with terminology like Alzheimer's and Palliative Care often result in resistance to care or feeling that what is being proposed is culturally incongruent and feels "unjust'. Fear is also common around terminology like Alzheimer's and Palliative Care. Language barriers, not just translation but helping patients and families understand and navigate the system. Understanding the individual's personal story and home environment to participate in their care plan were felt to be major contributors to patients having care that did not meet their needs. A front-line nurse explained the situation:

  The existing system is structured around rigid criteria, two different funding models, and silo'd guidelines and protocols for each basket of service available. Front-Line service providers have to work within their job description and a care plan, often provided

without family or community input, especially if the patient is from on-reserve. There is no oversight to support all team members to invest in learning the local resources available around them, so they can place patients at the center of their care by ensuring the referrals needed by the patients happen when they need to. Ultimately, the system has failed to teach front-line team members to truly listen to the patient as experts in their own lives and knowing what they are capable of doing to support their own healing. This means you have to be aware of the patients and family's culture, language, home conditions and capacity to follow care plans. Nurse, Grassy Narrows

A Note about the On-Reserve Experience

Time and again the messages were relayed regarding the strength in learning from Elders and that with limited HCCS frail elders were being isolated and the community was loosing valuable opportunities for intergenerational transfer of knowledge (language, traditional teachings, healing practices, activities). It was felt that a huge opportunity was missed by keeping elders busy during the day in meaningful ways which in turn would keep them safer after hours and on weekends because they would be satisfied and ready to rest after being busy. Unfortunately, family members and other allied service providers organizing events in the community worry about the liability and mobility of elders and the risks of them falling or getting injured (infrastructure and equipment for safe mobility is just not available requiring often two or three people to help with transportation). Repeatedly, there was a gap in being able to accommodate transporting and supporting elders to attend community events and programs, something that if it was facilitated, would create intergenerational connections and transfer of knowledge. It was felt that if elders were busy and respected and utilized their own health would be maintained and improved. If HCCS could adapt to allow for transportation, and the time and resources for caregivers and companions to go and pick up and drop off elders safely to community events so much would be gained.

7.8 Governance and Oversight

Community engagement speaks to a lack of coordination between federal and provincial models of service delivery, particularly impacting First Nation member care. Based on results from the Inventory of Services Survey and community engagement sessions, there has been little work to streamline, integrate and provide across all service providers. A consistent expectation for meeting equitable benchmarks and standards is reflecting these in policy, procedures, legislation and oversight bodies that are aware of the local conditions and resources available.

The Provincial and Federal models are described earlier in this report as the two bodies that provide funding for HCCS in the region. There are challenges with integration and coordination between the two funding sources, especially in regard to transitional care for First Nation Members and caring for members living off-reserve. This section focuses on community insights regarding compliance, consistency and accountability due to governance.

- Evidence and data-driven evaluations of programs are not adequate as the data is often for the larger Northwest Ontario region, including Thunder Bay. Consistently, there seems to be reference to failure to deliver adequate services but a lack of administration willing to acknowledge that failure. The feeling for this, is that funding bodies provide their

governance/oversight from Thunder Bay and truly are unaware of the unique failures/challenges faced by the Kenora ANHP region.

- Provincial assessment and eligibility criteria are too rigid and formulated on what is feasible in urban centres.
- Holding front-line teams and service providers accountable to consistently meet benchmarks and standards is a repeated theme. Every organization and service provider seem to have their own siloed structures that were created early in the formation of HCCS:
    - Federally, each community manages their own Home Care based on a population funding model implemented in 1999, with salaries never receiving any COL increases since this time. Accountability and oversight are managed from a regional office in Thunder Bay. The population-based funding model is perceived to be at the root of many challenges. Small communities do not have the resources to implement a consistent level of standards, policies, HR procedures, oversight and accountability structures.
    - Provincially, private contracts hold the largest funds from the LHIN to provide home and community care, but their governance and accountability structures – while bound to Provincial standards are felt to not have the oversight or review to be held accountable to them consistently.

ParaMed's services are very inconsistent with a very high turnover rate in Health Human Resources. There does seem to be inconsistent experiences in the care provided by ParaMed. DOKURA Focus Group participant.

- Patients and front-line service providers noted the largest gap linked to lack of coordination. Integration between the two funding bodies is in relation to transition planning from hospital to home and providing specialized care on-reserve.

Another key theme in relations to Developmental Supports and Community Support Services not captured under either the Provincial or Federally Home Care programs are often directly related to support individuals to succeed staying at home. Looking at unique services that are provided under other funding or co-pay programs, the value of building capacity within the ANHP and getting community supports in place to support holistic wellness and integration into community living is important to the Working Group and participants.

"It's not always about services but its also about building capacity in community and getting community supports in place… and connecting and integrating to many of the services provided outside of home care." KACL, Senior Director, District Services.

7.9 Caregiver and Community Support

It was consistently felt that family of patients become more of a burden to care planning than part of the care team. There are several noted reasons this theme is prevalent:

- The Federal (First Nation Members) and Provincial jurisdictional disconnect and lack of integration, especially with regards to discharge planning (Transitional Care Plan formation) and it appears that family members living on reserve are not regularly included in transition planning.

- The assessment and eligibility process is rigid and restrictive. Unfortunately, in the ANHP catchment overcrowded housing and Mental Health and Addictions are predominant issues that families face. But the assessment and eligibility criteria basically provide two choices. The care is "all in" because they live alone or there is limited help because other family live with the client and are deemed primary support for the client.

  Overcrowded housing usually means a family member of age is deemed as able to help support the client, but sometimes, or usually, these households have complex situations and the support is being asked of someone is struggling with addictions, mental health challenges, unable to manage basic meals, joblessness. So the client does not qualify for homemaking or PSW support but when you go in later the house is a disaster and the client has been neglected.

- Family members feel a lot of fear and shame for not knowing how to provide adequate care, especially in regard to cognitive impairment. The other area where fear limits healthy activities and increases feeling of social isolation of being the sole provider/responsible person should anything go wrong and the fear of an accident or incident, particularly if they happen after hours and weekends when limited safety nets or emergency response is available.

Family members mentioned the need to be trained and educated on how to participate fully. When thrown into care planning or supportive roles there is a feeling some feel lost and unable to follow what was needed. Sometimes related to the care team or provider not understanding the insurmountable challenges that would be faced at home so suggested care plans were not feasible and other times, simply not understanding how to implement and do care properly.

7.10 Technology

Technology was not brought up independently as a challenge or solution but rather indirectly through additional probing for finding care solutions to travel and transportation challenges. Technology seems to be linked closely to supporting equitable access and creating a 'safety net' within the travel and transportation challenges raised. The challenges, once probed include:

- Inconsistent and ineffective connectivity. Weather dependent and not available in high speeds for quality virtual appointments. Surprisingly this is not limited to remote or First Nation Reserve situations. Even those close to Kenora city boundaries struggle with quality and consistent connectivity, creating multiple situations of frustration when trying to provide virtual care.
- Having all forms of connectivity per household is cost prohibitive. Most households do not all have three usual forms of connectivity: Internet, landline and cellular phones. Many pay for internet connection and then use their mobile devices when internet is available without buying cell service.
- Virtual appointments, OTN works great once a relationship is already established. However, with a first-time interaction, there tends to be a mistrust and feeling like the treatment received is unjust and unequal to others getting treatment in person.

There is a feeling that if it was easy to call while en route to an appointment to let service providers know that a driver is late in getting a patient to an appointment, that much of the feelings of blame for

missing would be alleviated. However, often care plans don't come with direct phone numbers and individual patients don't have the cell service to make this connection. Perhaps transport drivers and vehicles need to be equipped with the ability to take on this role.

8 CONCLUSION

The Working Group, KCA Indigenous Coordination Team and Consulting Project Team worked together during Phase 1 to ensure the communities voice would be heard as the ANHP OHT embarks on reimagining and redefining how HCCS is provided in the region. Evidence is growing that development of community-based health transformation results in more sustainable and healthier program delivery.

While it takes time upfront to embark on a full community engagement process, the recommendations providing in this report speak to the local conditions and sentiment that needs to be included for sustainable decisions moving forward.

The insights and inputs within this report offer the key themes for which the working group should focus on, along with key principles when advancing care. Further engagement with the local community and improved data collection is required as OHT moves forward. The next steps for the Working Group have been identified for Phase 2, along with considerations that should be made regarding the *Connecting People to Home and Community Care Act 2020* to ensure equitable services are available for the communities served by the ANHP.

Appendix 1

List of Engagement Activities and Participants

ANHP Home Care and Community Services Project – Phase 1

Community Engagement Summary

February to June 2020

Stakeholder	Engagement Type	Participation
All Home Care Service Providers for ANHP Catchment:		
Inventory of Services Survey	March 17 2020 deadline Follow-up with non-response delayed to Covid-19	Completed Surveys received from: - SCFHT - Naotkamegwanning (Whitefish Bay) - Firefly - LWDH – Mental Health and Addictions - KDSB – EMS - KACL – Children's - KACL- Mental Health Programs - KACL – 24 Hour Supports - Waasegiizhig Nanaandawe'iyewigamig - CMHA – Kenora - BISNO - Alzheimer Society Kenora - Kenora District Homes for Aged – Community Support - Northwest LHIN Home and Community Care
First Nation Communities[1,2]		
Animkee WaZhing 37 (Regina Bay)	Focus Group discussion February 25, 2020 10a.m. to noon	Dora Henry (Health Director) Alfred Oshie (Elder and NNADAP Darlene Oshie (Mental Health and Healthy Babies and Healthy Children) Stacey Dewitt (Community member with experience with Grandmother's home care) Roberta Mandamin (community member)
Northwest Angle 33 (Dog Paw)	Focus Group discussion February 25, 2020 1:30 p.m. to 3:30 p.m.	Ruby Shebahkeget (Acting Health Director, Healthy Babies/Healthy Children, Community Health Representative, Referral Clerk) Agnes Paul (Elder) Sophia Copenance (Caregiver of HC client with dementia/diabetes) Therese Bird (Prevention Worker) Margaret Paul (Homemaker)

Stakeholder	Engagement Type	Participation
		Stephanie Bird (Education) Rodolfo Paul (Community member) Melvin Henry (Community member) Vanessa Paypompee (Community member) Gerald Blackhawk (community member) Tina Blackhawk (OntarioWorks/Long-term Care) Monica Shebahkeget (Family Wellbeing Program)
Naotkamegwanning (Whitefish Bay)	Focus Group February 26, 1p.m.	Maxine Crow (Home Care Coordinator) Kathleen Joseph (PSW) Elaine Joseph (Caregiver) Mary Helen Joseph (Elder) Betty Tom (Elder) Mary Mandamin (Elder) Arvel White (Homemaker) Jane Tom (PSW)
Obashkaandagaang (Wash Bay)	Focus Group March 3, 2020 1 to 3p.m.	Randy Sinclair (Home Care Coordinator) Stewart (Elder) Rick (Elder) Youth (requiring care)
Grassy Narrows	Interview and community visit March 4, 2020	Wayne Hyacinthe (Health Director) Community visit – informal discussions at Health Centre and Youth Drop In
	Phone Interview July 8 2020	Laurie-Ann Marshall, Home Care Coordinator
Niisachewan (Dalles)	Focus Group/Elders Meeting March 10, 2020 9: to noon	Laurie Perrault (Home & Community Care Coordinator) Clarence Henry Jr (Elder) Larry Kabestra Sr (Elder) Archie Wagamese (Elder) John Henry (Elder) Sherman Kabestra Sr (Elder) Karen Bluebird (Elder) Nancy McLeod (Elder) Terry Greene (Elder) Guy Henry (Elder) Theresa Jourdain (Elder)
Wauzhushk Onigum	Interview March 10, 2020	Linda Copenace (Health Director) Stella Skead (Homemaker)
Wabaseemoong (Whitedog)	Focus Group Scheduled for March 23 2020 Cancelled due to Covid-19	*note – 1 questionnaire was completed by CHCP Nurse
Shoal Lake #40	Focus Group scheduled April 6 2020	*cancelled due to Covid-19 not able to reschedule

Stakeholder	Engagement Type	Participation
Iskatewizaagegan #39	Request sent out	no follow-up was pursued due to Covid-19
Front Line Workers	Questionnaire	12 completed
Patients/Caregivers	Questionnaire	4 completed
ANHP Service Providers and Organizations:		
Home Care Front-Line Agencies	Workshop Engagement Session March 12, 2020 9:00 to 2:30	Susan Fobister, Elder Robin Gould, NWLHIN (phone) Matt Cavner, BISNO Colleen Niel, SCFHT/ANHP Crisna Alutaya, WNHAC Wade Gagnon, NWEMS/KDSB Jon Olson NWEMS/KDSB Andrew Tickner, NWEMS/KDSB Kendra Dobinson, LWDH - rehab Catherine Cameron, KCA Ryan Rioch, CMHSS/KACL Marlene Kilfoyle, CMHSS/KACL Lynn Moffatt, Community Support KDHA Sarah Lava, Community Support Supportive Housing Maxine Crow, Whitefish Bay HCCP Coord Rylee Rieu, Alzheimer Society Kenora/Rainy River districts Rossana Tomahawh, Alzheimer's Society Veronica Fobister, KCA Karim Suleman, Firefly Brock Chisholm, LWDH (Part of day)
Alzheimer's Society KRRD	Questionnaires - Front-line Team	5 completed
Northwest Local Health Integration Network	Questionnaire – Home and Community Care Coordinator	1 completed
LWDH	Phone Interview March 2, 2020	Donna Makowsky, VP Patient Services
LWDH	Focus Group with Patient Care Team Scheduled for March 19 2020	Cancelled due to Covid-19 (not able to reschedule within timeframe of Project)
District for Kenora Home for the Aged – Community Support	Focus Group – Zoom – May 27th 2020	Sarah Lava, Supportive Housing Supervisor Kari Neil, Care Coordinator Jan Creed, Client Services Nicole Taylor, Client Services Kandus Williams, Adult Day Coordinator Sharon McIsaac, Regional Visiting Hospice Coordinator Lynn Moffatt, Director of Community Support Services

Stakeholder	Engagement Type	Participation
All Nations Health Partners – Home Care and Community Services Bucket		
Project Steering Committee	January 23, 2020 - Kick-off Meeting February 5, 2020 – Inventory of Services Survey Planning February 12, 2020 – Engagement Session Planning February 25, 2020 – outreach for uptake with engagement March 12, 2020 – Taking stock/problem solving March 19, 2020 – Cancelled due to Covid-19 Next meeting not scheduled due to Covid-19 (Exploring Zoom options for April)	Colleen Neil, Sunset Country Family Health Team (Chair) Karim Suleman, Firefly Kevin Queen, District for Kenora Home for the Aged Liz Boucha, Kenora Metis Council Maxine Crow, Naotkamegwanning Home Care Community Services Coordinator Vicki Barnes, KCA/Community Health Care Professionals Lynn Moffatt, Community Support Services (DKHA) Rosanna Tomashowski, Alzheimer Society KRRD Adam Vinet, NWLHIN Diane Pelletier, KACL Corrine Coffey, LWDH Donna Makowsky, LWDH Maureen Calungsod, LWDH Lorraine Johnson, WNHAC Marva Griffiths, Southbridge Care (???) Bob Stewart, Unincorporated Rate Payers/ANHP Andrew Tickner, KDSB – EMS Sarah Stevenson, KDSB
ANHP Sub-group	May 29 2020 – Brainstorming/Problem-Solving next steps within Covid-19 context	Colleen Neil, Chair Daphne Armstrong, KCA Vicki Barnes, KCA/Community Health Care Professionals Stefanie Bryant, KCA Veronica Fobister, KCA
Other:		
Kenora Metis Council	Started planning a session (interrupted by Covid-19)	Liz Boucha (Three calls to figure out how to move forward with engagement, different levels of challenges raised – Liz's request was to ensure that consideration and commentary to inclusion of Kenora Metis Council members as having unique needs and perspectives for how service delivery reaches them and gaps experienced)

[1] Participants were asked to sign in and verbal consent for including their names as participating in the process was requested. The sign-in was acknowledged consent to be part of Report results with commitment for reports to be provided to each Community and organization.

[2] KCA coordination team included: Veronica Fobister, Stefanie Bryant, Cathy Cameron, Lucille McKenzie and Kathy Kishiqueb

Appendix 2

Federal Landscape Report: Home and Community Care

Home and Community Care

All Nations Health Partners

Home and Community Care

July 10, 2020

Prepared by Calvin A. Morrisseau, B.A., S.S.W.,C.F.N.H.M

INTRODUCTION

I have been asked to take a more functional role by gathering some pertinent information on the services currently being provided by the federal and provincial governments through the federal home and community care program and the provincial program currently being delivered by the North-West Local Integrated Health Network. The information provided in this report is based on phone and email correspondence with key individuals from Indigenous Services Canada and from the LHIN. Personal experience as the recently retired Executive Director of the FFTAHS and as an Indigenous advisor to the project has added depth to the understanding of information provided in this report. The delivery of the federal program is and has been the sole decision of each First Nation Community on how and who they want those services to be directed. The money allocated by the federal government (a bit of history to follow) is for the sole use of home care services on reserve specifically for band members; however, it is still a local decision by Chief and Council who they can or can't accommodate with these funds.

Some First Nations have elected to hold on to their funding allocation choosing to contract or hire their own nurse or in some cases pool their money together to provide a more comprehensive program for all First Nations participating. It must be clear that the role of the federal home care worker/nurse falls clearly under the supervision of the regional office in Thunder Bay and this office is responsible for ensuring each home care nurse follows the guidelines within their scope of practice. The federal homecare worker/nurse is different that the one Indigenous Services Canada funds for public health.

The federal landscape

Public home care was created in Canada over the last quarter of a century as a result of both the federal and provincial government combining their energies to events occurring in health. Prior to the 1970s. programs tended to focus primarily on professional services and the acute care needs of patients. These programs were primarily local, community programs often hospital-based or organized through agencies such as the Victorian order of nurses and/or the Red Cross.

Given the vast variation of needs across the country it was identified that there was a need for the sharing of information on outcomes and best practice models and in addition there appeared to be a need to address illness within a broader spectrum

of care. In the earlier days, there was a push to develop a more integrated institutional and community-based services. The Canada Assistance Plan in 1966, became an important milestone in the development of home care through the creation of the federal funding formula based on cost sharing.

In 1977 the "E**stablished Programs Financing Act**" provided a vehicle by which the federal government could transfer funding to the provinces based on a population formula. This allowed provinces and territories the flexibility to develop extended healthcare services including ambulatory care and home care. In addition, other long-term care programs were included like long-term institutional care. By the late 1980s, home care programs had been established in every province and territory within Canada.

In 1994, the National forum on health was launched with the intention of involving and informing Canadians regarding homecare. In 1997, this national form released its report calling for increased integration of homecare within the publicly funded health care system and recommended a fund to support pilot studies and evaluations.

In 1997, in a speech from the throne, the federal government reconfirmed its commitment to a publicly funded and administered, healthcare system that provides universal access to quality care for all Canadians. With the agreement of the provinces and territories a multiyear funding agreement was created with four priorities for initial research. Those four areas of priority were homecare, pharmacare, primary care reform and an integrated service delivery system. This health transition fund also provided funding for national conference on homecare which was co-by the federal government and the government of Nova Scotia. In todays federal health landscape the footprint of these discussions and decisions are still very much evident.

Currently, most home and community care services are funded by provincial, territorial and in some cases municipal governments with the funding support from the federal government through health and social services transfer payments. Within some jurisdictions like Ontario, institutional long-term care services are provided through this system using either public or private delivery agents. There is a perception that private-sector healthcare has risen as the percentage of total expenditures has increased since the early 1990's. Those increases have increased

dramatically over the course of time to a point where health will make up a large share of provincial expenditures across all sectors.

First Nations Health Services

In the early 1900's First Nation communities were decimated by small pox, tuberculosis and other communicable diseases. In 1904, the Department of Indian Affairs appointed a general medical superintendent to start medical programs and to develop health facilities on reserve. Yet it wasn't until 1945, that the Nations and Welfare department was created as they would begin to take responsibility to the health and wellbeing of First Nation citizens on reserve.

Within First Nations communities within the Treaty # 3 area, health services in First Nations communities developed on a much slower basis that that of the mainstream society. In the 1960's communities relied on Medical Services Branch, to provide health services. Prior to 1999, there were no resources allocated by the Federal government for any health services for First Nations people. Health was monitored through the provincial system or the Zone health nurse who was an employee of Health and Welfare Canada.

Out of this initiative came the Medical Services Branch of the National Health and Welfare department. Medical Services became the lead department responsible for "Indian health" and sent zone nurses into communities and launched the first Community Health Representative and Community Public Health nurses.

In 1979, **(Indian Health Policy 1979**) the Canadian government put out a policy paper concerning Indian health. The paper basically denied the inherit right to health as being part of the earlier treaty negotiations. They did; however, believe it was necessary to provide those basic health services to First Nations people, providing no provincial services do exist. These points have long been statements of disagreements between the Political Treaty organizations and the federal government as there was a medicine chest present during negotiations. Other parts of Canada have the right to health written into their treaty.

In the mid 1980's there was a push by First Nations to gain control over their own health and the resources necessary to provide optimum health for their citizens. This is one area where some work has been done through different funding agreement ie: health transfer, block funding but it is recognized by all parties more

work still needs to be accomplished. The federal Home and Community was established with funding being distributed across Canada to First Nations using a population base formula. **(Berger formula)**

In the following years First Nations chose how to utilize these dollars, within Treaty # 3, some communities like those in the southern territory pooled their resources and funding an agency to provide those home care services while other retained those dollars and contracted those services while still other hired their own home care nurse.

The next milestone took place in the 2000's when the Medical Services branch was renamed the "First Nations and Inuit Health Branch". In 2017, when the name again was changed to Indigenous Services Canada as the result of amalgamating Indian Affairs and First Nations and Inuit Health Branch.

See slide presentation: "HCC ISC history and funding appendix 1 for more information attached

What the Federal system is meant to do?

Program Objectives:

- Build the capacity within First Nations and Inuit communities to plan, develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.
- Assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.
- 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.
- 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.
- Assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.
- Build capacity within First Nations and Inuit communities to deliver home care services through continuing education sessions, evolving technology,

and the development and implementation of information systems that enable program monitoring, research, defining best practices and evaluation.

Program Essential Service Elements:

A. Structured Client Assessment: The assessment process utilizes an assessment tool and includes ongoing reassessment to determine client needs and service allocation.
B. Managed Care: This process incorporates case management, referrals and service linkages to existing services provided in the community or elsewhere.
C. Home Care Nursing Services: Home care nursing services include direct service delivery and care planning, as well as supervision and teaching of personnel providing personal care services.
D. Home Support Personal Care: Personal care services could include bathing, grooming, dressing, transferring and turning. This component enhances, but does not duplicate, AANDC in-home adult care services.
E. Provision or Access to In-Home Respite Care: This service is intended to provide family and other informal caregivers with short-term relief from caring for dependent family members.
F. Established Linkages with other Services: The linkages with other services may include other health and social programs available both within the community and outside of the community, such as respite and therapeutic services, gerontology programs and cancer clinics.
G. Access to Medical Equipment and Supplies: This involves the provision of and access to specialized equipment, supplies and specialized pharmaceuticals to provide the care required to maintain patients in homes and communities.
H. A System of Record Keeping and Data Collection: This component develops and maintains a client chart and an information system that enables program monitoring, ongoing planning, reporting and evaluation activities.

The Federal Home Care Program was never meant to replace or stand in for the Provincial Home and Community Care Program; however, this was designed to fill in the gaps or provide a service where none currently exists. It was meant as a means to ensure First Nations as a result of a variety of reasons from staffing to

distance, had equitable resources to ensure all Ontarion's had equity when it came to the provision of health services.

The Provincial system

in December, 2012, the Executive Director of the Kenora Chiefs Advisory and the Executive Director of the Community Care Access Centre met to discuss how the Community Care Access Centre, could be more involved in the communities currently a part of the Kenora Chiefs Advisory. When asked why the Community Care Access Centre's do not presently provide services to these communities the Executive Director's response provided no insight into the current lack of available services. This lack of engagement could have been and likely would have been the result of years of misinformation, prejudicial viewpoints and fear that non-indigenous people in the community for whatever reason could be injured or worse. Since First Nations had access to federal home care dollars this may have been one of the misunderstanding which prevented CCAC work in the community.

As a result of this meeting an agreement was reached which would see the Community Care Access Centre's provide the service with the stipulation that upon arrival into the community support personnel from the First Nation or from the local region agency would go with the health professional from the Community Care Access Centre. Unfortunately, services by the Community Care Access Centre was not acted upon resulting in fragmented services in some communities and no service in others. In order for CCAC to go into the communities, it would invariably double the cost of the service as additional human resources would be required.

The Kenora Chiefs Advisory continued to work with a private agency to provide home and community care services to some communities within the Kenora region. The other communities utilized the federal program home care to the best of their ability. At the time of this report, the Northwest LHIN failed to respond to a request for any information which could and would improve on the service delivery to all first Nations and general public within the Kenora region. As First Nations struggle with deplorable health issues, the institutions within Ontario still move forward with disregard for any measures which might improve the situation.

Prior to the 2018, Provincial Election, the North-west LIHN became responsible for the delivery on Home Care Program which had been delivered by the now defunct

Community Care Access Center. A decision was made by the Chief Executive Officer of the North-West LHIN to redefine how Indigenous groups would provide input and advice as well as meaningful discussions resulting in meaningful recommendations was launched. This group was to have an Indigenous co-chair which would provide the LHIN with the first meaningful input from Indigenous groups. The group is still trying to define itself amid the changing landscape and the health crisis currently being seen across the country.

Following the provincial elections things began to change as the new governing party made changes to the health delivery system. In March of 2019 the provincial government began to dismantle the regional LHINS leaving in its place five new agencies of which the CEO of the North-west LHIN became northern lead and Thunder Bay became the regional head office. First Nation agencies and professional had long since echoed the call for input, notification and collaboration on those changes so the high rates of disease could be mitigated.

In addition to the announcement regarding the dismantling of the LHIIN's in favour of 5 Regional bodies to provide health care services the new government also implemented an Ontario Health Team model which is intended to bring care closer to home and to ensure the four pillars of its mandate is implemented.

"There is a new bold vision for health care in the province of Ontario. The initiatives currently underway – such as Ontario Health Teams – will help create a system that is integrated, innovative, efficient and able to respond to the short- and long-term needs of our patients. There is a clear commitment from the government to end hallway health care by building a modern, sustainable and integrated health care system that starts with the patient.

This new vision for health care in Ontario is well-aligned with the 'Quadruple Aim,' an internationally-recognized framework that designs and delivers an effective health care system. The four objectives of the Quadruple Aim are:

1. Improving the patient and caregiver experience;
2. Improving the health of populations;
3. Reducing the per capita cost of health care; and,
4. Improving the work life of providers.

The recommendations included in this report are aligned with the new vision and will make a positive difference in each area of the Quadruple Aim. In addition to the work already underway at the ministries, these recommendations will provide a roadmap to a new approach to health care that will keep patients from having to go to the emergency department to access service and avoid an admission to the hospital, if possible." [i]

On December 4, 2019, Kenora and surrounding area, after much work, was officially recognized as an Ontario Health Team. Representatives from the government, First Nations and the general public made the announcement in Kenora and the process for implementing community and regional based services closer to home had begun. The process would become heavily reliant on the mutual partnerships created in the community and delivering home care services was now under the mandate of the Ontario Health Teams providing consultations and implementation plans were set in place.

CCACs help residents get health and home care services paid for by the provincial health insurance plan; they can also refer you to other local non-profit and private organizations that provide home care, assisted living, and other services. The first service you'll receive is an **assessment** to find out what's needed, what your overall condition is, what help is already being provided at home, and the urgency of your situation.

If you need home care services include personal care to assist with dressing and grooming, nursing care and nutritional guidance, social work services, medical equipment and supplies, and rehabilitative care such as speech therapy, occupational therapy, and physiotherapy. **Specialized nursing services** include **hospice palliative care** at home and **rapid response** nurses who make home visits to help with the return home after a hospital stay.

The CCAC can also refer you to other groups for **community care** services including hot meal delivery, community dining programs, housekeeping, transportation and errands, and friendly visits and well-checks. The centre may also have information on short-term caregiver respite programs in your area, low-cost adult day programs, assisted living programs for seniors who don't require skilled nursing but can no longer live safely at home, subsidized supportive housing for adults with physical and mental challenges, and short-stay care in a long-term care home while

your regular caregiver takes some time off of while you are recovering from surgery or illness.

List of services CCAC provided

- IV Therapy
- Bloodwork
- PICC and central line care
- Palliative Care
- Wound Care
- Catheter Care
- Injections
- Vital Signs monitoring
- Medication reminders
- Personal care work
- Home making assessments

It must be noted that in some jurisdictions, if not all, the federal requirement for services is different from those of the Ontario system. In a lot of cases, a First Nation client would be eligible for services on the First Nation but not be eligible for services if he or she were living within Ontario's jurisdiction. This is due to the fact that the federal on reserve program does not use the same intake or assessment tool.

The other big difference between the two is that when a federal home and community care worker goes into a community they may assess and provide services on the same day at the same time; thereby, reducing the cost by eliminating one round trip. More importantly any client who needs services get service.

Retirement home information and long-term care home placements

Seniors who no longer wish to live at home and who don't need skilled nursing may choose to move into a retirement home. Your local CCAC can help you decide if a retirement home is the right setting for you, explain the licensing standards that retirement homes must meet, and give you information about nearby retirement communities. It's important to keep in mind that retirement home costs are not

covered by OHIP; they are private businesses and residents pay from their own funds.

If you or someone you care for needs skilled nursing care and is having trouble remaining at home safely long-term care, (LTC) may be the best option. Your care coordinator can help you decide if this is what you need, and if so, he or she can help you apply for LTC home admission to any Ontario facility. You can build a list of as many as 5 LTC homes and be added to their waiting lists, and if you need help at home while you wait for placement, the Wait at Home program can provide that assistance. Medical and nursing services delivered in long-term care facilities are covered by insurance; room and board are the financial responsibility of the patient.

Long-term care homes are publicly funded and operated by municipalities, not-for-profit organizations and private organizations. They provide health care and services to people whose needs cannot be met in the community.

Long-term care homes are licensed and regulated by the Ministry of Health and Long Term Care. The province has specific laws and regulations for admission to long-term care homes that are designed to ensure fairness and equity in the system, so that it can serve the needs of people with greater care needs as well as people who are still independent and able to move about fairly easily. First nations people who enter into a long-term care facility are granted a subsidy paid to the institution.

Long-term care homes can provide a residential alternative for patients with high care needs, who meet the following criteria:

- 18 years of age or older
- Have a valid Ontario Health Card
- Have health care needs that cannot be met with any combination of caregiving in the home or community
- Have health care needs that can be met in a long-term care home

COSTS

Although the Ministry of Health and Long-Term Care pays for the care you receive, you are responsible for accommodation costs, which are standard across Ontario.

Rates are typically reviewed annually by the Ministry of Health and Long-Term Care. Current rates (effective July 1, 2018 and subject to change) are:

TYPE OF ACCOMMODATION:	DAILY RATE	MONTHLY RATE
Long-Stay Basic	$62.18	$1,891.31
Long-Stay Semi Private	$70.70 - $74.96	$2,150.46 - $2,280.04
Long-Stay Private	$81.35 - $88.82	$2,474.40 - $2,701.61
Short-Stay	$40.24	N/A

In the provincial system a phone assessment is made to determine eligibility if eligible, a face to face assessment is made followed by the actual service which may be on a different day. This proves costly and detrimental to the health of the clients.

Some services are not provided to First Nation primarily due to location and jurisdiction. The rapid response nurse in some jurisdictions do not travel beyond one and a half miles which eliminates some communities. In addition, the rapid response nurse may not go to the community unless there is a specific agreement in place. Issues related to communication can also be problematic as a federal home care nurse contracted by a First Nation Health Service and the rapid response nurse can arrive at the same residence at the same time to provide the same services to the client. The elimination of this issue needs to be addressed through a more integrated process.

In addition, paramedicine is another service which has not usually reach the boundaries of the First Nations. A coordinated effort to bring these services to the First Nation can be actualized through a comprehensive planning process and vehicle similar to the one being proposed through the All Nations Health Partners and the Ontario Health Team model.

Although fully capable in some jurisdictions federal home care programs do not provide intake and admission services for First Nations people ready for long term care homes.. Intakes and admission services are solely provided by the Community Care Program operated by the North region in Thunder Bay. (what is it now called).

What are some of the gaps in services?

To have the Ontario program provide services to all First Nations in the Kenora region would greatly benefit and serve to improve the health outcomes of Indigenous people on reserve.

In addition, greater communication and partnerships between the two programs could serve to provide the service at a more financially equitable way. In a time when the demand for services are becoming greater and the cases more complex, it is crucial to ensure every available resource in within reach of all Canadians.

Changes to the Ontario assessment model as well as their practice must also change especially if services to remote areas are part of the catchment area. Servicing as many individuals as possible on a single visit would be optimal; however, at this time it is not part of the Ontario practice.

What type of funding model would work the best?

The author of this report wishes to make clear a couple points when it comes to how services should be funded. It is obvious by reports on the financial status of the Community Care Access Centre that the best way to fund this program is by putting the client at the center of the funding arrangements based on the assessment and eligibility criteria. This makes the assessment and eligibility criteria and process a vital part of ensuring equity for all Ontarion's.

The federal home care program funding by Indigenous Services Canada has long been an underfunded program which has potential in the fight to reduce the poor outcomes of First Nations people. Each First Nation if it is to provide the proper level of services must rely on other services for its more complex cases. For example: when someone is requiring seven days a week care human resources becomes problematic. This means that other services must work in conjunction with the First Nations to ensure each patient is care for in a respectful and adequate manner.

Since there are restrictions around who can be serviced with the federal funding it would prove beneficial for the All Nations Health Partners to work with First Nations to develop a clear statement on the services which could be provided by an outside resource should they wish to participate.

Treaty # 3 Health Transformation

The Grand Council of Treaty # 3 is currently working on a health transformation plan for all four regions of Treaty three. Changing the health landscape to include First Nations in the planning, organizing and implementing of systems is vital to the health and well-being of First Nation peoples. Traditional ceremony and medicines have been identified as one of the facets of health which must be further entrenched into any health care system designed to service the people of the treaty regions. It would appear to be a vital exercise to connect with this group and share your vision with them.

Calvin Morrisseau, B.A., S.S.W., C.F.N.H/M

Attached documents

1. HCC ISC History & funding Appendix 1
2. FNHCC background fact sheet
3. ANNEX C program description h&cc

Home and Community Care
Indigenous Services Canada (ISC)

Summary for Kenora Chiefs Advisory

Dawn Bruyere, RN BA, BScN, MSCN

July 9, 2020

Ontario Region:

4 Geographic Areas:

- South (28 communities)
- Moose Factory (6 communities)
- Thunder Bay (65 communities)
- Sioux Lookout (34 communities)

Facility Classifications :

- ***Remote isolated***: no scheduled flights, minimal telephone or radio services, no road access (Nursing Stations) (type 1)
- ***Isolated***: scheduled flights, good telephone services, no road access (Nursing Stations) (type 2)
- ***Semi-isolated***: road access greater than 90 km to physician services (Health Centre with Treatment) (type 3)
- ***Non-isolated***: road access less than 90 km to physician services (Health Centre) (type 4)

History…

By the 1900s, First Nations and Inuit communities were decimated by smallpox, tuberculosis, and other communicable diseases.

1904: Department of Indian Affairs appointed a general medical superintendent to start medical programs and develop health facilities.

1945: Department of National Health and Welfare was created.

1962: Medical Services Branch was formed by merging Indian Health and Northern Health Services with other independent federal field services.

1974: the *Policy of the Federal Government concerning Indian Health Services* was tabled. The policy reiterated that no statutory or treaty obligations exist to provide health services to First Nations. However, the federal government wanted to ensure "the availability of services by providing it directly where normal provincial services (were) not available, and giving financial assistance to indigent First Nations to pay for necessary services when the assistance (was) not otherwise provided".

History…

1979: a new Indian Health Policy was announced. It stated that uninsured benefits would rely upon "professional medical and dental judgment." The policy also recognized the need for community development, a strong relationship between First Nations, the federal government, and the Canadian health system.

Mid 1980s: Medical Services Branch started to work towards transferring control of health services to First Nations and Inuit communities through the Strategic Policy, Planning and Analysis Directorate.

2000: the Medical Services Branch was renamed the First Nations and Inuit Health Branch (FNIHB).

2017: FNIHB moved from Health Canada to Indigenous Services Canada.

ON Region – Province of Ontario

- In 2017, MOHLTC LHIN and ISC organizations are under transition
  - Community Care Access Centres (CCACs) had just transitioned into the Local Health Integration Networks (LHIN) in June 2017
  - ISC formed in August 2017

- In 2018, MOHLTC Budgets provide funding to all First Nations communities in ON region for Home Care Services

Indigenous Services of Canada

"The creation of the Department of Indigenous Services Canada is an important development in our renewed relationship with Indigenous peoples. These structural changes will allow our government to work more effectively with Indigenous partners to provide services that improve people's day-to-day quality of life. Our work will be based on recognition and respect for the right to self-determination."

The Honourable Jane Philpott, M.D., P.C., M.P.
Minister of Indigenous Services (2017)

Indigenous Services of Canada:

- Improve access to high-quality services for First Nations, Inuit, and Métis peoples.
- Support and empower Indigenous peoples to control the delivery of those services; and
- Improve the socio-economic conditions, quality of life, and safety in their communities.

First Nations and Inuit Health Branch (FNIHB)

Works with First Nations, other federal departments, and provincial partners to:

- Improve health outcomes;
- Provide access to quality health services;
- Support greater control of the health system by First Nations (Government of Canada, 2013).

Examples:

- Supports the delivery of public health and health promotion services
- Provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence.
- Provides primary health care direct services on-reserve in remote and isolated areas.

FNIHCC – Background

- Funding circa 1999

- Program rationale:
  - Chronic and acute care needs
  - Accessibility of health care services
  - Jurisdictional issues in health care delivery

- Basic Home and Community Care services that are comprehensive, culturally sensitive, accessible, effective

- Indigenous Services Canada provides program funding, **the First Nation manages the program/is the employer**

- Community based, community paced program planning and implementation process – each program is unique, based on the needs and characteristics of the community it serves

Home and Community Care (HCC) Program - ISC

- Primarily delivered by First Nations communities or Tribal Councils (and in communities north of 60)
- In Ontario, HCC is a Registered Nurse-led program (in regional office), delivered at local level (Patient Support Workers/PSWs) supervised by home care nurses
- Objectives of the Program include:
  - Services that are comprehensive, culturally-sensitive, accessible, effective
  - Assist First Nations living with chronic and acute illness in maintaining optimal health, well-being and independence in their homes and communities
  - Ensure that all clients with an assessed needs have access to comprehensive continuum of services in the community where possible;
  - Assist clients and families in participating in the development of care plans;
  - Utilize community support services where available and appropriate in the care of clients;
  - Build capacity within First Nations to delivery home care services through training, evolving technology and information systems to monitor care and services, and to develop measurable objectives and indicators

Home and Community Care Essential Service Elements

Funding is provided to communities to manage home and community care program, based on community need, existing infrastructure and availability of resources:

1. Structured Client Assessment Process
2. Managed Care Process
3. Home Care Nursing Services
4. Home Support Services
5. In-Home Respite
6. Established Linkages
7. Medical Equipment and Supplies
8. Capacity to Manage Program Delivery
9. Record Keeping and Data Collection

FNIHCC – Eligibility Criteria

- First Nations of any age; and
- Who live on a First Nations reserve or First Nations community North of 60; and
- Who have undergone a formal assessment of their continuing care service needs and have been assessed to require one or more of the essential services; and
- Who have access to services which can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice.

Home and Community Care Funding Formula

- The approach of the FN/HCC funding model is ongoing program funding process which enables the necessary development and planning to occur
- 9 principles of funding

i. Flexible
ii. Sustainable and Longevity
iii. Integrated and Linked
iv. Accountable
v. Accessible
vi. Needs based
vii. Plan based
viii. Non penalization
ix. Non duplication

In addition, the formula is required to be based on 9 essential services elements of the program; support current service delivery patterns; support the variety of federal funding arrangements; and respect the AFN Annual General Assembly Chief' resolution.

In developing the funding approach, a review of suggested funding formulas was used, and included: AFN Modified Berger (e.g. Brighter Futures); Prior Approval Model (NIHB); CWIS; and Lemchuck Favel Costing Model.

Home and Community Care Funding Formula

Recommended Formula (1999 Programming)

The recommended funding option is a combination of the CWIS and Lemchuck-Favel Costing Model
It consists of four components:

A. Service Delivery (Home Nursing and Personal Care plus Program Support);
Program Management including Case Management and Coordination of Services

B. Operating

C. Remoteness Adjustment

The calculation is as follows:

A + B (30% of A) = C* (25% of B) = Total Funding

* for type 1 and type 2 communities (CWIS definition)

Home and Community Care Funding Formula

A. An amount for Direct Program Services

A. Nursing Services @ 84000 for Type 1 and Type 2 communities or @ 72000 for Type 3 and Type 4 Communities (additional funding for nursing will be calculated on the following health status indicators of population served)

X Personal Care Requirements = 2.4% (total on reserve population x 2.4% x .5hr/client x 26 weeks

X Diabetes/Arthritis/Cardiovascular rate = 8% (total on reserve population x 8% x 32% x .5hour/client x 52 weeks

X Early Hospital Discharge/Post Hospitalization (20% of on-reserve population x 35% x 2hours/client)

X 10% of total nursing time for nursing management

Personal Care Services @50000 for Type 1 and Type 2 communities or $45000 for Type 3 and 4 communities

X Personal Care Requirements = 2.4% (total on reserve population x 2.4% x .60hr/client x 52 weeks

X Diabetes/Arthritis/Cardiovascular rate = 8% (total on reserve population x 8% x 32% x .5hour/client x 52 weeks

X Early Hospital Discharge/Post Hospitalization (20% of on-reserve population x 35% x 2.5hours/client)

X 10% of total nursing time for nursing management

Program Support Services @36000 for Type 1 and Type 2 communities or $30000 for Type 3 and 4 communities

(.35 hours of service x total population x hourly wage for Type of Community)

Case Management, Coordination Services & Case Assessment Services

1 Nurse: 3500 Population @ $114, 960 (client load = 10% or 350 clients

X Client Assessment 2 hours/client x 350 clients = .59 FTE

X Care Planning @ 1 hour/client x 350 clients - .197 FTE

X Care coordination/Client @ 1 hour/client x 350 clients = .197 FTE

A. An amount for Operating Costs (30% of A) ; C. Adjustment for Remoteness (25% of B for Community Types 1 and 2)

Total funding for each HCC program is A+B (30% of A) + C * (25% of B) = Total Funding (note; * is for Type 1 and Type 2 Communities)

FNIHB HCC Budget 2017 Enhancements ON Region

- Current operating ISC FNIHB budget for Home and Community Care approx. 28.6 M
  - Budget 2017 provided enhancement of these funds to expand and enhance home care, including palliative care (currently in year 4)
  - In 2019, directed HCC $2.6 M and FTE $285K Palliative Care
    - Increasing funding arrangement for nursing services (minimum of 0.5 FTE)
    - Hosting palliative care networking workshops (2018)
      - Kenora Chiefs Advisory (KCA) $ 51, 226
      - Nishnawbe-Aski Nation (NAN) $ 75, 350
      - Southwest Home and Community Care Association (SW HCC) $ 85, 000
      - Wahnipitae First Nations $ 73, 424

- In 2020, funding approach was community-based projects(KCA did not apply)

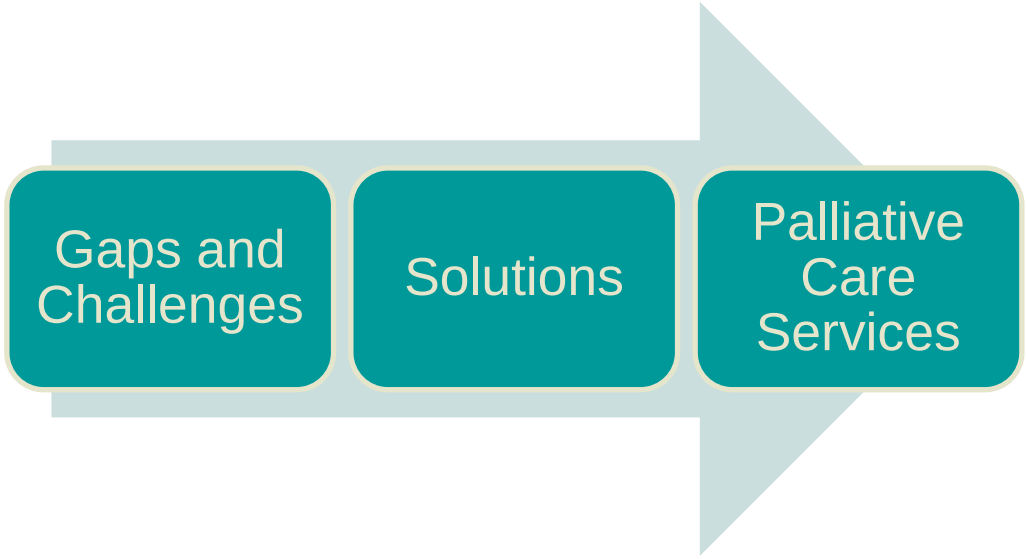
Component	17/18	18/19	19/20	20/21	21/22	Total
Home and Palliative Care						
Home and Community Care	$1,464	$2,650	$4,181	$4,577	$8,450	$21,322
Palliative Care	$179	$285	$507	$824	$1,293	$3,088
Sub-total	$1,643	$2,935	$4,688	$5,401	$9,743	$24,410

Next Steps

Budget 2017 – Years 3-5 2019-2022

- **Identified solutions from the 4 Palliative Care "Planning Workshops" will be combined and used by FNIHCC Ontario Region to inform the direction of future palliative care funding priorities for First Nation communities.**

- **Results will be reported to Treasury Board to support future palliative care funding submissions.**



Next Steps, Considerations and Opportunities 2020-21

Continue with Budget 2017 Year 4 Implementation

- Stabilize HCC programming with 1.0 FTE in all communities and provide data support
  - Does the funding formula have to be revised? (Asked Chiefs of Ontario in 2019)
  - What communities/tribal council need data support for cEMR? (partnered with First Nations Digital Health Ontario)
- Capacity development for Palliative Care services

New Programming: 127/133 have programs in the community deliver the program via individual programming or Tribal Council arrangements

- 4 new communities added under HCC program in 2018-19

Site visits: Integration of services and assessment of needs

- Focus on new community programming; linkages within local services delivery models; partnerships with provinces (communication and coordination)
- Risk Management Tools to support Service Delivery

New funding arrangements: Align for flexibility in funding

- 10-year grants for greater autonomy and control & Management Operating Plan (MOP)

Home and Community Program: Evaluation

- Alignment with assisted living programming
- Retention and Recruitment

Thank You

- Garry Best, Regional Executive, FNIHB ON Region
- Shari Glenn, Director Primary Health Care, FNIHB ON Region
- Dawn Bruyere, Assistant Director of Nursing Services, FNIHB ON Region
- Cynthia Magiskan, Nurse Advisor, FNIHB ON Region
- Nicole Corbiere, Nurse Advisor, FNIHB ON Region

FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE PROGRAM (FNIHCC)

The FNIHCC Program provides a continuum of home and community care services that are comprehensive, culturally sensitive, and accessible and that respond to the unique health and social needs of First Nations and Inuit. The home care program is a coordinated system of health services that enable First Nations and Inuit of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities. Launched in 1999, FNIHCC works with First Nations and Inuit partners to provide core home and community care services. It is provided primarily through contribution agreements with First Nation and Inuit communities and Territorial Governments and strives to be equal to home and community care services offered to other Canadian residents in similar geographical areas. Home and Community Care is delivered primarily by home care registered nurses and trained and certified personal care workers. Service delivery is based on assessed need and follows a case management process. FNIHCC is a mandatory program.

Program Objectives:

- Build the capacity within First Nations and Inuit communities to plan, develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.
- Assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.
- 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.
- 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.
- Assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.
- Build capacity within First Nations and Inuit communities to deliver home care services through continuing education sessions, evolving technology, and the development and implementation of information systems that enable program monitoring, research, defining best practices and evaluation.

Program Essential Service Elements:

A. Structured Client Assessment: The assessment process utilizes an assessment tool and includes ongoing reassessment to determine client needs and service allocation.
B. Managed Care: This process incorporates case management, referrals and service linkages to existing services provided in the community or elsewhere.
C. Home Care Nursing Services: Home care nursing services include direct service delivery and care planning, as well as supervision and teaching of personnel providing personal care services.
D. Home Support Personal Care: Personal care services could include bathing, grooming, dressing, transferring and turning. This component enhances, but does not duplicate, AANDC in-home adult care services.
E. Provision or Access to In-Home Respite Care: This service is intended to provide family and other informal caregivers with short-term relief from caring for dependent family members.

F. Established Linkages with other Services: The linkages with other services may include other health and social programs available both within the community and outside of the community, such as respite and therapeutic services, gerontology programs and cancer clinics.
G. Access to Medical Equipment and Supplies: This involves the provision of and access to specialized equipment, supplies and specialized pharmaceuticals to provide the care required to maintain patients in homes and communities.
H. A System of Record Keeping and Data Collection: This component develops and maintains a client chart and an information system that enables program monitoring, ongoing planning, reporting and evaluation activities.

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

Clients:

First Nations and Inuit people with disabilities, chronic or acute illnesses and the elderly. First Nations and Inuit of any age:

- Who live in a First Nations reserve community (or in a First Nations community North of 60) or Inuit settlement;
- Who have undergone a formal assessment of continuing care service needs and have been assessed a requiring one or more of the essential services; and
- Who have access to services which can be provided with reasonable safety to the client and by the caregiver, within established standards, policies and regulations for service practice.

ANNEX C

FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE

PROGRAM FRAMEWORK

1. INTRODUCTION

The First Nations and Inuit Home and Community Care (FNIHCC) Program will provide basic home and community care services that are comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit. The Program is a coordinated system of home and community based health related services which enable people with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their home communities.

2. PROGRAM OBJECTIVES

The objectives of the FNIHCC Program are:

2.1 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;

2.2 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;

2.3 To facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan;

2.4 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;

2.5 To assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients; and

2.6 To build the capacity within First Nations and Inuit to deliver home care services through training and evolving technology and information systems to monitor care and services and to develop measurable objectives and indicators.

3.0 PROGRAM MODEL AND ELEMENTS

3.1 Eligible Recipients

The eligible recipients for this program are:

3.1.1 First Nations and Inuit of any age; and

3.1.2 Who live on an Inuit settlement, First Nations reserve or First Nations community North of 60; and

3.1.3 Who have undergone a formal assessment of their continuing care service needs and have been assessed to require one or more of the essential services; and

3.1.4 Who have access to services which can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice.

3.2 Program Model

The First Nations and Inuit Home and Community Care Program will provide basic home and community care services that are comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which respond to the unique health and social needs of FN/I. The program is a coordinated system of home and community based health related services which enable people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need within their home communities.

The program will be delivered primarily by trained and certified personal care workers at the community level supported and supervised by home care nurses.

The home and community care program will be comprised of essential service elements and may be expanded to include supportive service elements provided that the essential services are provided and contingent on the availability of resources and identified needs determined in the program planning phase.

Where communities already have some or all essential services through alternate sources, the program will not duplicate these services, but will allow communities to augment, through the supportive services components, the current services and "Reach For The Top" levels of home and community care.

3.3 Service Elements

Essential service elements provide the foundation upon which future program enhancements can build. They include:

3.3.1 A structured client assessment process that includes on-going reassessment and determines client needs and service allocation. Assessment is a structured dynamic process of continuous information gathering and knowledgeable judgements which attach meaning to the information being gathered. Assessment and reassessment processes can involve the client, family and other care givers and /or service providers.

3.3.2 A managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/settlement;

3.3.3 Home care nursing services that includes direct service delivery as well as supervision and teaching of personnel providing personal care services;

3.3.4 The delivery of home support personal care services that are determined by the community needs assessment plan and that do not duplicate, but enhance existing DIAND adult care services.(Eg. Bathing, grooming, dressing, transferring; care of bed bound clients including turning, back rubs and routine skin care etc)

3.3.5 Provision of in-home respite care.

3.3.6 Established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with such providers as hospitals, physicians, respite and therapeutic services;

3.3.7 Provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide home and community care;

3.3.8 The capacity to manage the delivery of the home and community care program that is delivered in a safe and effective manner, if existing community infrastructure exists; and

3.3.9 A system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

It is expected that the essential elements of the home and community care program will be developed initially in each First Nation and Inuit community. Based on community needs and priorities, the existing infrastructure and availability of resources, the home and community care program may expand to include supportive service elements. These supportive elements that may be provided within a continuum of home and community care might include but not limited to:

- facilitation and linkages for rehabilitation and therapy services
- respite care;
- adult day care;
- meal programs;
- mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness. These services might include traditional counseling and healing services, medication monitoring;
- support services to maintain independent living which may include assistance with special transportation needs, grocery shopping, accessing specialized services and interpretative services;
- home-based palliative care;
- social services directly related to continuing care issues;
- specialized health promotion, wellness and fitness; and

First Nations and Inuit Home and Community Care will not:

- fund the construction and/or delivery of long term care Institutional services; and
- will not duplicate funding for existing on reserve adult care services.

4.0 NATIONAL CRITERIA

4.1 Before implementing the FNIHCC Program, each First Nations or Inuit community must complete a Home and Community Care Service Delivery and Implementation Plan. Funding will be provided when the plan which must include the following criteria is approved.

4.1.1 An assessment of community home care needs and services already available;

4.1.2 Identification of how essential service elements will be established, including the supportive service elements that may be introduced by the program;

4.1.3 Identification of capacity building requirements from a capital, human resource and management infrastructure development perspective;

4.1.4 The implementation addressing all of these program development related activities and costs;

4.1.5 A service delivery model supported by client assessment tools and client monitoring system, program policies and standards, data gathering and evaluation system;

4.1.6 Demonstration of coordination and/or integration with existing and proposed home and community care programming and infrastructure such as adding components to existing services provided in the community in order to maximize outcomes;

4.1.7 Demonstration that duplication of services will not occur;

4.1.8 Evidence of strong community involvement in the design, planning, operation and evaluation of all aspects of the program; and

4.1.9 Demonstrated ability of the organization to manage effectively projects and programs.

4.2 In a holistic approach, each Plan will be expected to address the 9 national essential components outlined in Section 3.3.

5.0 METHOD TO ACCESS PROGRAM RESOURCES

5.1 The First Nations and Inuit Home and Community Care Program is initially driven by plans submitted by communities or by organizations on behalf of communities. First Nations/Inuit will submit their Home and Community Care Service Delivery and Implementation Plans to regional offices of Health Canada, Medical Services Branch. The initial plans will be updated on an annual basis in order to reflect latest community requirements and priorities and submitted to regional offices for information.

5.2 Review and Approval Process of the Initial Plan

Before being considered by regional review processes, all plans will be reviewed by Health Canada staff on receipt for eligibility, completeness and adherence to the national criteria identified in Section 3 before they are referred to regional review.

The regional review process will play an important role to ensure that available resources are distributed according to the funding formula and that priority home and community care needs are treated on a priority basis. The regional review process will review initial plans for:

5.2.1 adherence to regional criteria, if established, complementing national criteria;

5.2.2 the presence of a program model that demonstrates the delivery of essential service elements at both a first and second level;

5.2.3 demonstration of economic feasibility and sustainability;

5.2.4 processes to ensure standard development, training, program monitoring and evaluation that is equitable to home and community care services enjoyed by other citizens; and

5.2.5 capital requirements to deliver the planned program.(e.g. Minor capital, facility renovations, staff accommodations where necessary).

As a result of the regional process, recommendations will be made:

- for the approval of the Plan by the Regional Director; or
- for revisions prior to reconsideration of the Plan and approval by the Regional Director.

Organizations will be able to appeal recommendations to the Regional Director.

6.0 MONITORING/EVALUATION

6.1 The Accountability Framework will form the basis of the evaluation framework for the FNIHCC Program and along with departmental framework components will be used to conduct the evaluation of the FNIHCC Program which will be undertaken at the end of the fifth year of this program. The evaluation, as identified in the Framework, will clearly outline:

6.1.1 the principles and objectives of the evaluation in relation to the program goals, objectives and key results;

6.1.2 the roles and responsibilities for program evaluation at the community/program, regional and national levels;

6.1.3 the evaluation methodology that will be used;

6.1.4 the detailed questions and indicators to be used in annual local and regional evaluations and in the initial 5-year evaluation of the Home and Community Care program; and

6.1.5 reporting and approval mechanisms for evaluation reports.

6.2 Existing mechanisms will be utilized to ensure that adequate reporting relationships, policy directions and administrative processes are in place to support the implementation and monitoring of the FNIHCC Program with the goal of meeting the accountability of the recipient and the Minister.

Appendix 3

TABLE OF COMMUNITY ENGAGEMENT ANALYSIS NOTES

Theme	First Nations and Front-Line - barriers/gaps	Solutions/Visions shared:
1. Recruitment and Retention of Home Care Teams:		
Recruitment/Retention	▪ Recruitment and retention of qualified, skilled, good 'fit' individuals who feel valued is essential. ▪ Health Human Resources Shortages ▪ Access and motivation for training ▪ Change over ▪ Positions are not monitored/HR inconsistent ▪ Underpaid (on reserve PSW/Homemaker positions have not increased in pay since initiated in 1990's) ▪ Empty positions unfilled ▪ Training ▪ In-Kenora (Paramed turnover/unfilled positions a chronic and ongoing problem) ▪ Services are not delivered when ability to provide services is not there (i.e. Para Med or in FN Communities) ▪ First Nations with long standing community members in PSW/Homemaking positions have all spoken to the person going above and beyond their job. ▪ Nurses/PSW's coming as a job from out of community – can't meet demand because they work set hours. ▪ Biggest challenge is consistency of worker and availability of workers/professionals willing to build trusting and caring relationships with clients and families. Too much extra in their job (i.e. coordination, no manager to turn to for	▪ Retention – nurses interest group, PSW/Homemakers have teams and support and get training and education and awareness, so they feel safe and confident ongoing. ▪ Support organizations and schools to 'grow your own' ▪ Build mentoring ▪ Make a living wage ▪ Make sure communities have more than one PSW and Homemaker so there is a team to get each other's back. ▪ Provide a coordinator position so there is a support and HR/Governance/policies/procedures implemented/accountability ▪ Training ▪ Providers need to feel supported ▪ Community Health Services "Recruitment and support strategy" needs to be developed. ▪ Locally controlled Home Support Workers and not managed from Thunder Bay. (Coordination/coordinator/navigation roles become essential to get all roles/HR teams to work together and feel useful/confident in their jobs). ▪ Find a way to demonstrate appreciation.

	help, PTSD/trauma and needs debriefing, distance/weather) ▪ Paramed is largest provider of home care supports but their ability to retain team members is very low, so clients get multiple phone calls, multiple points of contact and same questions – very frustrating.	▪ PSW/Homemakers on FN reserves need new payment model/compensation (outdated 1999 pay). ▪ Cross-training across all organizations involved in HCCS – Alzheimer's, dementia care, cultural awareness, appreciation for other persons positions and agencies ▪ Work with Brigette Loepkey at Seven Gens for more 'events'
Training	▪ On Reserve – the best situations/teams are those who train and keep **local** members in PSW/Homemaker and NP positions. ▪ Not enough positions filled because lack of training (also outdated payment model). ▪ Family members 'don't' know what they don't know' or are scared to be part of the care team.	▪ PSW/Homemaker/CPR/First Aid/Palliative/awareness ▪ Family members/caregivers should have access to training in community (this way if the 1 PSW or Homemaker for community is sick or on vacation – then a family member can step in and feel confident in providing the care and be reimbursed for that fill in) ▪ Get as many community members/families trained in the basics of caregiving without it being associated with job/employment ▪ Make PSW/NP training more accessible – encouraged in community.
2. Limited Services by Geographic Distance:		
When care is needed beyond Monday to Friday 9 to 5	▪ Monday to Friday 9 to 5 isn't adequate. ▪ 24/7 – still cheaper and healthier to care for patients 'at home' but its not an option on reserve or for those living far away. ▪ "The ability to keep a person at home with dementia is far more difficult with inadequate	▪ Respite options need to be available ▪ Safety net (i.e. trained and coordinated EMS services to provide the check-in or after-hours urgent wellness check/lift from fall etc.) ▪ Engage in any resource that is available after hours so they can participate in providing care

	home support, causing care partners to seek 24-hour care in hospitals because they have no other options" ▪ The further away one is from Kenora the harder it is to qualify and set up Weekend/after-hours care and safety net ▪ Weekends/after-hours – accidents happen. Health fails/issues come up ▪ Social isolation and loneliness/boredom – leads to accidents/poor health issues after hours/weekends. ▪ Remoteness – limiting access to options/community supports and services that add to quality of life. ▪	when "sticky" situations come up – security at clinic, First Response Team, O.P.P/GCT#3 Police ▪ Create culture of 'safety net' – be creative, create a phone numbers page/easy read instructions and triage colours for windows for people to know when someone is need of help (Green=ok, yellow=please check on me and red= Need help NOW) ▪ Remove barriers for Persons Living with Disabilities to participate in community activities - (offer respite/support to participate in activities) ▪ -accessibility ramps/infrastructure/vans ▪ Day programs ▪ Need to provide programming/supports that meet mental, spiritual, physical and emotional wellbeing – improvements/supports. ▪ do what needs to be done outside our job description so you help the person achieve feeling hopeful
Physicians/primary care/specialists **Especially nurse and foot care**	▪ Access needed ▪ Better approach/ diagnosis and treatment that is within awareness/coordination within context (realizing extent of travel and fear of being heard) ▪ Visits to community limited – dependent on community size and source of programming ▪ For various reasons – professionals coming from urban centers to reserve communities have reasons they cancel – when they cancel or bring	▪ Dr's should be funded to see any client whether they are registered to them or not. ▪ Specialists should be available/hold clinics in community (SW, PT, OT, optometry, dental) ▪ Training for a palliative care team on reserve 24/7 ▪ Pay should reflect the effort/remoteness/travel/time etc. ▪ FOCUS ON INCREASED outpatient support services for the biggest health issues in the

	in a replacement – trust and seeing everyone in que is not always possible. Or they are cancelled altogether (it is regular enough – that foot care and health issues come up) ▪ Nurses visit Reserve 2X week – so wait times for assessments for Home Care often 1 to 2 weeks for assessment by physician and then transfer of information/care plan seems to have varying degrees of coordination/support.	region – diabetics, CHF, COPD, mental health and addictions ▪ Create a culture where University trained professionals can understand their clients and families as experts in their own lives – most need help seeing the opportunities, strengths, gifts, talents and experience/expertise of community members/patients. ▪ On-reserve clinics, mobile clinics/services need to be consistent and applied across all communities (part of equitable service model). ▪ People coming to Reserve must be educated in cultural and traditional ethics. This means approaching conversations to ensure there is a clear and open understanding of individual needs.
Referral/access coordination	▪ On reserve or outside in unorganized territory often conditions/persons wait until situation is so bad referrals can't wait and hospitalization needed. ▪ Often coordinated care not available further away from Kenora one is located. ▪ Wound care is often delayed referral process and easier to access only if palliative diagnosis.	▪ System navigation to all the different aspects of complex needs is essential (Chronic disease management, frailty, MHA, Community supports, cognitive impairment, barriers to meet follow-up get to community services, reliance on others to meet their own needs/attend appointments) ▪ Specialty services (Wound care, OT, PT) needs better assessment/referral timing and process/access. ▪ Programs requiring referral/eligibility assessments are always delayed in getting access. LHIN RIE assessment – the LHIN is the only one doing assessments/eligibility reviews – delays and creates a bottle neck.

		▪ Referrals for supportive housing takes place in Thunder Bay over phone. Seniors and elders can't manage this intake over phone easily. Need support through process.
Adequate services are dependent on physical location of client.	▪ The more rural a client is the less likely adequate services are available or consistently provided. ▪ Services are adequate if client lives in city. ▪ Population that needs services living outside city limits means large population not receiving adequate services. ▪ No alternate options for rural clients other than hospital beds and complete dependence on home care allocations that generally are 2X week visits.	
Equipment/supportive devices and accessibility infrastructure	▪ On reserve the road and infrastructure conditions are not taken into account when getting approval for assistive devices/accessibility modifications to houses (wheelchairs break easier because there are no concrete roads, stairs/walkways are not even and adaptable to ramps easily. Buildings and public spaces are not accessible – and transporting people from home to social events is very difficult. ▪ Application/wait times are very long (often resulting in accidents or overwhelming stories of resilience/adversity – i.e. wife dragging husband by a bed sheet to get him to bathroom)	▪ More equipment needs to be readily available ▪ Realistic costs for modifications ▪ Realistic equipment for conditions ▪ Change timelines for qualification and criteria for replacement equipment ▪ This is one of those areas where funding is pinnacle for individual house modifications for supporting individuals getting in and out of homes. ▪ Ramp building for elders on reserves should just not be this difficult
Expanding services on reserve	▪ On-reserve services vary – but in general only available Monday to Friday and limited to	▪ Help with budgeting/money management ▪ Grocery shopping

	PSW/Homemaker (who all work part-time and paid under living wage) and visit from nurses ▪ Assessments disqualify many residents because household composition/quality of housing ▪ Type of home care is too rigid for lived experience of client (i.e. dogs, standard of housing, too many people in house – cleaning/meals only for client)	▪ More cleaning/home care (even when younger generation living with elder – due to mental health/addictions/child development – pay attention to the complex situation t home and don't limit assessment/access) ▪ Drivers course ▪ Family members and community members get training on PSW, CPR, First Aid (limit stigma and fear of doing something wrong for their family members)
Consistency – Timely and Efficient delivery– geography/ climate/ relationships	▪ Many issues arise that prevent workers/team members from showing up on time, cancelling last minute or sending substitutes without built trust. ▪ No respite options	▪ If services were in place and happened as assessed and promised the home care would be great. ▪ Back-up/depth that allows for adapting, improvising and overcoming these very real climate/travel/geographical barriers – better connected/technology in care, ability to phone a family member or a community-based service provider to give notice and to share load or trade work when conditions change the original plan.
3. Travel and Transportation		

Travel/transportation	▪ Policy ▪ Problems are rooted in effectively listening. Patients are not foolish, they're not ignorant. They know what they're talking about. We cannot undo how we make an individual feel and the policies and way travel/transportation are dealt with is laden with shame and blame and problems. ▪ Staff not paid to travel from home to home (on reserve/or during weather) this adds unreasonable number of hours and stress to day ▪ Patients stranded in regional hospital centers once care is received (medical transport gets them there) then they are discharged without the capacity to arrange their own travel back ▪ Specialized care/agency referrals don't qualify for medical transport (clients from remote areas can't get easy travel reimbursement for additional services) or for respite workers etc. ▪ Visiting resources/Health Canada can't go into homes. ▪ Follow-up appointments – missed and lots of shame/blame around this. Often elderly/community do not have cell service, non-access to cell phones, technology. Not easy to 'call and reschedule or say your late' ▪ Nurses coming to remote communities drive up to 2 hours on windy roads with hazards in winter/weather condition s – some days travel is not advised. ▪ At mercy of external transportation provision/schedules.	▪ A full post medical transportation services program/policy – model between the region areas and the regional hospital and Winnipeg services. ▪ Medical transportation Policy with more HR workers/trained back up and available beyond Monday to Friday. ▪ A facility for elders to go to so they can receive services as most have houses in disrepair that services won't come into (day program/day assessment) ▪ Equipment for shoveling/hauling wood/yard/garbage ▪ Staff/HR teams travel time part of 'hours worked'/reimbursed/supported ▪ Options for connection to care/nurse when travel adversaries stop community visit (Technology). ▪ Nurses to be aware of cultural/family context to be able to ensure implemented care while they are away. ▪ So important to provide transportation to attend appointments that allow for assistive devices to come with patient and for patient to be on time and get to go home soon afterwards. ▪ Transportation needs trained skills for helping someone get ready to leave their home or get settled back into home. ▪ Travel grants are difficult and restrictive ▪ In Kenora, Handi-transit requires registration, fee, and pre-booked along a set root. OR cab fair

	▪ Can't even open their doors or get ready to get out the door.	needed and half the time the cab is too small for the accessibility equipment. ▪ Need our own buses/vans
Travel/transportation/accompany client to appointments	▪ Wheelchair/accessible transport – space for client a companion and walker/wheelchair. ▪ Reimbursements/policies fair and reasonable considering circumstances ▪ Wait times for approval/applications too long and complicated ▪ Difficulty with getting home ▪ Extremely challenging and dependent/at mercy of medical transport – when available ▪ Reimbursement levels for a personal family member is at 28cents/km – but would reimburse $600 to a taxi to go to Winnipeg and back. ▪ So much focus and worry about 'abusing the system' by people taking travel grants and using them as a 'city visit' or do shopping/stay extra in city	▪ Travel/transportation Program and Policy across ANHP ▪ **Remove shame/blame for creating multi-purpose trips** (If a younger grandchild/youth can accompany an elder and/or parent to a medical appointment in the city – it provides a unique opportunity for intergenerational connection, safe way to experience urban Centre which is often ▪ Allow PSW/Homemakers compensation for travel time from home opt home, increase wages so can afford vehicle for transportation.
4. Limited Choice – Home or Hospital as the Only Options:		

Long Term Care Bed shortage	▪ Need more beds – option for transitional/LTC beds –and respite beds so families/patients aren't limited between Home (burnout/dangerous) or Hospital. ▪ Options on many of reserves are at home or at hospital.	▪ Need to provide a continuum of choice.
Loneliness, helplessness, and boredom	▪ Social isolation and loneliness/boredom – leads to accidents/poor health issues after hours/weekends. ▪ Remoteness – limiting access to options/community supports and services that add to quality of life. ▪ So many ends up in hospital beds and unable to stay in community ▪ It's cheaper to keep them at home if we could only get the services/and supports	▪ Remove barriers for Persons Living with Disabilities to participate in community activities - (offer respite/support to participate in activities) ▪ -accessibility ramps/infrastructure/vans ▪ Day programs ▪ Need to provide programming/supports that meet mental, spiritual, physical and emotional wellbeing – improvements/supports. ▪ do what needs to be done outside our job description so you help the person achieve feeling hopeful ▪ Elders want to be at home and to have company and feel they are part of community wellbeing
Palliative Care	▪ There are no funded programs on reserve, but the communities all speak to have a way of being there and sitting with an elder when the primary need is comfort care and end of life care. Families just come together and sit with the person. It just happens. ▪ Hospice program is volunteer based…inconsistent. Need better supports/retention programming.	▪ Palliative care respite/services need to take into consideration and be carefully adapted to not interrupt the way of community response. ▪ Consistency is essential (not always available/after-hours/weekend on reserve – weather/travel condition dependent) ▪ Education, training, workshops for everyone involved. ▪ Aftercare/check-in after death

		▪ Pain management/options and choices – dying at home with dignity and/or MAID. ▪ On reserve the health human resources capacity is not there. Need: 1. Consistency (Electronic connectivity may be part of answer for days were weather/conditions require creative approach to ensure consistency), 2. On-call support 24/7 3. Family education/integration 4. Pain management with consideration of household composition/addictions/medication theft. ▪ Of reserve the integrated/coordinated care to move toward wrap around care of entire family is not effective/timely ▪ Hospice beds close to nursing stations for in community options would be valuable. ▪ Hospice beds in Kenora are well received/important contributors to service delivery. Need more and consistent standards.
5. Community and Front-Line Staff Safety:		
Safety	▪ On reserve – accidents/falls/incidences not responded to by paramedics for hours ▪ On reserve – due to safety concerns with household composition/environment	▪ Community needs to be safe – support programs to encourage safety ▪ Ramps/entry ways need to be in good repair.

(determinants of health)	conditions/cleanliness –often clients are required to go to nursing station to receive care. ▪ No transportation available for emergency (family members/community worries about liability of bringing someone themselves – no travel/transportation costs covered) ▪ Transport vans out during day on scheduled transport runs. Don't operate evenings and weekends ▪ Mobility infrastructure does not meet geographic conditions. ▪ Staff/front-line – weather and road conditions	▪ Outside visitors need resiliency to various conditions and flexibility/adaptability mindset.
Equipment wait times create unsafe discharge situations	▪ Equipment applications/wait times too long ▪ Used go through shoppers but not having to deal with Thunder Bay -	▪ Need to simplify process and remove limitations – accept and acknowledge environmental conditions cause extreme wear/tear. ▪ Stability/balance support is needed more timely and efficiently to slow rate of unplanned emergency department visits.
6. Poor Determinants of Health		
Deal with basic needs first	▪ Difficult to provide input to home and community care when we don't have adequate housing or food security. ▪ When Household size/composition – often compounding situation ▪ Bed bugs/drug abuse in house by younger generation leaves elder in care hungry because their meals on wheels is stolen. ▪ When having poor housing conditions and having younger generation in house disqualifies you from services because they can 'caregive' for you – but they are struggling with mental	▪

	health and addictions and it leaves the elderly frail and neglected. ▪ When people are unable to buy basic groceries. ▪ Mold ▪ Boil water advisory	
Infrastructure/housing improvements	▪ Service providers won't come into houses in disrepair. ▪ Family members can't get patients/frail out of houses when there are no ramps ▪ Elderly struggle with activities of daily living without adequate assistive devices/modifications.	▪ Housing needs to talk with/integrate with nursing and home care – improve ramps, toilet/door modification, bathing seats, etc.
7. Trust - Culturally congruent Services		
Trust by Listening and wholistic care	▪ Impact of the parachute professional where they come in and take care of 1 piece of work (OT, Footcare, Dialysis etc.) or come for a block of nursing/physician care, get paid and then they're gone. Lack of trust/coordination/referral process ▪ Lots of comments to fear of being stigmatized and feeling shame/blame for issues and not being able to qualify for help at home – fear of being sent away from home. ▪ Fear/stigma with terminology like Alzheimer's and Palliative Care.	▪ Listening – the patient and family need to feel heard/listened to ▪ Priority for building respect and trust is listen to learn, not to react. ▪ Once a health care provider/professional starts to be "known" in the community and recognized as being part of the care plan for the long-haul there is trust/coordination and sense of community. Results in better referral, success and community. ▪ Translators need to be available ▪ Health Professionals need to approach clients with appropriate level of respect for their specific culture. With education, training, knowledge on approaching conversations that ensure clear/open communication and work toward identifying and meeting needs. N/B doesn't necessarily mean the 'traditional

	▪ Language barrier miscommunication (not just need for translation into different languages but in providing information that can be heard/understood) – i.e. may perceive unjust treatment when actual description/treatment same as everyone else but delivery is not culturally congruent and feels 'unsafe' or 'unjust'. ▪ "culture shock" both ways – HR professionals coming to reserve with pre-conceived expectations of what is reasonable care/self-care and Clients going into city for follow-up overwhelmed/uncomfortable in urban situation. ▪ Communications should meet capacity of patient to understand (this can be cultural/language barrier or cognitive functioning abilities)	Anishinaabe practice' so not a 'cookie cutter' cultural approach. ▪ Traditional medicines are accessible and valued ▪ Approach building of trusting relationship-based communication ▪ beginning conversations thinking about a person's cultural ethics/values. ▪ Allow/facilitate beliefs and practices that are not harmful to be part of patient's environment (i.e. if client believe beaver castors will help their loved one recover, allow the family to hang them where they want. Allow spiritual practices, especially with the dying.) ▪ Recognize and bring in family to be part of the plan of care team ▪ Service delivery model needs to incorporate "respecting a person's unique cultural practices" ▪ Use and accept humor without judgement (especially in palliative care)
Revolving door of 'starting from beginning' again…. Re-assessments/repeat client interactions/point of entry	▪ PLWD – struggle with stigma and lack of trust when too many assessments take place ▪ Client and families having to repeat assessment/question process and care plans etc. because exhausting and limits long-term success seen with built trusting relationships. ▪ Privacy laws veils the ability for transparent coordination of care. Yes, we should ensure patient privacy but as professionals we should be bound by the confidentiality and be able to	▪ **Improved patient information sharing to avoid patients from having to tell their stories repetitively** – caregivers and patients all have same knowledge and same time and go through journey collectively knowing where patient came from and where they are going – with identified benchmarks/goals.

	share as a coordinated team to offset need for constant repeating/silo processes. ▪ Within Kenora/unorganized territory - Paramed is largest provider of home care but there is no retention of team members, so clients get multiple phone calls and multiple points of contact with same questions.	▪ Consent can be verbal and one check of a box to allow for non-complicated coordination of assessment/care planning.
Prevention	▪ Cannot be overstated the importance of culture and programing as a consistent service is related to prevention/after hour activities and programming availability is linked to reducing addictions and mental health issues, improving physical health and connection to early morbidity/PLWD situations	▪ Elders consistently said have music, parties, activities and community events when asked what change would make the most difference (they all, in their own way, speak about alleviating boredom and anxiety by keeping busy and knowing their youth in the community are busy with healthy activities/land-based activities)
Strengths of elders should be utilized in community	▪ Loosing traditional knowledge/language/elders' activities and teachings.	▪ Listen and learn and be guided by elders ▪ Sweat lodge/teachings encouraged and facilitated ▪ Visits to elders ▪ Field trips ▪ Cooking ▪ Roundhouse – create comfortable place to teach.
Mental Health and Addictions part of needs to be met	▪ Culturally, this region has highest rate of mental health and addictions– part of cultural makeup of region and needs better options for integrating into care/aftercare) ▪ Mental Health is hand in hand with the stress/anxiety/falls/accidents related to home care situations.	▪ Develop tools in a community toolbox so when gaps in services arise, the community happen to still be able to support and provide continuity of MHA support. ▪ Addressing mental health should cross all areas of health care and focus on local culturally congruent approaches to dealing with these challenges.

	▪ Mental health and addiction issues can't be scheduled. ▪ Need to have HCCS inclusive of substance abuse/addictions so really spot light lack of resources in community. ▪ Children and youth with complex needs not getting services on-reserve (mostly connected to MHA but also to developmental challenges)	
8. Governance, Oversight and compliance accountability:		
On-reserve funding model inadequate **Lack of coordination between federal and provincial models of service delivery**	▪ Home care $'s Based on on-reserve population for that First Nation – not on actual need/community size (i.e. complex palliative care clients, non-reserve married couples/family members, mental health and compounding household issues, distance workers have to travel from house to house, hazards/challenges for staff.) ▪ Part time PSW/Homemakers ▪ Provincial provided/LIHN provided PT, OT, Specialized care/nursing is very inconsistent the further away from city Centre. ▪ Funding model red tape between federal/provincial models. ▪ Referral/transitional care plans not being relayed to the community or in-community services (on-reserve nurse/family or in Alzheimer's diagnosis case to Alzheimer's society)	▪ On-Reserve/Off-Reserve models and funding should be equitable. ▪ More mobile services units that can drive to outlying communities are needed. ▪ Training of local family members and fair payment to PSW/Homemakers living in community – who can help support telehealth (i.e. train everyone as PSW/Homemaker together so everyone has the same job skills and mentality) ▪ Start supportive care ▪ Rounds need to include community partners (there should not be a LHIN/ISC divide in care planning from Hospital) ▪
Governance/oversight	▪ Consistent work ethic/accountability/transparency of funding/job descriptions to work within/	▪ Policies and procedures – universally updated, accepted and managers in place for oversight.

	▪ Need to acknowledge failure to deliver adequate services. ▪ Need to take over Para Med's services by a connected/collaborative service model/provider accountable to a stronger governance structure. ▪ Provincial system managed without integration to Federal System. ▪ Federal System managed from Thunder Bay and bases funding and compensation on model implemented in 1999. ▪ Consistency in holding accountable to standards, policies, HR procedures and policies, job descriptions/roles and responsibilities. Needs oversight.	▪ Organization of staff duties/responsibilities within clear job descriptions and congruent with client-centered care but also safety of staff in mind. ▪ More respite/team/integration models learned and implemented. ▪ Connection to families for their involvement and in education so they know what to expect/are more satisfied with care. ▪ Benchmarks and standards ▪ Every community should have a home care coordinator to help support the governance/management of homecare and coordinate/navigate client care plans and team cohesiveness ▪ Band Managers/Health Directors – when these positions are filled and consistent the health human resource teams seem to be more cohesive/supported ▪ Link partnerships to Kenora, Winnipeg, Thunder Bay
9. Caregiver and Community Support Integrated into care planning:		
Caregiver support	▪ Choices are either 'all in' or 'no help' / qualifications/assessment process is rigid – overcrowded housing usually means a family member is of age and ability to help support client – but sometimes complex situations (Addictions, mental health, food security, joblessness) means the elderly person should qualify for homemaking/PSW support.	▪ Client and family education programs ▪ Awareness of care plans/available services ▪ Men health programs ▪ Physical activity programs ▪ Health services presented at schools (kids often influence and know and transfer knowledge to their households) ▪ Be encouraging, ask/refer/support calls and enquiries on behalf of family/client if needed.

	▪ Family seem to be burden on providers not part of care team.	▪ Find a way to celebrate family ▪ Create a system where time is valued – investing in spending time with individuals
Transition from hospital to home (keeping people healing at home	▪ Out of all the quality improvement/indicator themes from transitioning hospital to home the two biggest issues/challenges repeatedly mentioned: o Assessments resulting in fair/adequate and useful amount of home care and community supports to return home and fully healthy (qualifying has a lot of red tape/stringent criteria that make it more and more difficult the more remote you are) o Coordination so home care and services are implemented and ready to go at point of discharge and without delays and gaps. ▪ As a side note – costs and issues with transportation for follow-up and outpatient services and getting adequate assistive aids/home repairs/materials and supports for successfully healing at home are repeated barrier ▪ 9 out of 10 First Nations Home care/PSW's learn about patient coming back to community by medical drivers (consistent theme across many FN focus groups) ▪ Seniors/elders not cognitively able to implement their care plans, understand	▪ Integration/communication/coordination ▪ Awareness of geography and determinants of health and culture/household composition and finding flexible/adaptable solutions for these barriers. ▪ Rounds need to include community partners (there should not be a LHIN/ISC divide in care planning from Hospital) ▪ LHIN referral process needs to be adaptable and not have time-limits/re-admittance challenges. ▪ If client enters referral for services, then admitted to hospital, referral is closed after two weeks and needs to start all over again. Coordinated care is needed (there are not options beyond home and hospital and with lag in assessments the likelihood of having to re-start referral is great). ▪ System navigators should make sure the patient feels like the care is seamless, even if referral process has to start over again after 2 -weeks, someone should be tasked as their job to consistently do this regardless of who/where patient in region lives. (Case Coordinators) ▪ Hospital to Home transition works best when there is a family meeting, community support services are included in meeting, everybody is hearing the same expectations and the day of the week aligns with Medigas/OT. Also, when

	instructions when under fear/stress and leads to lack of getting follow-up ▪ Discharge process from hospital is inconsistent and often lacks communication with unique situations – especially if someone is deemed palliative in community or is living in unorganized/FN community. Discharge at hospital planned according to rounds but doesn't take into consideration that OT only available on specific dates to get home set up for patients discharge. Same with Medigas Tuesday and Thursday only etc. Often home care not set up when person discharges.	the staff with coordinating roles are not on vacation or away. ▪ All the different referral process/plans/communications need a DOCTORS signature before discharge. This could be managed better with allowing other professionals to be able to make those decisions.
Family seems to be a burden to care team	▪ If household composition is too high – then homecare is disqualified because make assumption that family members in-house can-do groceries, meal prep, housekeeping, yard work. Reality is compounding/complex situations – so money/groceries get stolen/eaten and elderly or person requiring the home care is neglected. ▪ Often surprised and felt in dark with transition plans/once patient discharged with who/when supports coming.	▪ Train anyone and everyone who wants PSW training regardless if tied to a job. They can be respite and/or fill in on vacations as an opportunity for short-term income. They can feel more in control and able to participate with team. ▪ PSW/Homemakers need to be valued and full-time – those who live and work in community go well above and beyond their jobs (they live as volunteers with an honorarium/paid part-time) ▪ Encourage family support but also provide a system/program where if someone doesn't have family there is a "surrogate"

	▪ Caregiver lives in fear of the accident and incident that happens after hours and weekends.	
Lack of confidence, training and validation as care team member	▪ Reluctant to get involved because repeated stories of feeling like they "don't know how to do it right" – referring to transfers, dressing, helping with self-care. And also, with driving/transport to appointment or activities (feel there is a liability 100% on them and cost that would otherwise be approved/reimbursed to someone who has the job to do it)	▪ Leadership and roles of supervision matter. It's a milieu that doesn't happen overnight and shouldn't be taken lightly when promoting individuals within care teams. Best leaders want to provide mentoring, find solutions and provide opportunity for ripple effect of team to keep effective communications and leadership all the way to family members.
Fear and Stigma stop family members from participating in care	▪ In city services "Alzheimer's society" but rural/remotely – left to care on own and cognitive impairment is so misunderstood and complicated to deal with for family. ▪ On reserve – loosing hope/option of being at home. ▪ Family members with compounding issues ▪ Fear of being blamed to do something wrong but not taught or encouraged to learn (no time or no bridging the gap for cultural/environmental conditions).	
Monitoring Tools for family to support	▪ Medication management o Forgets medication o Medical driver forgets to pick up o Not always in blister packs o Worry about meds being taken by other family/household members – making way to streets for sale. ▪ Behavior's	▪ Bubble packaging and solid instructions/supports ▪ Medic Alert ▪ Teaching Gentle Persuasion Approach ▪ Wellness Checks ▪ Identifying potential new clients ▪ Connect to help lines

	▪ Safety	
Growth of volunteer programs	▪ Need a paradigm shift in thinking about caregiver/family involvement (removing shame/blame – i.e. 'can't do it all so I do nothing…. To I'm a valuable member of a team and I have support to help' ▪ When volunteer programs don't have a paid coordinator/position – it is at mercy of volunteer's schedule/dropped balls and if 'other things come up' then service not provided.	▪ Wellness checks ▪ Visiting ▪ Grocery delivery ▪ Meal sharing/meals on wheels ▪ Transportation programs ▪ Meals on Wheels needs paid program and volunteers and needs expansion ▪ Funding for programs or activities to keep clients busy and healthy and for families to engage in.
Constant stress and anxiety	▪ Patients – elders – spend too much time alone with their worries for the younger generation ▪ Caregivers – spend so much time stressing and exhausted because no respite, after hours and weekends feeling completely alone. No monitoring or safety net as support	▪ Activities and opportunities. ▪ Day programs/adult day programs as part of respite ▪ First Nations elders would like to come use adult day program/Club Day Away – need LHIN assessment/referral – struggles with timing and getting access. ▪ Transportation policy/procedures to alleviate fear of liability – so people will escort elders to community meals and activities. ▪ Companion program ▪ Have fun, alleviate other family members stress/anxiety.
Transition	▪ So often it feels like the nursing staff and home care staff in community don't know that discharge is happening and are caught off guard in preparing for home care – almost too late.	▪ If coordinated – could go into house and do a thorough clean and be prepared before arrival back from hospital ▪ Simple supports available through 24/7 (training/education – flip side to side and other things – preventing known problems)

	▪ Nurses/in community complaints to hospital met with "we tried calling" we "faxed care plan" but they don't make the personal relationship a priority to ensure good transition – client information is not shared effectively and on time.	▪ Focus on procedures, policies and processes that revolve around transferring patients not 'releasing' them from hospital care.
Palliative care	▪ "Based on my experience and what I've seen happens – I don't want to die at home because the burden and suffering that happens is too much for family to bare." ▪ Story from an elder of a passing "We took the patient home. They wanted to be at home. But the family got scared. They took them back to hospital. They were in pain in the ER for 4 hours with the family in the waiting room. The family had to ask supervisory what was going on, nobody came to talk to them because it was the weekend."	▪ Visual/monitoring systems ▪ Pain and personal care/cleanliness help ▪ Palliative care on reserve seems to be an unspoken community-response. Caution should be applied not to 'program' palliative care. ▪ "We do have a system where we sit with our elders that are at end of their life. Everyone participates, brings food and simply sits" ▪ Honour and acknowledge the way our community members meet the need to sit with someone before they go to be with the creators ▪ It is important to provide support and connect resources when it can be useful and helpful but to create a 'program' may be a disservice.
Community engagement	▪ Elders don't get to community meetings – information needs to be brought to them. They need to be kept informed.	
10. Technology		
Use of telephone and internet for consistent communication and supports	▪ Elders/Patients/Families tended to prefer in person and at same time they talked about reality that poor connection and not having a cell phone was a problem because then they could know and plan for when an appointment or a visit would be canceled.	▪ Front-line service providers suggested depth and more consistent service delivery could be facilitated with the option of dialing in/connecting remotely/virtually to specialists. Even if a navigator or other support staff sat with client to guide the appointment. This would be

	▪ Sometimes a telehealth appoint/OTN appointment is very useful but technology on reserve is inconsistent.	useful to offset missed appointments due to bad weather/long-distance gaps.
EMR/Shared Records	▪ Confidentiality should not hold back good case management and coordinated care. Supporting technology that allows to share files/health information is highlighted as valuable.	

Appendix 4

March 12 2020 Front-Line Services Workshop

ANHP Home Care and Community Services Project
Record of Engagement Session with Front-Line Services
March 12, 2020

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Design of the Day

On March 12th, 2020 (Appendix 1), the Home and Community Care steering committee worked with the Front Line Service Providers to identify their thoughts on gaps within the current system and how the All Nations Health Partners (ANHP) can work to improve the quality of care for the communities we serve.

20 people came together across HCCS in the ANHP region, representing 13 different organisations with a common goal of improving the services available to our community. The day was opened in prayer by Susan Fobister.

The day started with setting the stage for the community service providers present, identifying the goals of the day – for the steering committee as well as the service providers present - introducing them to the ANHP Ontario Health Team (OHT) and identified their importance in identifying gaps and helping to create solutions for HCCS.

The frontline workers were split into three groups, with each group working together to identify barriers that patients faced when receiving home and community services and with transitions between services. The group then came together to present their findings and identify common themes. From the identified commons themes, 3 high priority areas were chosen by the group.

Following lunch, the frontline staff went back into their groups, with each group identifying one high priority area to break down further. The groups looked at reasons for the barriers in the system, goals to work toward, measures of success and who needs to be involved in working together to create the solutions to create a seamless pathway for HCCS in the ANHP

Health Concerns Identified from Community Engagement

Following community engagement with First Nations Communities and through questionnaires sent out to organisations within the region, we were able to identify the perceived biggest health concerns of community members, as well as their thoughts on the causes affecting their health and well-being (appendix 2)

Barriers to a seamless journey

In the first activity of the day, the team identified barriers, in groups, preventing seamless care. The following common factors were identified by the groups as barriers. Each factor has been grouped into one or more categories, where change is required within the ANHP HCCS.

Barrier to seamless care	Health Service Provider Education	Organisational Improvements	Governance	Community Partnerships	Patient facing improvements
Understanding the experience First Nations go through	■				■
Lack of equitable funding			■		
Wait times for equipment		■	■		■
No relationship with HSP	■			■	■
Language barriers		■			
Lack of communication/coordination/awareness - between organization		■	■		
Transport (get back home) ◆ for medical appointments ◆ For daily living		■	■	■	■
Poor referral process		■	■	■	
Navigating the system	■				■
Support for the more vulnerable populations			■	■	
IT		■	■		

	Health Service Provider Education	Organisational Improvements	Governance	Community Partnerships	Patient facing improvements
Difficulty supporting all communities with the current infrastructure		■	■	■	
Transitions and discharge planning (especially ER) ◆ And pts understanding		■	■		■
Medication management	■	■			■
System is always dealing with crisis			■		
Finding clients/patients after discharge					■
Medical Records			■		
Use services “properly”					■
Communication/education to Public	■	■		■	
SDOH			■		
Isolation at medical services		■	■		■
Not asking clients “how are you”/Not listening	■				■
Timely access to services		■	■		
Feeling lost in the system					■
Siloed funding models		■	■		

Note - The highlighted barriers were identified as the highest priority

Following the identification of all the barriers within the patient journey, each member was provided with stickers to identify which barriers were should be prioritized to bring the most impact for change (appendix 3).

The top three Priority areas identified were:

- *Lack of communication/coordination - between organizations*
- *Transport (get back home)*
    - *for medical appointments*
    - *For daily living*
- *Navigating the system*

Home and Community Care Services – Creating Solutions

The three priority barriers identified were then taken on board for the next activity. Each group worked though one priority area, taking the barrier, breaking it down further to identify what happens in the client journey and identifying solutions for the HCCS team to work towards to ensure change takes place (appendix 4)

Priority 1 – Improving Communication and Coordination between organisations

What is the gap/barrier?

- Lack of communication between service providers leading to patients receiving inadequate care
- EMR systems that are not compatible with others
- Patients are unaware of discharge instructions and therefore are unable to provide information to different organisations at follow up
- No support when the patients leave one care setting and move home or into another care setting leading to reduced continuity of care and failed discharges
- No ownership from organizations to ensure that patient handover is correctly completed, or no follow up to ensure patient is cared for once they leave the setting

What are the goals to make an impact?

- Streamlining the system to reduce waste (time/money/resources)
- Creation and maintenance of partnerships
- “Services driving funds” rather than “funds driving services”
- No wrong door for patients – help direct anyone to what they need
- Educate service providers and the community about what services are available
- Provide choice to communities
- Improve cultural awareness
- Improve trust in the system

What actions need to be taken?

- Using a multi-disciplinary team approach to care
- Interdisciplinary communication both personally and through electronic medical records
- Behavioural change
- Reduction of working in siloes – create team based goals, rather than organisation based.

What does success look like?

- Reduced wait times
- All patients getting the RIGHT CARE at the RIGHT TIME in the RIGHT PLACE
- Clients centered care – subjective feeling
- Patients feel empowered in the care they received
- Improved recruitment and retention of staff due to increased satisfaction of care provided
- People feel "heard" regarding their care
- Positive community stories

Who needs to work together in this priority area to make it work?

- All levels within the health care system from health care providers → federal government
- Communities – with each other and the health system

<u>Priority 2 – Navigating the system</u>

What is the gap/barriers?

- Not everyone has a family doctor, therefor there is no key point person and lack of access to programs where a referral is required
- Lack of knowledge of what is available to patients and communities
- No formal connections
- No accessible referral system for services
- Lack of infrastructure within communities to help patients navigate the system

What are the goals to make the impact?

- Empowered and educated patients and families
- Ensuring that agencies are connected and informed
- Accessible IT solutions supporting real time referral
- Ensuring patients and families have appointment / follow up instructions available to them in a language they understand and a format they can access.
- Simplified system with increased transparency

- Streamlined system that reduces waste

What actions need to be taken?

- Simplify education → appropriate language and concepts
- Use of appropriate, clear and relatable concepts
- Public engagement and education of services
- Have common goals between agencies to reach tangible solutions
- Connect patients to service navigators
- Develop strategies and system that are compliant with privacy legislation but allow for real-time sharing of client information.
- Develop an accessible inventory of services that are routinely updated
- Use technology for messaging or texting clients reminders of appointments with reminders of locations and name of care provider. But this cannot be a "one size fits all" solution as not all clients have technology or access to data/cell service.

What does success look like?

- Patients following through of treatment plans given to them
- Reduced No Shows at community-based appointments
- Reduced re-admissions to hospital and ED re-visits
- Patients feel they are able to ask questions and feel they are directing their care
- An IT portal with uptake from all organisations within the ANHP
- Ability to see where the patient has been within the system (with consent)

Who needs to work together in this priority area to make it work?

- Patients and their families should be connected with the system
- Service Navigators and patients/families
- Senior leaders between organisations
- All service providers need to have the ability to be connected to each other
- IT departments to help develop reasonable solutions, respecting PHIPA

<u>Priority 3 – Improving transportation</u>

What is the gap/barrier?

- Patients are late for appointments with current transport arrangements – deemed by organisations as "missed appointments" and therefore don't rebook
- No connection (wifi) to communicate
- Limited options for transport and limited hours available for travel
- No wheelchair accessible transport
- Lack of staff/drivers for transport to function
- Cost of taxis are too high

- Re-imbursement for personal travel too low
- Barriers within our services - disqualifies certain situations

What are the goals to make impact?

- Having multi access to transportation beyond 9-5
    - A full inventory of transport options
    - Adequate staff for all transport to function
    - Adequate re-imbursement options for personal travel
- Mobile medical services with a full interdisciplinary team (Primary Care / Mental Health / Addictions)
- Allow escorts to attend appointments (without jumping through hoops!)
- Better data systems to track the needs of patients
- Solution for some people - community mental health services → serious mental illness – dementia

What actions need to be taken?

- Creation of an ANHP travel program
- Purchase of adequate transport
- Provide paid staff and volunteers to make a successful program
- Confirmation of transportation prior to appointments
- Innovations

What does success look like?

- More vehicles, including those that are accessible
- More staff
- Reduction in missed appointments
- Improved community well being
- Reduced stress for communities (subjective measure)

Who needs to work together in this priority area to make it work?

- Different levels governments and organisations (on funding issues)
- Communities and healthcare organisations
- ANHP group – to identify what is currently available so that there is a baseline of services

Appendix 1

ALL NATIONS HEALTH PARTNERS HOME CARE AND COMMUNITY SERVICES

DRAFT AGENDA
March 12, 2020 – 9:00 a.m. to 2:30 p.m.
LWDH Training Centre

1. Opening
   - Introductions and goals for the day

2. Setting the Stage:
   - All Nations Health Partners and the Ontario Health Teams
   - Change theory – your voice matters
   - Understanding Home Care and Community Services Project Phase 1

3. Health priorities for ANHP catchment (what we've heard to date)

4. The client journey from home to care to home
   - What are the challenges and barriers faced by patients on their journey from home to care to home?
   - Exercise – prioritizing areas where most impact for change will be felt

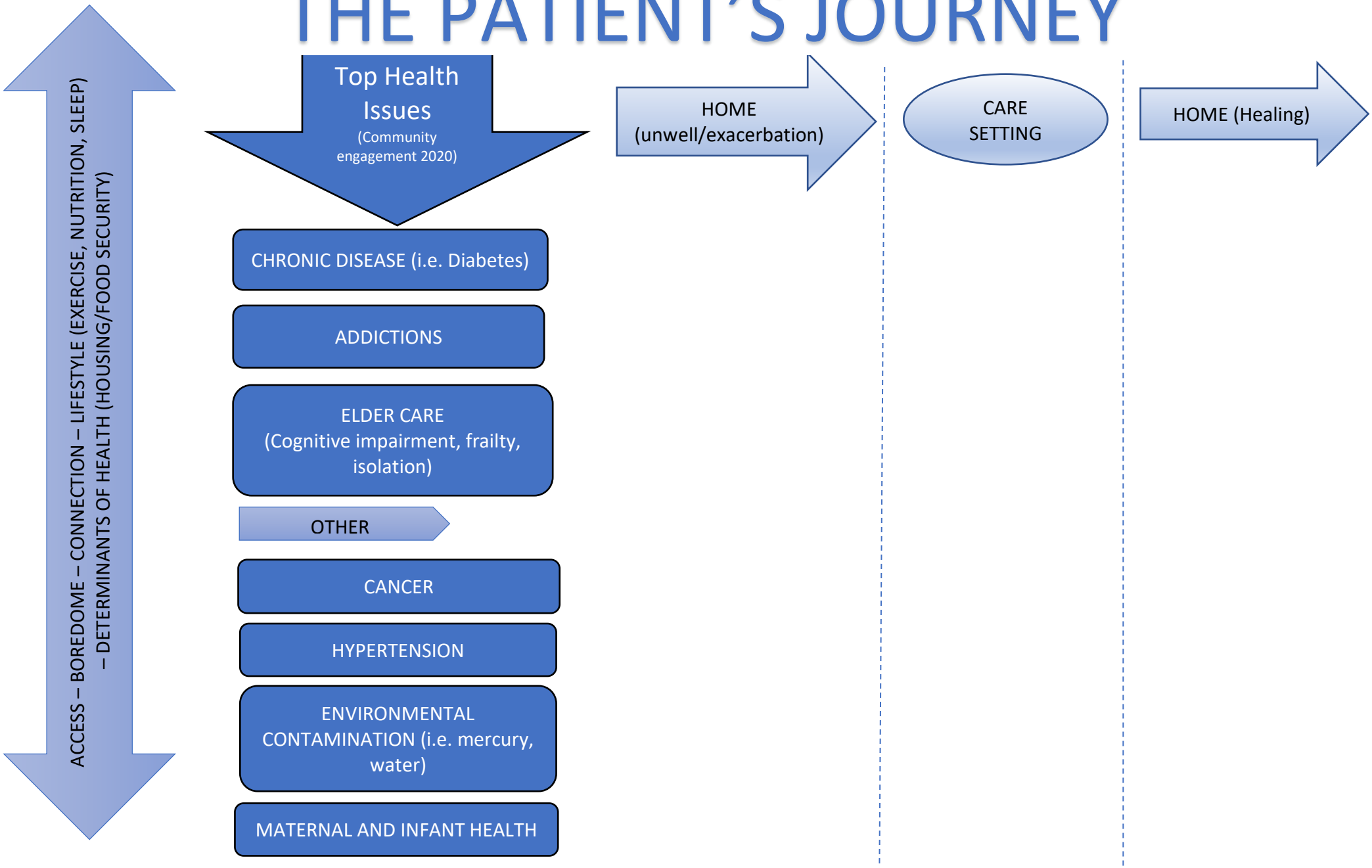
LUNCH

5. The client journey continued…
   - Understanding where the journey breakdown…
   - Brainstorming solutions

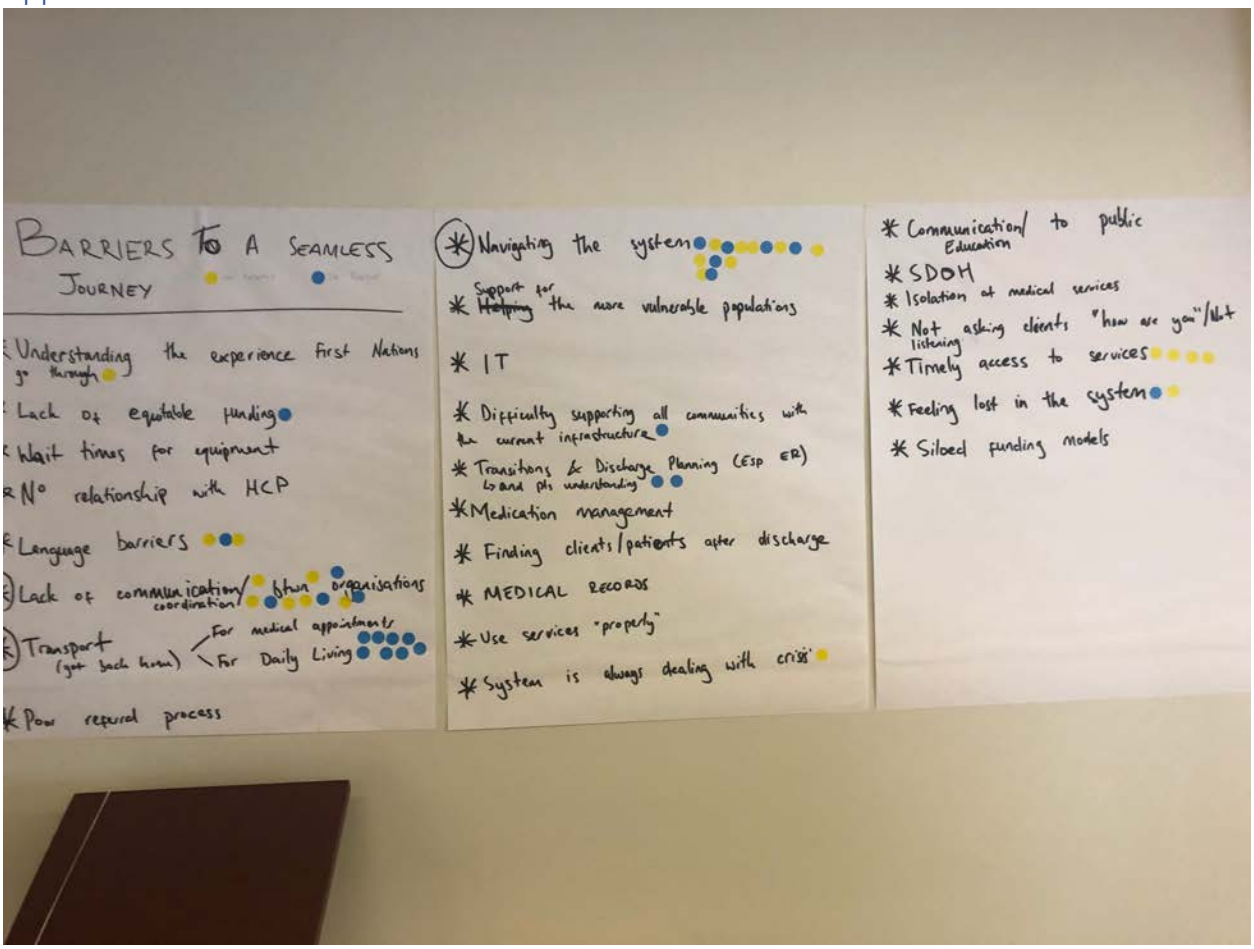
6. Next Steps
   - The patient journey – questionnaire for impact stories
   - Communicating results
   - Phase 2

Appendix 2

THE PATIENT'S JOURNEY



Appendix 3


BARRIERS TO A SEAMLESS JOURNEY
Understanding the experience First Nations go through
Lack of equitable funding
Wait times for equipment
N° relationship with HCP
Language barriers
Lack of communication/coordination between organisations
Transport (get back home) For medical appointments For Daily Living
Poor referral process
Navigating the system
Support for the more vulnerable populations
IT
Difficulty supporting all communities with the current infrastructure
Transitions & Discharge Planning (ESP ER) to and its understanding
Medication management
Finding clients/patients after discharge
MEDICAL RECORDS
Use services "properly"
System is always dealing with crisis
Communication/ to public Education
SDOH
Isolation at medical services
Not asking clients "how are you"/Not listening
Timely access to services
Feeling lost in the system
Siloed funding models

Appendix 4

MARCH 12 2020
HOME CARE AND COMMUNITY SERVICES –

PRIORITY GAP/BARRIER: _____

What is the gap/barrier? Define the actual breakdown in the journey.	
What are the goals to make impact? Be as specific as possible – including partnering goals, program changes or new initiatives, service, access, participation, coordination	
What ACTIONS need to be taken? What needs to be done – including building, change current programs/partnerships – including those things that are working well that need to stay the same.	
What does success look like? How can you measure that things are working?	
Who needs to work together in this priority area to make it work? (and how) – Funding, planning, delivery of service (Fed/Prov/Org/department/job titles)	

Appendix 5

Participants

Susan Fobister, Elder
Robin Gould, NWLHIN (phone)
Matt Cavner, BISNO
Colleen Niel, SCFHT/ANHP
Crisna Alutaya, WNHAC
Wade Gagnon, NWEMS/KDSB
Jon Olson NWEMS/KDSB
Andrew Tickner, NWEMS/KDSB
Kendra Dobinson, LWDH - rehab
Catherine Cameron, KCA
Ryan Rioch, CMHSS/KACL
Marlene Kilfoyle, CMHSS/KACL
Lynn Moffatt, Community Support KDHA
Sarah Lava, Community Support Supportive Housing
Maxine Crow, Whitefish Bay HCCP Coord
Rylee Rieu, Alzheimer Society Kenora/Rainy River districts
Rossana Tomahawh, Alzheimer's Society
Veronica Fobister, KCA
Donna Moir, KCA
Karim Suleman, Firefly
Brock Chisholm, LWDH (Part of day)

Facilitation Team:
Karim Suleman, Firefly
Cynthia Carr, EpiResearch
Anneke Gillis, CA2Gillis Consulting

*Consent to list representatives and their organizations in attendance was requested and acknowledged. A commitment to providing a record of meeting to all in attendance by end of March 2020 (Covid-19 has delayed distribution of notes, but it is anticipated these will be distributed before April 10, 2020).

Appendix 6

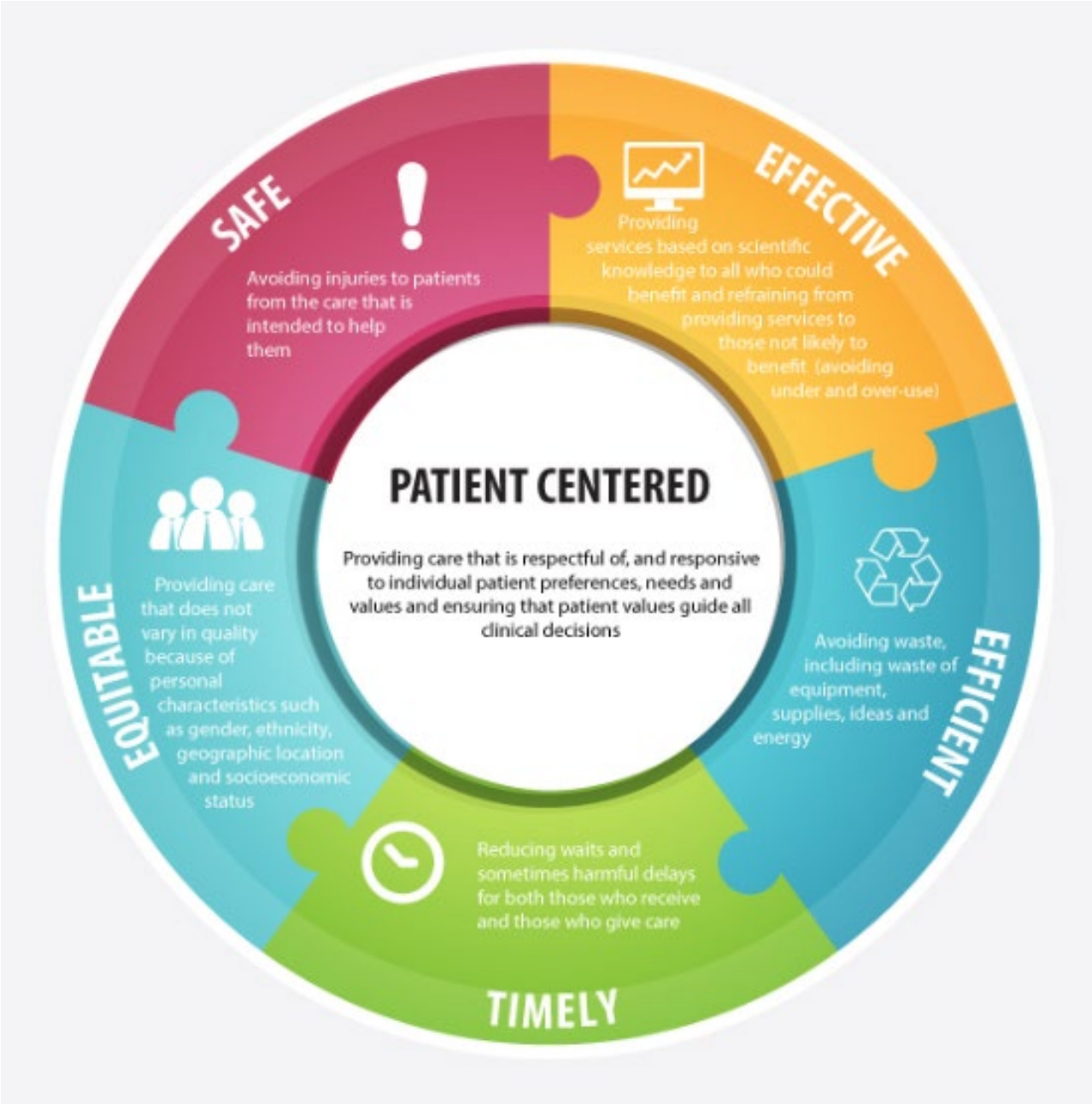
Change Theory

Your Voice Matters!

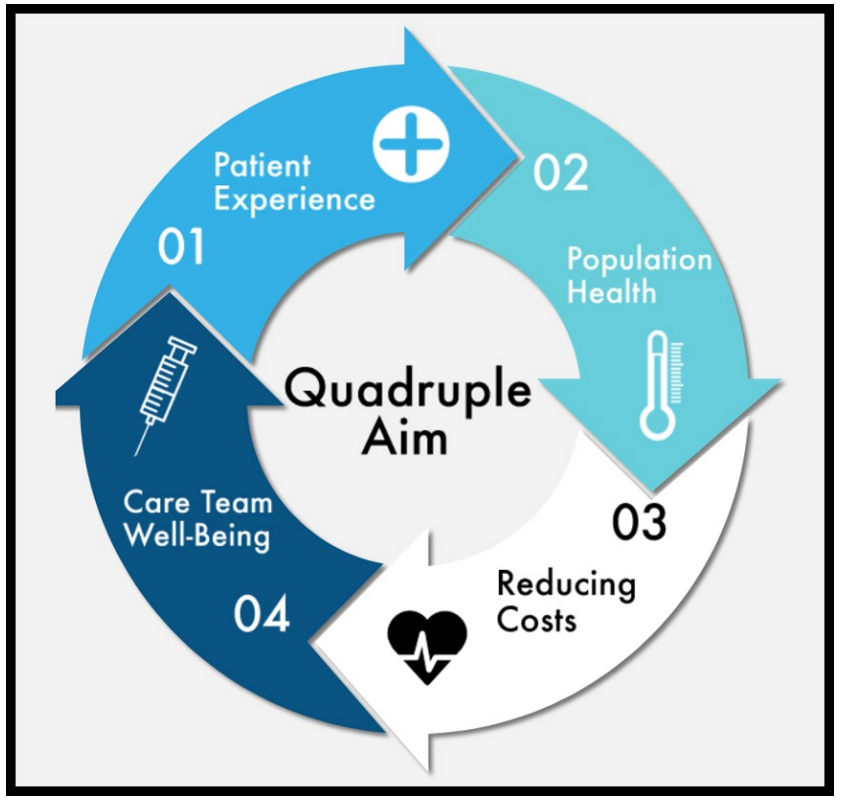
Why are we here?

- Community driven process
- Change the health and well being of the communities served under the ANHP
- Create partnerships to improve home and community care in the region

Institute of Medicine – Principles to Improve Health Care (2001)


SAFE
Avoiding injuries to patients from the care that is intended to help them
EFFECTIVE
Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under and over-use)
PATIENT CENTERED
Providing care that is respectful of, and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
EFFICIENT
Avoiding waste, including waste of equipment, supplies, ideas and energy
EQUITABLE
Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status
TIMELY
Reducing waits and sometimes harmful delays for both those who receive and those who give care

Let’s achieve the Quadruple Aim



Seismic Shifts to realize the potential of integrated care

Shared by @jodemegoldhar @thechangefoundation

THE CHANGE FOUNDATION

FROM:	TO:
• Organizational Mission	• Shared Purpose
• Ego-centric	• Eco-centric
• From formal leads	• Focus on super-connectors
• Transactional	• Relational
• Sharing Information	• Co-Design
• Organizational Impact	• Collective Impact
• Independent	• Interdependent
• Old Power	• New Power
• Face to Face	• Virtual

Why do we want a community driven process?

- The experts in what needs to be done and what can be improved are…
    - Patients
    - The Community
    - Front line Staff
    - (With some input from senior leadership!)

For Integrated Care to be successful, we need to use **experience based co-design**

What is the importance of having your voice heard?

- Knowledge and expertise of the people who provide the services to patients day in and day out is invaluable

- We can learn from each other
    - What works well?
    - What doesn’t work so well?
    - What are the challenges that other organization face?

We need to Innovate and Collaborate to make home and community care a success…

Integration of care involves deep collaboration enabled through local trusting relationships between patients and providers and amongst providers, enabled by system level supportive policies and funding.

Interdependence

School for Change Agents

Sources: Being First team (2017) Going for the Big Win in Your Organization
: S. Mukherjee (2017) *We Must Rescue 'Win-Win' From Its Buzzword Status*

@HelenBevan

Credit: NHS England Horizons Team

The skills for 2030

Judgment and decision making: Considering the relative costs and benefits of potential actions to choose the most appropriate one.

Fluency of ideas: The ability to come up with a number of ideas about a topic (the number of ideas is important, not their quality, correctness, or creativity).

Originality: The ability to come up with unusual or clever ideas about a given topic or situation, or to develop creative ways to solve a problem

Learning strategies: Understanding the implications of new information for both current and future problem-solving and decision-making.

Active learning: Learning strategies—selecting and using training/instructional methods and procedures appropriate for the situation when learning or teaching new things.

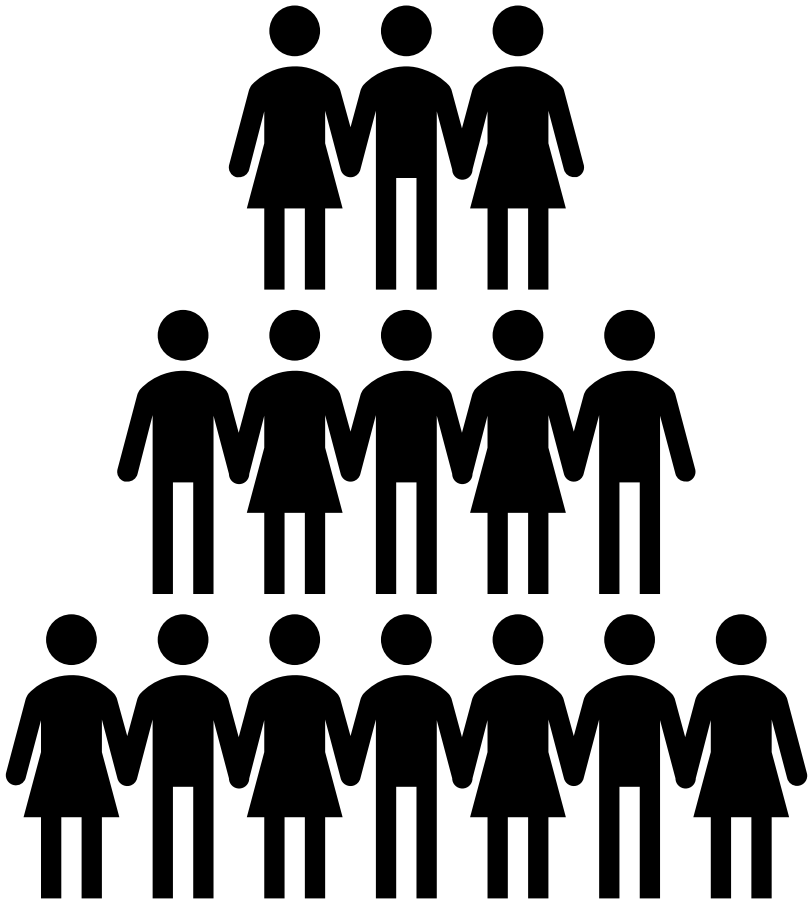
Nesta, Pearson and the Martin Oxford School: The future of skills: employment in 2030

Graphics by @scriberian

Credit: NHS England Horizons Team

We want you empowered as Change Agents

- *Embrace The Process*
- *Enjoy The Process*
- *Celebrate Your Achievements*



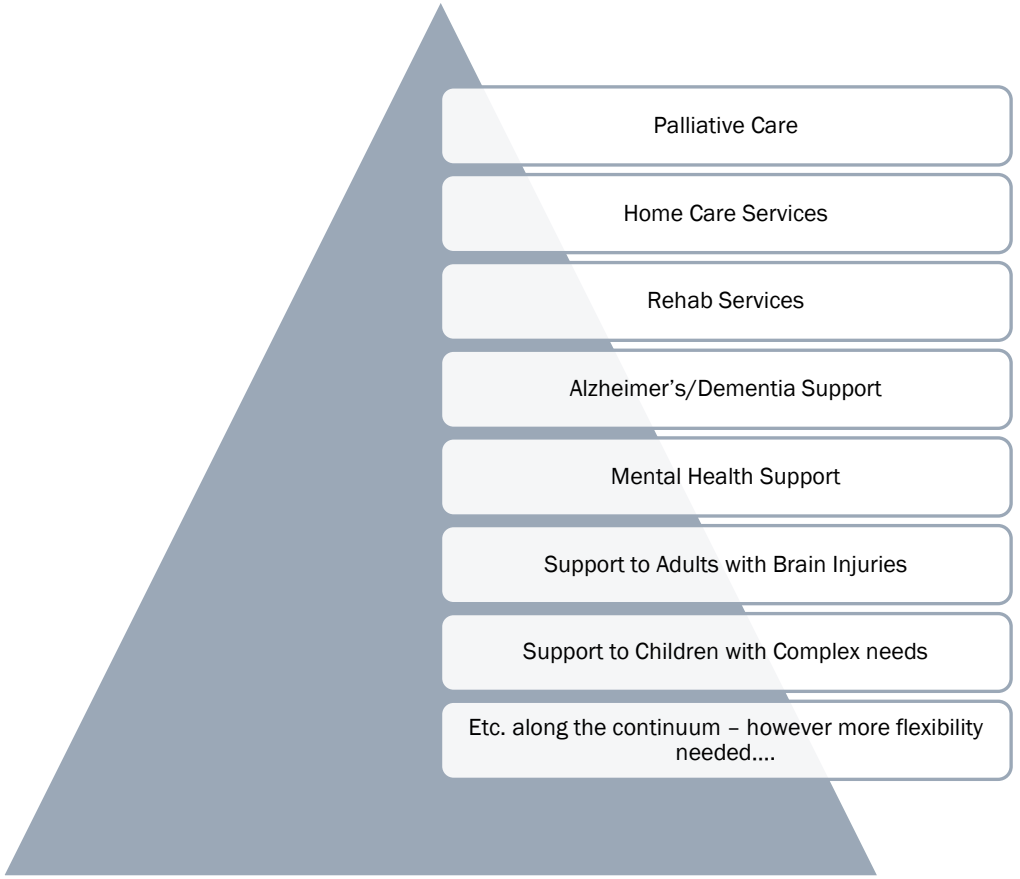
Home Care and Community Support Services

“Building Together”

ALL NATIONS HEALTH PARTNERS

MARCH 12, 2020

HCCSS – foundation in continuum of care and along life span

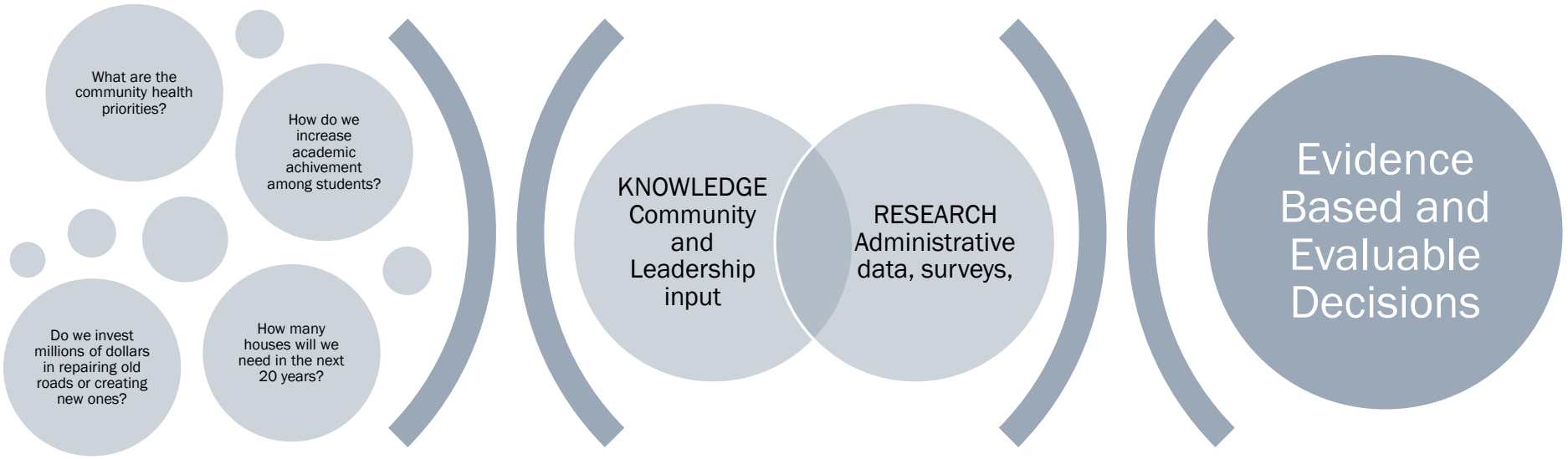


"Management is efficiency in climbing the ladder of success; leadership determines whether the ladder is leaning against the right wall."

- STEPHEN COVEY

(AUTHOR – "SEVEN HABITS OF HIGHLY EFFECTIVE PEOPLE")

How Do I Support Your Process



Leadership Pressures

Find the Data Points

Desired Outcome

Home and Community Care Act - 1994

Rigid care coordination: Decisions about patient care are often made away from frontline care.

Siloed care: Patients often interact with home care separately from primary and hospital care, which often includes multiple assessments leading to delays in care.

Restrictive care plans: Patients have care plans with a set number of hours or visits with service maximums that can curtail care.

2020 New Legislation:

Connecting People to Home and Community Care Act

2020 Vision for Change…

"Home Care Ontario welcomes the government's move to modernize home and community care. Today's changes will allow patients to better access the right care, at the right time, and in the right place. These changes will make the system work more efficiently, and ultimately will allow local health teams to better work together to keep people healthier at home."

- Sue VanderBent, CEO of Home Care Ontario

What Will Stay

1. Definition of home and community care services and eligibility criteria.
2. **Ability to fund Indigenous organizations directly through the *Ministry of Health and Long-Term Care Act*. This will maintain the nation to nation relationship between the parties.**
3. Ability for approved organizations to deliver home care indirectly through contracts.
4. Provisions regarding funding clients and families for self-directed care.
5. Restrictions on client co-payments for services, to preserve the existing approach where only community services can have co-payments.
6. Restrictions limiting the delivery of community services to non-profit corporations.
7. Requirements for a complaints process.
8. Right to appeal certain decisions to the Health Services Appeal and Review Board.
9. Inclusion of home care in the jurisdiction of the Patient Ombudsman.
10. The Bill of Rights for home and community care would continue in regulation, updated to reflect the realities of modern home and community care.

Goals of New Legislation:

Make it **easier for people to access** home and community care in hospital, primary care or community settings. Hospitals and primary care settings and others will be able to arrange home care directly for patients, instead of referring people to a separate home care organization. Doing so will reduce administration and transitions for patients.

Help people **connect with their care providers** through secure video conferencing and remote monitoring devices. People with chronic conditions will be monitored at home, with a nurse checking in as needed. Nurses or therapists can use video conferencing to work with a personal support worker in the home to provide more specialized care.

Provide more choice for people with high care needs to get care in new community settings. People will be discharged from hospital into a transitional care setting to gain strength and functionality to return home.

Keep people healthier at home by empowering care teams to work together. Enabling frontline care providers to make more decisions about care, integrating home care into primary care and acute care, and breaking barriers to access to information will create teams that work together to support patients.

Great Goals!
How Do We Measure Progress?
Start thinking now of data needs!

- Easy Access
- Connect with Care Providers
- Provide More Choice
- Keep People Healthier

- What are the Key indicators to track success – inputs, activities, inputs, outcomes (short, medium, long).
- What can you measure now? How do we start?
- What do you want to measure? What human resources, IT, methods do you need to plan for success?
- What other agencies can support you?

How Will You Know You Got There?

Baseline Community Health Assessment

- Identify your partners and catchment area

- Identify "current state"
- Identify "preferred state"
- Identify gaps
- Prioritize needs
- Identify pathway to change gaps to points of access

Evaluation

Use measurable goals for inputs, activities, outcomes.

Identify ongoing data sources and new sources to be developed.

Empower staff to assist in ongoing data collection

Develop ongoing plan for data review and assessment of progress to addressing client and community needs.

Compare against your baseline data, fill in the gaps where you didn't have data.

What are the Baseline Data Points?

Community Health Assessment Data Points

Can keep it focused to the indicators that illustrate the need for Home Care and Community Support Services.

Or, one time investment in broader Assessment to support the work of all ANHP moving forward.

HCCSS need is impacted by multiple factors – although may not be planning acute care services, without knowledge of leading drivers of acute illness and in-patient and specialist needs, difficult to plan for community based need.

- How can services prevent progression to need for rehab, inpatient, specialist care?
- What is needed to prepare people for care?
- What is needed after care?
- What is the navigation and decision making mechanism to enhance client success and well-being.

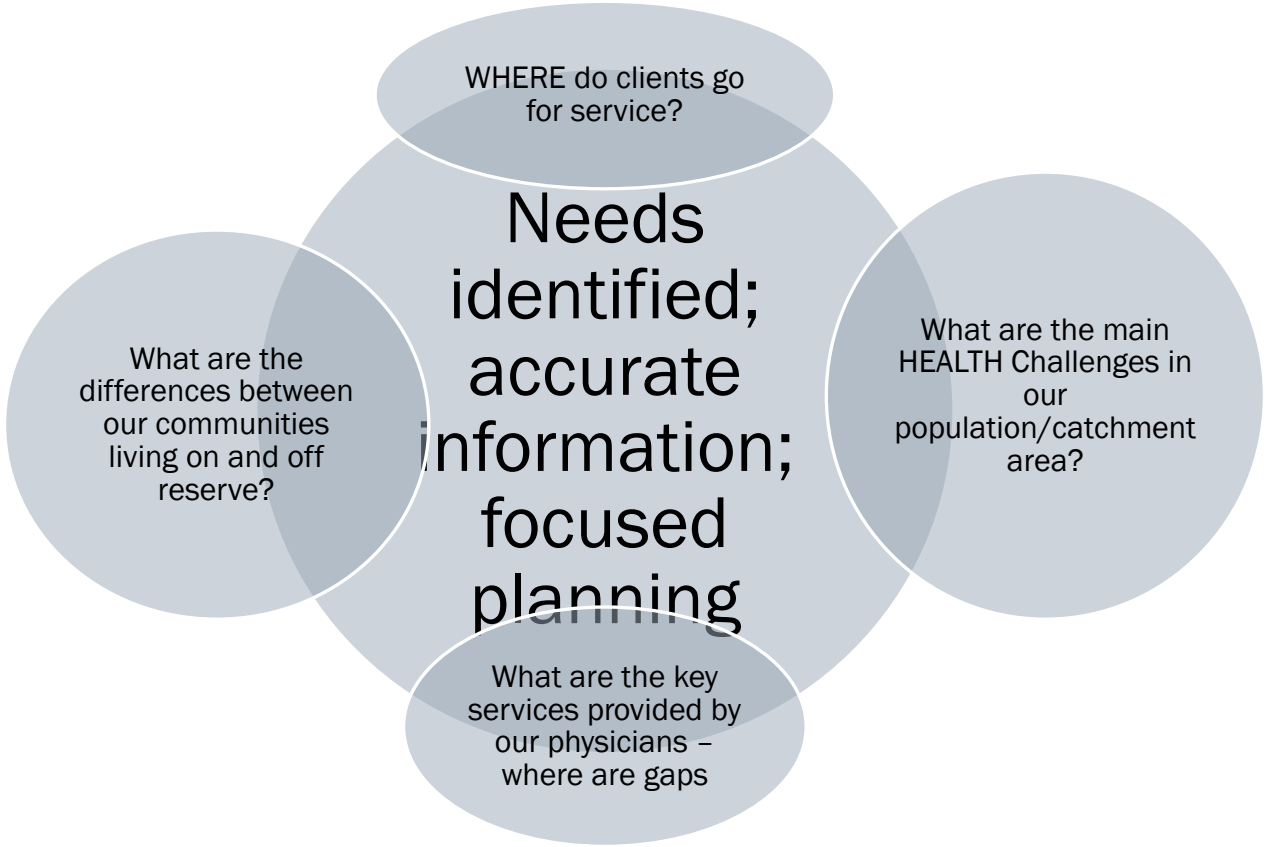
Example of CHA Indicators – options pursued depend on time/budget/scope needed.

Birth rates	Deaths that occurred before age 20	Injury treatment prevalence (physician visits)	MRSA
Birth weight (low/high birth weight)	Diabetes treatment prevalence (physician visits)	Mental health treatment prevalence (physician visits)	Other reportable communicable diseases
Cardiovascular disease	Hospitalizations for congenital anomalies	Morbidity (illness) and service utilization	Physician Visits
Cardiovascular disease hospitalizations	Hospitalizations for diabetes	Mortality rates	Population and Socio-Economic Status
Cardiovascular disease treatment prevalence (physician visits)	Hospitalizations for infections of skin and subcutaneous tissue	Mortality rates due to diseases of circulatory system	Pregnancy Rates
Causes of mortality	Hospitalizations for mental health disorders	Mortality rates due to diseases of respiratory system	Premature mortality
Causes of Potential Years of Life Lost	Infant Mortality	Mortality rates due to endocrine and metabolic disorders	Selected reportable gastrointestinal communicable diseases
Chronic diseases	Infections of skin and subcutaneous tissue	Mortality rates due to injury & poisoning	Self Reported health from surveys
Determinants of health from surveys	Injury hospitalizations	Mortality rates due to neoplasm	Tuberculosis

Data Sources

Your own data… multiple sources and Formats	Ontario Health Analytics – Key Support to all OHT's	Canadian Institute of Health Information (routinely published reports and direct data access through portals)	Survey Data – focus on determinants of health – CCHS and RHS are national surveys
Census Data	FNHIB	Medical Travel for First Nations Communities	Others…

What do you need to know at a minimum?



Challenges

Current Health Analytics

– focus on PHYSICIAN Roster not your catchment area or community of residence.

- All client data combined – no disaggregation by First Nations and non-First Nations communities - we know there are disparities in health determinants, health status, service use, needs (example medical travel), and access.

- Only addresses data for ANHP are providers – does not capture any data for any activity in other locations – Winnipeg, in the FN communities (unless fee-for-service physician billed).

- Does not tell you WHERE people go for services and how long they stayed there.

- this describes physician workload/activity – NOT the health status or pattern of access to care of your area – we cannot identify gaps this way.

Determinants of Health Examples

Topic	Response	RHS (National)	RHS (Regional)	CCHS (off-reserve) Canada
High school education or equivalent	Yes	66.30%	56.90%	92.0%
Employment status	Employed	47.10%	50.40%	61.8%
Difficulty affording food	Yes	32.00%	28.40%	8.30%
Difficulty affording shelter	Yes	11.40%	12.80%	
Difficulty affording utilities	Yes	25.30%	32.90%	
Difficulty affording clothing	Yes	20.50%	19.00%	
Difficulty affording transportation	Yes	26.50%	22.80%	
Difficulty affording childcare	Yes	9.30%	8.00%	
Use of traditional medicine	Yes	37.70%	36.20%	
Current Smoker (daily or occasional)	Yes	53.50%	50.40%	16.40%
Alcohol use	Yes	57.40%	55.70%	75.9 %
Binge drinking	Never	12.00%	17.70%	19.50%
Difficulty accessing healthcare services	Primary Reason	Waiting too long 27.0%	Waiting too long 29.2%	Waiting too long 51% (2013)

Health Status Examples

Topic	Response	Health Analytics (ANHP OHT)	Health Analytics (ONT)	RHS (National)	RHS (Regional)	CCHS (off-reserve) Canada
Asthma	Yes	1.25%	2.21%	9.60%	12.60%	8.30%
Chronic Liver Disease (incl. Hepatitis)	Yes	0.35%	0.15%	1.20%	1.70%	
Acute Liver Disease & Other Hepatic Disorders	Yes	0.56%	0.21%	1.20%	1.70%	
Diabetes Mellitus	Yes	8.42%	7.59%	15.90%	23.40%	8.30%
Chronic Kidney Disease/Failure	Yes	0.87%	1.00%	3.3% (Kidney Problems)	3.4% (Kidney Problems)	
Tuberculosis Disease	Yes	0.05%	0.25%	1.30%		.49 (2017)
Dementia (incl. Alzheimer's)	Yes	1.04%	1.19%	3% (Alzheimers and other dimentia)		
Bipolar/Manic Mood Disorder	Yes	0.23%	0.61%	7.8% (mood disorder)	7.6% (mood disorder)	8.9% (mood disorder)
Neurotic/Anxiety/Obsessive Compulsive Disorder	Yes	4.18%	6.63%	8.9% (Anxiety only)	6.9% (Anxiety only)	
Physical health rating	Very good to excellent			34.30%	35.10%	59.00%
Physical health rating	Poor to not very good			19.40%	25.20%	12.10%
Mental health rating	Excellent to very good			30.50%	47.20%	68.50%
Mental health rating	Poor to not very good			22.50%	1.60%	7.5%

Opportunities

- Health Analytics - Request feasibility assessment of set of indicators for catchment area residents REGARDLESS of where they get the service for true assessment of Health Status and Need

- For limited indicators – request analysis by home community and service location (often do this with inpatient and specialist care and even physician access in general – where do people go for service and how does this impact their lives and access to continuous linked care).

Challenges – current means of identification through postal code and community postal code overlap – will need to work to identify other identification opportunities, such as “home community” if captured on health card.

Further Partner Opportunities

Make use of all resources being offered.

However, continue to empower ANHP with direct access to data so that you can use this as needed along the way and not continually “que” in a larger organization.

- That is, use all services/resources offered but take this as an opportunity to build and enhance ANHP capacity for ongoing planning and independence.
- Use this opportunity to direct the larger organizations to re-think how data are collected and amalgamated – particularly standards of “location” – this does not work for First Nations communities who often share postal codes or have mail delivered to a totally separate community (ex. Kenora).

- CIHI – Addressing disparities by enhancing access to data for Indigenous people is a strategic priority – leverage this and look for opportunities to pilot with them access to their health portals that other organizations can access. Does CIHI have funding to support this?
- Ontario Health Analytics, in addition to accessing all supporting services offered, request access to the online INtelliHEALTH – more flexibility and real time access to data that are already cleaned and set up for analysis.

Next Steps

Analyze and report results of inventory survey

Present some initial findings of data provided and opportunities and pathways for more supporting data to support your planning.

Merge key findings with Anneke's Engagement work

Further evidence for PRIORITIES

Phase 2 Potential:

Ideally – comprehensive Community Health Assessment based on data that represents residents of your catchment area. Support to ANHP for each area of planning.

Your Questions and Feedback