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HEALTH SYSTEM IMPROVEMENT PRE-PROPOSAL (H-SIP) FORM

Introduction

On April 1 2007, as part of the Ontario Ministry of Health and Long-Term Care's (MoHLTC) health system transformation plan, Local Health Integration Networks (LHINs) assumed responsibility for planning, funding, and integrating health services at the local level. LHINs, working in collaboration with health service providers (HSPs) will plan, coordinate and assess local health system performance to ensure the development of a quality health care system that is responsive to local health service needs, improve the health status of the population and is sustainable in the long term. To this end, each LHIN has developed an Integrated Health Service Plan (IHSP) to reflect the current health status of their local population and to identify areas of focus for the next three years.

To create the health care system envisioned by the MoHLTC, HSPs and LHINs need to focus their efforts to ensure that available resources are targeted to local health system priorities. Within this context, all proposals submitted to the LHINs will be assessed against local health system needs. The onus for reviewing, evaluating and acting on proposals submitted by HSPs is the responsibility of the LHIN.

To reduce the time and costs HSPs incur in preparing detailed business cases the LHINs have established a pre-proposal process. This process, known as an H-SIP, will enable the LHIN to make a preliminary assessment of any request or activity contemplated by an HSP that requires the LHIN's approval.

All H-SIPs will be evaluated using the LHIN's decision-making criteria, as provided in the North West LHIN website (see "Helpful Links", below), taking into account strategic fit, population heath, system values and system performance. Following the LHIN's review and evaluation of the H-SIP, an HSP may be invited to submit a detailed proposal and a business plan for further analysis by the LHIN. Guidelines for the development of a detailed proposal and business case will be provided by the individual LHIN.

The submission of an H-SIP is not formal notice of a proposed integration to the LHIN as contemplated by s. 27 of the *Local Health System Integration Act, 2006* ("LHSIA"). HSPs wishing to provide notice to the LHIN of a proposed integration under s. 27 of LHSIA, should contact the LHIN for more information.

Guidelines for Completion of an H-SIP

1. HSIPs should be completed and submitted by mail or email via a downloadable Word form available through the LHIN's website.
2. All sections need to be completed before you are able to submit
3. Pre-proposals that involve new technology must reference the Ontario Health Technology Advisory Committee's (OHTAC) recommendation supporting the request
4. Pre-proposals must have CEO approval.
5. When considering whether to submit an H-SIP, and when completing the H-SIP, please keep in mind that it will be evaluated against the North West LHIN's decision-making criteria, as well as the resource requirements and key challenges to achieving the proposed improvement.
6. If you have any questions regarding the completion of this form please contact Melissa Dillon, Business and Performance Analyst at 684-9425 ext. 2035 or toll free at 1-866-907-5446.

Form submission: Please mail or e-mail your form to:

Kathy Plaskett
Program Assistant
North West LHIN
975 Alloy Drive, Suite 201
Thunder Bay, ON P7B 5Z8

nwlhin.submissions@lhins.on.ca

Helpful Links:

- North West LHIN *Integration Health Services Plan*
- MOHLTC Transformation Agenda at www.health.gov.on.ca/transformation
- Ontario Health Technology Advisory Committee at www.health.gov.on.ca under Health Care Professionals (Programs & Services)
- *Local Health System Integration Act, 2006* at www.e-laws.gov.on.ca/index.html
- North West LHIN Priority Setting & Decision-Making Criteria

Glossary:

Service Change (Enhancement) refers to pre-proposals to expand or improve an existing service (e.g. introduction of new model of care, increase number of patients treated/visits).

New Service refers to pre-proposals to introduce a new service that the organization has not previously provided. The new service must align with the organization's strategic direction/plan.

Integration: refers to pre-proposals that aim to coordinate, partner, transfer, merge or amalgamate services/operataions for the improvement of health service delivery and patient flow through the local heatlh care system. (As defined in *Local Health System Integration Act, 2006*)

Section 1 – Proposal Information

Section 1 A – Pre-proposal Name and Submitting Health Service Providers

Proposal Title: Wiisokotaatiwin Program, Naotkamegwanning First Nation

Name, Address and Email of Health Service Provider(s)

Contact: Health Director Naotkamegwanning

Name: Eddie AJ White

Email: naot.healthdirector@gmail.com

Proposal CEO Approved: Chief and Council ☒ **Yes**

Section 1 B – Proposed Improvement Summary

Type of improvement being proposed (check applicable box(es)

- ☒ Service Change (Enhancement)
- ☐ New service
- ☒ Integration activity (I acknowledge that this is not a formal request for integration, as described in the attached Glossary)
- ☐ Other (please specify)

Does the proposed improvement require capital: (check if applicable)

- ☐ Renovation
- ☐ Expansion
- ☒ Equipment investment
- ☒ IT investment

If the proposed improvement involves a capital project, provide a brief description of the capital project and indicate if you have submitted a capital request to the MoHLTC.

N/A

☐ **Yes –** Please provide date and if available the MoHLTC Capital Branch consultant assigned to your request.

☒ **No**

Has this pre-proposal from been submitted to other LHINs?

☐ **Yes –** Please indicate which LHINs**:**

☒ **No**

Section 1 C – Define the Project *(maximum 300 words)*

*Wiisokotaatiwin will provide coordinated, comprehensive, person-centred and compassionate care to those who are very sick whose wish is either to remain living at home receiving home care or return home from hospital to journey in the community while supporting individual traditions beliefs and values.*This program will coordinate the palliative care services of local health care providers in Naotkamegwanning including Home and Community Care Program (HCCP), Long term care, medical transportation, and respite care. The program includes partnerships and service agreements with Regional health services such as: the First Nations Inuit Home and Community Care (FNIHCC) program (Ontario Region), North West Community Care Access Centre (NW CCAC), Waassegiizig Nanaandawe'lyewigamig (WNHAC), Thunder Bay Regional Health Sciences Centre (TBRHSC) and Regional Cancer Centre, St. Joseph's Care Group Telemedicine Nurse, Lake of the Woods District Hospital (LWDH), Community Health Care Professionals, Lakehead University's Centre for Education and Research on Aging & Health's (CERAH) Palliative Care Education, Lakehead University's Centre for Education and Research on Aging & Health's Improving End-of-Life Care in First Nations Communities project (EOLFN), Wesway, and the Kenora/Rainy River Hospice Volunteer program. These partnerships do not duplicate existing services but provide enhanced and more integrated services that address gaps in current community capacity to support people and their families to receive palliative home care. In particular, the Wiisokotaatiwin program will offer clients and families care and support 24/7. In the current state, there is no home care available evenings and weekends.

In the current state, all people living in Naotkamegwanning who are dying from progressive chronic or terminal illnesses (expected death) die in hospital. The FNIHCC Program does not fund palliative care as an essential service element (see Appendix A). While the actual number of hospital days is not known, the estimate from the local community care program is an average of 1 month of hospitalization prior to death. NW LHIN data indicate the average length of stay for a final admission leading to death is 21 days. The majority of these deaths occur in LWDH where the per diem rate is $2000/day. This means an in hospital death could cost the health care system between $42,000-$60,000 for a 3-4 week stay. These costs do not include additional hospitalization and visits to the emergency department in the last year of life.

Rationale *(*Identify the LHIN population (health service consumers) that would benefit from the proposed service improvement, and the service or quality gap that exists now – ***maximum 150 words***).

The LHIN population that would benefit from the proposed service are people that are living in Naotkamegwanning that have been diagnosed with a chronic or terminal illness and are in the last year of life. The majority of these individuals have advanced chronic

disease and multiple co-morbidities, including diabetes and frailty. Currently, there are three to five individuals who are receiving support from the Home and Community Care Program that would meet the criteria for the Wiisokotaatiwin Program. In the current state, all these individuals would be expected to die in the hospital. Based on available data, their projected length of stay will be 3-4 weeks prior to death. These clients would benefit by receiving palliative care assessments in the community, enhanced home care services, and improved access to palliative care specialist's, consultations and family education and support (Hospice Volunteer visiting, respite care.)

Benefit to the Community *(*Briefly describe how this proposed improvement will improve the health care system and/or health status of the community e.g. health outcomes, access to health services, quality of care, coordination of services, patient's choice, uptake of best practice – ***maximum 150 words***).

A needs assessment conducted in Naotkamegwanning in 2012 indicated that if services were available and adequate the majority of community members would prefer to die at home. Recommendations included:

1. Increased funding and community resources that allow for 24 hour, 7 day a week home care provision, and greater support for family caregivers
2. Advocating for improved communication and collaboration between external health care providers and institutions and Naotkamegwanning health care providers to improve continuity of care and discharge planning
3. Formalized partnerships between internal and external health care organizations to support, enhance and build local capacity for providing palliative care services
4. Advocating for external health organizations to collect data about palliative care service use by residents to assist with health service planning and evaluation
5. Provide education to local health care providers about palliative and end-of-life care
6. Provide education to external health care providers to improve the cultural safety of care

The proposed Wiisokotaatiwin program will give people with advance chronic or terminal illness the choice to receive palliative care in their home. Clients will receive a comprehensive palliative care assessment and participate in a case conference with care providers to develop a coordinated, individualized care plan in the comfort and security of their own home. Expert consultation will be available to them. Additional after hours nursing and PSW support will prevent unnecessary ED visits and reduce transportation issues to access care in Kenora. Community members will receive culturally safe and relevant care in their home. Being able to receive palliative care at home enhances the opportunity to meet the individuals' psychological, emotional, and spiritual needs within the context of their family, community, and culture. The program will also provide families with informational and emotional support in their caregiving role and respite care. The addition of evening and weekend home care services and respite care services will reduce the cost and stress of residents needing to access care outside the community, primarily in Kenora.

Collaboration (Briefly describe your partnerships and how the collaborating HSPs will work together, (in general terms) to implement the proposed improvement – ***maximum 150 words***).

Ove the last year, three workshops have been held involving 24 internal and external health care providers for purposes of "journey mapping" the experience of people from Naotkamegwanning who require palliative care and wish to receive their care at home. These workshops have identified who the key partners are, what services are currently provided, gaps in service, and the needed service enhancements. The current and future state of palliative care service provision in Naotkamegwanning has been mapped out. This proposal is the outcome of these workshops.

The collaborators are Naotkamegwanning Home and Community Care/LTC, FNIHB, NW CCAC, WNHAC, TBRHSC and Regional Care Centre, St. Joseph's Care Group Telemedicine Nurse, LWDH, Community Health Care Professionals, CERAH Palliative Care Education, CERAH EOLFN project, Wesway, and the Kenora/Rainy River Hospice Volunteer program. These collaborators are committed to working together to achieve the objective of supporting clients from Naotkamegwanning to die at home if that is their wish.

Health System Sustainability (Briefly identify how this proposed improvement will result in efficiencies to the health care system and/or your organization, e.g. reduced duplication of services, new model of care, reduce length of stay, reduce readmissions, demonstrated cost benefit, collaborative budgeting, reinvestment of existing resources – ***maximum 150 words***)

This is an enhanced model of care which is aligned with the NW LHIN's population based goal to improve the health status and care experience for individuals living in North Western Ontario with a focus on the First Nations population. Currently all residents of Naotkamegwanning receive their end-of-life care in LWDH at an estimated cost of $42,000-$60,000 per person, assuming 21-30 days of hospitalization at $2000/day. Data are not available on the actual number of hospital days and emergency department visits in the last year of life, however, they are perceived by Naotkamegwanning Home and Community Care providers to be frequent and avoidable if services were available within the community.

The model addresses the gap for palliative home care services in First Nations communities. The model has potential to reduce hospital length of stay at end of life, reduce hospital admissions and ED visits in the last year of life, improve client and family satisfaction, improve health care provider's satisfaction and increase collaboration between primary care providers internal and external to the First Nation. A unique feature is the enhanced collaboration between federally and provincially funded health care services. There will be no duplication in services. Home care costs for palliative care services are much less than hospital costs.

Alignment with Integrated Health Service Plan (IHSP) (Please identify which of the LHIN IHSP priorities relate to this proposed improvement and explain how they are connected - ***maximum 150 words)***

Almost 20% of the NW LHIN's population is Aboriginal, many living in more than 60 First Nations communities. This pilot project will contribute to the development of an integrated regional palliative care program by creating a model of care that is transferable from Naotkamegwanning throughout the district and province.

The Wiisokotaatiwin program directly aligns with all four of the NW LHIN IHSP priorities.

1. Building an integrated health care system: The program will improve access to palliative care by increasing collaboration between primary care providers and improving communication between local stakeholders and the primary care providers. The Naotkamegwanning Home and Community Care/LTC, FNIHB, NW CCAC, WNHAC, TBRHSC and Regional Care Centre, St. Joseph's Care Group Telemedicine Nurse, LWDH, Community Health Care Professionals, CERAH Palliative Care Education, CERAH EOLFN project, Wesway, Kenora/Rainy River Hospice Volunteers have all agreed to partner in this pilot. This new model provides a community based alternative to receive palliative and EOL services in the community. This collaboration between the primary care providers and local stakeholder's goal is to improve transition between care settings, improve coordinated post discharge support for the client and to provide access to community based palliative care assessments and enhance palliative home care.
2. Building an integrated eHealth Framework: Naotkamegwanning is a rural community without the infrastructure or training to support advances in eHealth. The pilot is collaborating with partners to bridge this gap through the use of telemedicine and tablet which are innovative eHealth technologies.
3. Improving access to care: The pilot is collaborating across sectors with health care providers to improve identification, assessment, and care planning for clients in need of palliative care services. These clients can be in the acute care setting or in the community of Naotkamegwanning.
4. Enhancing chronic disease prevention and management: All clients with the Wiisokotaatiwin program are living and managing with one or more chronic diseases. The program is providing enhanced nursing, PSW, Homemaking and respite services in order to support individuals to stay in their home and community. These individuals will have the option to stay at home to the end of life if they choose.

Pre-proposals that do not align with the LHIN's IHSP (Please identify why this proposed improvement should be a priority to the local health of the community - ***maximum 150 words*****)**.
N/A

Section 2 – Health Service Provider Partners

Identify HSPs that you collaborated with in developing this pre-proposal and identify those that have agreed to actively collaborate/partner on the proposed improvement.

Organization	Contact Information	Nature and objective of the Collaboration
First Nations Inuit Health Branch, Ontario Region (Health Canada)	**Edey Hobson, Nurse Advisor, First Nations and Inuit Home and Community Care (FNIHCC) Program**	**Coordination of FNIHCC with NW CCAC services, project advisor** Provide assistance to HCC Coordinator with documenting palliative care service provision using the existing FNIHCC electronic Service Delivery Reporting Template (eSDRT) Assist with data analysis and interpretation of (eSDRT) to provide quantitative information about program functioning and client utilization of services Assist with review of Loan Cupboard contents to ensure appropriate equipment and supplies available for palliative care clients Collaborate with NW CCAC on the development of an information sharing protocol with HCC programs Assist with the development of service delivery plans related to palliative care Assist with establishing linkages with other services and programs Facilitate communication with other federally administered programs, e.g. Non Insured Health Benefits
NW CCAC	**Tuija Puiras CEO; Kathryn Hughes Director**	**Coordination of NW CCAC with FNIHCC services, project advisor** Assist pilot with case conferencing/assessment of PC client needs at LWDH and in Naotkamegwanning Assess eligibility of clients for CCAC services and provide services required For evaluation, assist pilot with quantifying and costing service provision for palliative home care provided on Naotkamegwanning Accept palliative care referrals for nursing from the physician or NP for clients in Naotkamegwanning Accepts referrals from the HCC for PSW, OT, PT, SW Share equipment catalogue with pilot as a resource for palliative clients receiving home care Collaborate with FNIHB on the development of an information sharing protocol with HCC program

Waasegiizhig Nanaandawe' Iyewigamig, Kenora Ontario	**Anita Cameron, ED**	**Provision of palliative care assessment and services, project advisor** NP goes to community twice a week (currently going once a week due to staff shortage): - Assist with identification and assessment of clients for program - Conduct home visits for palliative clients as requested by HCC (see budget $350/month) - Provide monthly PPS for clients in program and weekly PPS if client is EOL. - Can provide client consultation via telemedicine tablet once in use Provide staff opportunity for palliative care education e.g. LEAP offered in Kenora in March 2015 Health Promotion Team will organize community palliative care awareness sessions
Thunder Bay Regional Health Sciences Centre	**Trina Diner, Manager of Palliative Care and Telemedicine**	**Collaboration on telemedicine project; First Nations community awareness sessions, facilitate hospital discharge planning** Collaborate to provide HCC access to telemedicine licence and use of tablet Facilitate discharge planning with TBRHSC and First Nations communities
St. Joseph's Care Group	**Robin Cano, Telemedicine Nurse, Hospice Palliative Care**	**Collaboration of telemedicine community palliative care consultations** Assist/provide PC consultations via OTN and tablet Assist HCC Coordinator with client care planning Train HCC Coordinator in the use of the tablet and OTN Hospice Program can be called after hours by those involved in care if there is a need for specialty consultation Interdisciplinary hospice team can be accessed by telemedicine for consultation and assessment.
Lake of the Woods District Hospital, Kenora, Ontario	**Kathy Dawe, VP Patient Services/Chief Nursing Officer**	**Collaboration to improve discharge planning protocol with Naotkamegwanning Home and Community Care, improve access to palliative care assessments, assist HCC to develop cultural competency training for external home care providers, improve patient navigation for HCC clients from Naotkamegwanning**

		Provide Acute care services that are culturally safe and relevant Identify clients benefitting from PC approach D/C plan that includes HCC Coordinator- enhance communication and early d/c planning Every effort will be made not to discharge patients on a Friday unless HCC services have been organized (measure indicator) Phone consultation with palliative care nurse as needed for pain and symptom management OTN used for family visits and client consultation as needed Promote physician awareness of the Wiisokotaatiwin program in hospital and emergency department and promote their engagement in the pilot
Community Health Care Professionals	**Vicki Barnes, Owner/Manager**	**Enhanced provision of palliative nursing services in Naotkamegwanning** Provide PC assessments in the community Facilitate and participate in PC case conferences Provide an on-call nursing service (consultation and visit if required) for evening and weekends as required (see budget) Provide and promote opportunities for staff to take PC education e.g LEAP (see budget)
CERAH EOLFN Project	**Mary Lou Kelley, Holly Prince**	**Pilot project facilitation** Provide facilitation of pilot project (facilitate partnerships, facilitate management committee activities, assist with managing the budget as requested by AJ White, facilitate data collection) Assist with evaluation of pilot Provide final report for pilot project
CERAH Palliative Care Education Initiative	**Stephanie Hendrickson**	**Organize LEAP course in Kenora in February/March 2015** Provide PC education to HCC staff and external health care providers. Service providers from Naotkamegwanning, CCAC, WNHAC, LWDH and Community Health Care Professionals will participate (tuition will be subsidized as required - see budget)

Section 3 – Accountability, Service Details, Financial Impact & Implementation Timelines

Section 3 A – Accountability. Please describe in detail how you would:

a) demonstrate the value of the project both in the short term and long-term *(This should include any narrative successes that are not clearly measurable, proof that the public would see this project as good value for money/value to the system, etc.)*

The pilot project will be managed by a committee chaired by Maxine Ranville, HCC Coordinator. Membership includes: AJ White, Health Director; Melanie Copenace, Band Councillor/Health Portfolio; Holly Prince and Mary Lou Kelley, CERAH EOLFN. The management committee will meet monthly by telephone to monitor activities, solve problems and to ensure that the goals of the project are being met.

Clients and internal and external health care providers will agree that the following objectives have been met by the pilot:

1) Clients have the choice to receive palliative care at home
2) Clients receive quality palliative home care in Naotkamegwanning
3) Families are more educated and supported in their role as caregivers
4) Local health care providers are more competent and confident in the delivery of palliative care
5) External health care providers provide more culturally relevant care
6) Health system organization and care processes are improved to provide palliative home care in Naotkamegwanning
7) Residents of Naotkamegwanning have improved access to palliative care
8) Clinical information sharing among health service provider agencies has improved
9) Improved accessibility of health care using technology i.e. OTN and tablet
10) Better communication and continuity of care between primary care and palliative care specialists
11) Fewer unnecessary ED visits, fewer avoidable admissions to hospital
12) Increased adoption of best practices for palliative care
13) System integration is improved to utilize resources more efficiently
14) Naotkamegwanning Model of Care is transferable to other First Nations communities

b) measure accountability and success of the project both in the short-term and long-term (*This should include clearly defined project performance indicators including comparisons with historical performance, benchmarks for similar services, and performance targets with rationale. Consider inclusion of system level impacts (e.g. % of ALC days, decrease in (re)admissions to hospital, decrease in LTC waitlist), improvements in client satisfaction, increase in efficiency of service delivery, etc.*)

Level	Baseline	Predicted Outcome
Program Level More residents in Naotkamegwanning receive palliative services at home for advanced chronic disease and end of life	0	5 clients by end of pilot March 31, 2015
Clients receive a palliative care assessment in community when identified	0	5+ clients assessed in community by end of pilot
Palliative Care Case Conferences are held that include local and external health care providers with pilot partners (NW CCAC, LWDH, WHNAC, TBRHSC)	0	5+ Integrated service delivery (LWDH, NW CCAC, WHNAC and HCC)
Integrated care plan is developed and implemented. Track clients by CHA scores/amount of service based on PPS/frequency of service	0	5+
Cost of having a palliative care nurse on-call for evening and weekends as required. Track Number of hours of service and type of service and time of day	unknown	$ value known
Cost of palliative care nursing services is known (days, evenings, nights, weekends) Track Number of hours of service and type of service	unknown	$ value known
Cost of PSW and homemaker services is known (days, evenings, nights, weekends) Track number of hours of PSW and type of work and time of day	unknown	$ value known
Cost of Respite Care services is known (days, evenings, nights, weekends) Track number of hours of PSW and type of work and time of day	unknown	$ value known
Cost of Professional services to support palliative home care is known (PT/SW/OT etc.) (days, evenings, nights, weekends) Track number of visits and reason for referral	unknown	$ value known
Cost of medications (oxygen) and equipment/supplies to support palliative home care is known	unknown	$ value known

Cost of client/family transportation related to PC is known	unknown	$ value known
Hours of Wiisokotaatiwin program coordination is known	Unknown	# of hours known
HCC attendance at PC case conference	0	5+
HCC attendance at PC/EOL discharge planning	0	5+
Education for direct care providers	6 PSW have received PC for Front Line Workers	1 HCC provider to complete LEAP 6 External HCC to complete LEAP (Kenora March 2015) 1 HCC provider trained to use Inter-Rai CHA
Clients who would benefit by palliative care are identified earlier in their journey by Home and Community Care Program (prior to 50% on the PPS)	3 clients identified as eligible for Wiisokotaatiwin	5+ clients on the program
HCC consultation with PC experts	0	10+
System Level Wiisokotaatiwin Program	No palliative care program description relevant to First Nations Communities	Description of program model disseminated to other First Nations communities
The number of hospital days for client in the last year of life (registered with Wiisokotaatiwin) including reason for admission.	Unknown (average EOL admission in Kenora/Rainy River is 21 days)	# of hospital days known
The number of ED visits by clients in the last year of life (registered with Wiisokotaatiwin) Track reason for visit	Unknown	# of ED visits known
Discharges from hospital are planned collaboratively with HCC	0	10

Fewer Hospital Deaths	5 in 2014 for eight months	2 in 2014 for 7 month period (September 1 – March 31, 2015)
HCC health care providers receive palliative care education	6	10
External health care providers receive palliative care education (LEAP)	0	6

Section 3 B – Service Details

Service/Volume Details	
Proposed Service Change (Volume/Outcome)	**Provide Details i.e. additional number of visits, services provided or residents (clients) served by type of service,**
☐ No Change	
☒ Increase	Increase access to palliative home care services and support services in Naotkamegwanning. Palliative care education for family, internal, and external health service providers will increase local capacity of PC knowledge and skills to provide local palliative care services. Use of OTN equipment will increase access to PC consultation with interprofessional health care providers, and address gaps of access to specialized health services. Increase client satisfaction by receiving care in setting of client's choice and supporting client access to cultural, spiritual, and language needs
☒ Decrease	Decrease hospitalization and hospital deaths. Decrease number of hospital days in last year of life.

Section 3 C – Financial Details

Financial Details			
	Provide Details	**$ One-time**	**$ Base**
☐ No new funding required			
☐ Savings Identified			
☐ One time project funding (ongoing funding not required)			

☒ Start-up funding	☒ Consultation/training/ evaluation ☒ Staff ☒ Other (specify) equipment	$7000 $19,000 $4000	
☐ Ongoing operating (out-year funding)	☐ Staffing ☐ Supplies ☐ Other (specify)		
☐ Capital			
☒ Other funding sources	Improving End-of-Life Care in First Nations Communities Research Project	In kind project facilitation (0.5day/week= $4145/7mths)	In Kind Community Facilitator, Admin Assistance $37,452/7 months

Section 3 D – Implementation Timelines. Please provide estimated timelines for project development and implementation

Project to run September 1, 2014 - March 31, 2015

I acknowledge that this submission is not formal notice of a proposed integration to the LHIN as contemplated by s. 27 of the Local *Health System Integration Act, 2006* ("LHSIA"). HSPs wishing to provide notice to the LHIN of a proposed integration under s. 27 of LHSIA, should contact the LHIN for more information.

Signature: _____

Name: _____

Title: _____

Date: _____

APPENDIX A: First Nations and Inuit Home and Community Care (FNIHCC) Program Program Description and Capacity to Support Wiisokotatawin Program

Program Description[1]

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 responsive to the unique health and social needs of First Nations and Inuit.

The program is comprised of essential service elements and may be expanded to include supportive service elements, provided the essential service elements are met. When communities already have all essential services through alternate sources, the program will not duplicate these services, but will allow communities to augment, through supportive service components, the current services.

The program will coordinate and link with existing programs and services at the community and/or provincial/territorial level.

Eligible Recipients

The eligible recipients for this program are:

- First Nations and Inuit of any age; and
- Who live on reserve, Inuit settlement 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

Essential service elements include[2]:

- A **structured client assessment process** that includes on-going reassessments and determines client needs and service allocation
- A **managed care process** that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/settlement
- **Home care nursing services** that include direct service delivery as well as supervision and teaching of personnel providing personal care services
- Delivery of **home support services** (personal care and home management)
- Provision of **in-home respite care**
- **Established linkages** with other professional and social services
- Provision of and access to specialized **medical equipment, supplies** and specialized pharmaceuticals

[1] Adapted from: Program Criteria, FNIHCC Planning Resource Kit, FNIHB, Health Canada (2000)
[2] Adapted from: Summative Evaluation of the FNIHCC, Health Canada (2007/2008)

- The capacity to **manage** the delivery of the home and community care program
- A system of **record keeping and data collection** to carry out program monitoring, ongoing planning, reporting and evaluation activities

Supportive service elements may include (examples)[3]:

- Home-based palliative care services
- Facilitation and linkages for rehabilitation and therapy services
- Adult day programs
- Meal programs
- Mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness
- Traditional counseling and healing services
- Social services directly related to continuing care issues

Capacity to Support Wiisokotatawin Program

As detailed in the Program Description, home-based palliative care services may be offered as a supportive service element through the Naotkamegwanning Home and Community Care Program (HCCP) provided that essential service elements are being met. Regarding funding, this does not change the funding amount Naotkamegwanning receives from First Nations Inuit Health Branch to deliver their HCCP. Should the program wish to offer supportive services to meet a determined community need, this must be done within the existing budget and not affect the delivery of the essential service elements.

Working with the Wiisokotatawin Program, the Naotkamegwanning HCCP could facilitate the following services for palliative care clients:

- Provision of any of the essential service elements (based on the structured client assessment and care plan)
- Palliative care specific services as supportive service elements (enhanced essential services and palliative specific services as described by the Wiisokotatawin Program)

[3] Adapted from: Program Criteria, FNIHCC Planning Resource Kit, FNIHB, Health Canada (2000)