Nova Scotia Aboriginal Home Care Project
Project Evaluation

Aboriginal Health Transition Fund Project

Submitted to
Aboriginal Health Transition Fund Secretariat
First Nations and Inuit Health Branch
Health Canada

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A Report of the Nova Scotia Aboriginal Home Care Steering Committee

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1.0 EXECUTIVE SUMMARY

The Nova Scotia Aboriginal Home Care Aboriginal Health Transition Fund (AHTF) project was initiated in response to concerns regarding the delivery of home care services on-Reserve. The project, a collaborative effort between First Nations communities, provincial government, federal government, and district health authorities set out to address gaps in home care services and initiate a process to improve the delivery of culturally appropriate home care services for First Nation people living on-Reserve. The project was organized around three streams of activity: development of a trilateral policy forum, development of a home care framework, and undertaking an assessment of a discharge planning pilot project to inform a province-wide roll-out.

The project largely achieved its intended outcomes, with the exception of implementing the discharge planning model across the province (which continues to involve consultation regarding the strategy for memoranda of understanding), and the official release of the Aboriginal Home Care Framework (although this document has successfully been signed off by all project partners). This speaks to the fact that some aspects of the workplan took longer to bring to fruition because of the time required to establish and build upon relationships across all stakeholders, and the length of time required for internal processes of engagement and approval within all levels of government.

The integration of home care into the district-level portfolio added an additional layer of complexity to policy development and communications. Finally, H1N1 pandemic planning resulted in uncontrollable redeployment of human resources at the community, district, provincial and federal levels that had direct impact on this project workplan.

The Aboriginal Home Care Framework provides strategic direction, includes valuable baseline data, acts as a resource guide and lists recommendations that will reshape and improve the delivery of home care services over the next several years. The formation of an Aboriginal Continuing Care Policy Forum (ACCPF) will continue to advance the work of the AHTF project steering committee and provides a sustained mechanism to address gaps in continuing care services. The Cape Breton Discharge Planning Pilot Project Evaluation is being used to inform the roll out of a province-wide

home care discharge planning process serving all First Nation communities in the province. The AHTF project was extended to include consideration of long term care issues affecting Aboriginal people living on-Reserve and to explore best and promising practices in addressing their needs. This information and the resulting recommendations will be released in a separate report.

In addition to measuring the success of intended project outcomes outlined in the project proposal, the evaluation presents a document review, steering committee survey results and community stakeholder survey results. A summary of project challenges and key learnings follows the evaluation results, which will help to inform the work of the Aboriginal Continuing Care Policy Forum (ACCPF) and provide direction and lessons to future AHTF projects and other groups carrying out similar projects in the future.

Key Words: Aboriginal home care, Aboriginal long term care, Aboriginal continuing care, First Nation home care, First Nation long term care, First Nation continuing care, home care, long term care, continuing care, home care on Reserves, home and community care.

2.0 PROJECT DESCRIPTION

In the summer of 2007 a group of community, provincial and federal stakeholders came together to address shared concerns regarding the delivery of home care services on-Reserve under the auspices of an Aboriginal Health Transition Fund (AHTF) initiative. According to Indian & Northern Affairs Canada (2009), the total registered First Nations population in Nova Scotia is 14,239 people. There are 13 governing First Nation Bands overseeing 33 Reserve land communities scattered across Nova Scotia. These Reserves are home to 9,480 First Nation individuals or about 67% of the First Nations population. Based on utilization data estimate there are 250-300 individuals on reserve each year in NS receiving home and community care services on-Reserve.

The goal and objectives as set out in the project funding proposal guided all aspects of the steering committee's work.

2.1 Goal

To initiate a process that will improve the delivery of home care to First Nation people living on-Reserve.

2.2 Objectives

There are three general streams of activity that guided this project: [1] development of a trilateral policy forum, [2] development of a home care framework/strategy, [3] assessment of a district-level home care discharge planning pilot to inform a possible province wide roll out.

Specific activities to support these objectives include:

- Create an on-going forum where intergovernmental issues (federal, provincial and local) affecting the delivery of the continuum of continuing care services to First Nation people living on-Reserve can be discussed and resolved.
- Establish a shared understanding between the Continuing Care Branch (DoH), FNIH and First Nations health care delivery providers regarding current home care definitions, service types, scopes of practice and employment, responsibility for service provision, service delivery mechanisms, funding, and eligibility for service for First Nation people living on-Reserve in

Nova Scotia. This will include examination of the continuum of services that are part of both the federal and provincial programs (i.e. self managed care, palliative care).

- Conduct an assessment of home care service needs for First Nation people living on-Reserve.
- Develop strategies/recommendations to address gaps and build on community capacities, including the identification of process/service delivery improvements, funding strategies, and policy amendments where required. Strategies will be based on a culturally appropriate model of home care services which addresses the unique needs of First Nation communities and builds on their strengths and capacities.
- Complete a comprehensive evaluation of the Cape Breton Home Care Discharge Planning Project to determine what worked, what didn't and what aspects are applicable to and needed by other First Nation communities in Nova Scotia.
- Develop a recommended action plan that addresses the home care needs of First Nation people living on-Reserve. This action plan will serve as a road map to implementing home care discharge planning to First Nation communities across the province and to move forward the home care framework toward implementation.

As a addendum to the original project workplan, the steering committee secured additional funding from the AHTF envelope to conduct a review of long term care issues as they relate to the provision of services to Aboriginal people. The evaluation of this component of work is included in this report.

2.3 Project Partners

The Confederacy of Mainland Mi'kmaq (CMM)
Union of Nova Scotia Indians (UNSI)
Atlantic Policy Congress of First Nations Chiefs (APCFNC)
Health Canada First Nations & Inuit Health (FNIH Atlantic Region)
Nova Scotia Office of Aboriginal Affairs (NSOAA)
Nova Scotia Department of Health (NSDoH)
Indian & Northern Affairs Canada (INAC)
Guysborough Antigonish Strait Health Authority (GASHA)
Cape Breton District Health Authority (CBDHA)

3.0 EVALUATION APPROACH

The overall aim of the Home Care project was to address the provision of continuing care services in general and discharge planning services in particular for First Nation people living on-Reserve. The project evaluation assesses progress toward achieving this goal, recognizing that the full impact of this initiative will be long term in nature. A summary of project financials, including the AHTF funding under the Contribution Agreement as well as a profile of additional resources provided by the Department of Health, is appended to this report although a financial audit is not within the scope of this evaluation review (see Appendix D).

3.1 Evaluation Domains

The following domains were used to assess project performance: Planning & Communication; Coordination; Implementation of Provincial Home Care Discharge Planning Model; Development of the Home Care Framework; and Completion of a Review of Aboriginal Long Term Care Issues. The short-term outcomes are listed under each domain below.

Planning & Communication (Project Management)

- Development and strengthening of partnerships and communication between First Nations leadership and communities & Provincial and Federal governments.

Coordination (Tri-lateral Policy forum)

- Increased involvement of First Nations in planning of home care services on-Reserves.
- Development of sustainable relationships and forums for ongoing resolution of continuing care issues for First Nations in Nova Scotia.

Implementation of Provincial Home Care Discharge Planning Model

- Understanding the effectiveness and impact of the Cape Breton home care discharge planning pilot project.
- List of recommendations to support the implementation of a provincial discharge planning service model for First Nations on-Reserves.
- Provincial roll-out of discharge planning model.

Development of the Home Care Framework

- Improved understanding within the provincial government of the local home care needs and service capacity on First Nations Reserves.
- Agreed upon common understanding of current policies and responsibilities for service delivery.
- Increased understanding of culturally appropriate home care service delivery options.
- Development of an action plan and recommendations.

Appendix A includes a figure depicting the relationships between project domains, short term outcomes and the long term outcome.

Completion of a Review of Aboriginal Long Term Care Issues

- Improved understanding within the provincial government of the local long term care needs and service capacity on First Nations Reserves.
- Agreed upon common understanding of current policies for long term care.
- Increased understanding of culturally appropriate long term care service delivery considerations.
- Development of recommendations regarding the delivery of long term care services to Aboriginal people living on-Reserve.

3.2 Performance Indicators

Within the domains several performance indicators were identified for each outcome. Table 1 lists the performance indicators and intended outcome, by domain.

Table 1: Performance Indicators

Domain – Planning and Communication (Project Management)

Outcome	Performance Indicator
Active engagement and participation opportunities of First Nations leadership and provincial and federal governments in the project.	Number of steering committee meetings Representation at steering committee meetings # of engagements with FN communities and decision-makers

Strengthened partnerships and communication between First Nations leadership and provincial and federal governments in the project.	Steering committee perceptions

Domain – Collaboration (Trilateral Policy Forum)

Outcome	Performance Indicator
Increased involvement of First Nations in planning of home care services on-Reserves through the establishment of a trilateral policy forum.	# of persons/organizations and key stakeholders engaged in the trilateral policy forum from First Nations, provincial government and federal government
Development of sustainable relationships and forum structure for ongoing resolution of continuing care issues for First Nations in Nova Scotia.	Establishment of a long term forum meeting schedule and forum structure/terms of reference

Domain – Implementation of Provincial Home Care Discharge Planning Model

Outcome	Performance Indicator
Understanding the effectiveness and impact of the Cape Breton home care discharge planning pilot project .	Completion of the Cape Breton home care discharge planning evaluation (signed off on by the steering committee)
List of recommendations to support the implementation of a provincial discharge planning service model for First Nations on-Reserves.	List of recommendations endorsed by the steering committee
Provincial roll-out of discharge planning model.	Implementation of the discharge planning model by DHAs.

Domain – Development of the Aboriginal Home Care Framework

Outcome	Performance Indicator
Improved understanding within the provincial government of the local home care needs and service capacity on First Nations Reserves.	Complete home care service profiles for First Nations Reserves
Agreed upon common understanding of current policies and responsibilities for service delivery.	'Common understanding' document outlining current policies and responsibilities for service delivery endorsed by tri-lateral forum stakeholders
Increased understanding of culturally appropriate home care service delivery options.	Agreement among stakeholders that the process has fostered greater awareness of how to customize culturally appropriate solutions
Development of an action plan and recommendations.	Agreement of stakeholders on action strategy and associated timelines to monitor progress.

Domain – Completion of a Review of Aboriginal Long Term Care Issues

Outcome	Performance Indicator
Improved understanding within the provincial government of the local long term care needs and service capacity on First Nations Reserves.	Completion of long term care service profiles for First Nations Reserves.
Agreed upon common understanding of current policies and responsibilities for long term care.	Development of a long term care companion summary 'Common understanding' document outlining current policies and responsibilities for service delivery endorsed by tri-lateral forum stakeholders.
Increased understanding of culturally appropriate long	Completion of research into examples of best and

term care service delivery considerations.	promising practices in the provision of long term care to Aboriginal clients.
Development of recommendations regarding the delivery of long term care services to Aboriginal people living on-Reserve.	Agreement among stakeholders on recommendations for further action.

3.3 Methodology

Project evaluation tools included a detailed document review and two targeted evaluation surveys: a community home care service profile stakeholder survey and a steering committee survey. In addition to helping populate the performance indicators, the targeted surveys assess project progress and overall experiences as perceived by stakeholders directly involved with the project.

All data collection instruments were developed in collaboration with steering committee members to ensure that fields of inquiry addressed all evaluation domains and supported participant organizations' accountabilities. Surveys to measure stakeholder satisfaction and lessons learned were administered on-line and collated by the Department of Health, Monitoring and Evaluation staff.

The involvement of District Health Authorities (DHAs) occurred after the official project approval was received (due to policy decision by the Nova Scotia Department of Health (NSDoH) to integrate home care with DHA management responsibilities during the project period). As such, evaluation questions were broadened from the original logic model to capture DHA experience in Aboriginal home care planning and delivery.

3.3.1 Project document review

The document review was based on a comprehensive inventory of project materials and meeting notes. It focuses on assessing quantifiable indicators to track progress. The document review was also used to evaluate the performance of the project against the indicators outlined in the proposal logic model.

3.3.2 Community Home Care Service Profile Stakeholder Survey

The *Community Home Care Service Profile Stakeholder Survey* targeted individuals who helped develop the community service profiles. Stakeholders were asked to complete a survey measuring the degree to which they agreed or disagreed on a scale of one to seven (one = strongly disagree,

seven = strongly agree) with a list of statements evaluating project process and the usefulness of results to the community. Survey participants were asked to provide a written comment where responses of three or lower were given.

The *Community Home Care Service Profile Stakeholder Survey* was administered as an on-line survey. An e-mail invitation with a link to the survey was sent to stakeholders who participated in the development of the community service profiles. A reminder e-mail was sent one week after the initial request. Stakeholders representing seven of the communities responded to the survey. Notably, there was a high rate of turnover during the life of the project of community-level staff. Two-thirds (67%) of the twenty-one individuals originally participating in the development of the community service profiles were no longer in their respective positions at the time of the project evaluation. As a result, while everyone who was still in their role did participate in the evaluation, this represents only seven individuals. See Appendix B for a list of the survey questions.

3.3.3 Steering Committee Survey

Steering committee members were asked to complete a survey measuring the degree to which they agreed or disagreed with a list of statements evaluating the effectiveness of project engagement, project activities, project outcomes, and project process. In addition, all survey participants were asked to respond 'yes' or 'no' to the question, *"Has the initiative achieved progress in its to goal to increase access to home care services by First Nation people living on-Reserve in Nova Scotia?"*. Respondents answering 'yes' were asked to indicate the critical success factors and respondents answering 'no' were asked to indicate the barriers and limitations that prevented progress. See Appendix C for a list of the survey questions.

The *Steering Committee Survey* was administered as an on-line survey. An e-mail invitation with a link to the survey was sent to active steering committee members at the time of the evaluation. For several of the organizations, representatives changed over the course of the project. Two reminder e-mails were sent to encourage participation. Steering committee members were also reminded at the final steering committee meeting to complete the survey. Seven of the eleven steering committee members responded to the survey. The survey results were used to help evaluate the objectives identified in the logic model.

3.4 Evaluation Limitations and Challenges

There were two main limitations to this evaluation. The first was the high turn-over among community health professionals, as two-thirds (67%) of those involved in the initiative had left their respective positions by the end of the project. This resulted in a smaller pool for evaluation feedback.

The second limitation was the low response rate by steering committee members, which may be explained by an 'AHTF fatigue' factor. It should be noted that this response rate is not reflective of the level of involvement steering committee members invested throughout this initiative. It may also be the case that there was disinclination to participate in an online survey, rather than completing a hard copy form at a meeting.

4.0 DOCUMENT REVIEW

4.1 Steering Committee

The steering committee included representation from the Union of Nova Scotia Indians (UNSI), Confederacy of Mainland Mi'kmaq (CMM), Atlantic Policy Congress of First Nations Chiefs (APC), Nova Scotia Department of Health, Nova Scotia Office of Aboriginal Affairs, Health Canada First Nations and Inuit Health – Atlantic Region (FNIH), Indian & Northern Affairs Canada (INAC), Guysborough Antigonish Strait District Health Authority (GASHA) and the Cape Breton District Health Authority (CBDHA). In addition to the eleven official steering committee members, there was regular participation at the steering committee meetings by representatives of other provincial AHTF projects contributing to and/or impacted by this initiative. Section 7.1.1 elaborates further on the steering committee and stakeholder engagement and community participation. There were 12 steering committee meetings held over the course of the project. This followed the initial work-plan, which was approved by the steering committee at the beginning of the project. Steering committee meetings averaged an attendance rate (either in person or by phone) of over 90%.

4.2 Community Engagement

First Nation communities provided critical input to all components of the project including the home care service profiles, the Cape Breton home care discharge planning project review and the long term care service profiles. Section 7.1.2 elaborates further on community engagement efforts.

4.2.1 Home Care Service Profiles

All thirteen communities participated in the development of the Home Care Service Profiles. The project management team held in-person interviews or phone interviews with representatives from each community. Twenty-one (21) representatives participated in the interviews. At the very minimum, the Home Care Director (if the community had a designated home care director) or nurse responsible for providing home care services participated in the interviews.

4.2.2 Cape Breton Home Care Discharge Planning Evaluation

The five Cape Breton Unama'ki communities, UNSI's health representative, and management and front line service providers from Cape Breton Regional Health Authority and Cape Breton Continuing

Care District Office, Department of Health participated in the program review. Twenty-four (24) people were consulted as part of the evaluation.

4.2.3 Long Term Care Service Profiles

All communities but one participated in the development of the long term care service profiles. The questionnaires were completed by the health director or home care coordinator. In one community, the home care coordinator consulted a group of Elders for input. The health director which did not participate was not able due to a lack of time. The project management team made multiple attempts to get the questionnaire completed but after a month of trying proceeded without it.

4.3 Issues Examined and Recommended Solutions

During the course of the project several gaps in services and program delivery issues were raised at the steering committee meetings. Many of these issues were directly addressed by the steering committee. In the following cases, provincial policies were formally changed.

4.3.1 Bed Loan Program

The hospital Bed Loan Program was extended to include First Nation clients living on-Reserve.

4.3.2 Caregiver Allowance Program

The Caregiver Allowance Program was extended to First Nation clients on-Reserve.

4.3.3 ALC fee suspension

The alternate level of care (ALC) fee charged to First Nation clients living on-Reserve when waiting in hospital for a long term care bed was suspended.

4.3.4 Facility Based Respite Policy

The long term care respite services policy was changed so that First Nation clients living on-Reserve were charged the same fees as other Nova Scotians.

4.3.5 Continuing Care Assistant (CCA) placements

As part of the CCA certification program students must complete a 100 hour placement in a DoH contracted home care agency. In 2010 the Continuing Care Assistant Provincial Advisory Committee supported by the Department of Health began allowing students to complete up to 50 percent of their home care placement on Reserve as part of the FN Home and Community Care program. Placements have been approved on 5 Reserves - Waycobah, Wagmatcook, Eskasoni, Potlotek and Paqtnkek.

4.4 Aboriginal Continuing Care Policy Forum

All groups that participated on the Home Care AHTF Project steering committee have joined the Aboriginal Continuing Care Policy Forum. The first meeting was held in June 2010. Tracking the number of participants, representation from First Nations, provincial and federal government, frequency of meetings, and number of issues addressed will be documented for future evaluations.

4.5 Gender based analysis

The project considered the different roles of men and women in continuing care, recognizing that First Nation communities have a strong cultural history of women caring for the wellbeing of their family and community members. The project design, needs assessment, analysis and home care framework recommendations were careful to consider the role of women recognizing their disproportionate share of care provision and service use. It is well documented that women provide the vast majority of both formal and informal home-care support. In a First Nation context, these caregivers are often and increasingly challenged to care for three generations (their grandchildren, their spouse and other extended family, and their parents). Substantially more women than men use home care services. In the general Nova Scotia population, according to Department of Health statistics 72% of the provincial home care clients are female. Of note is that all of the home care providers, health directors and other health professionals participating in the project (with the exception of one) were female.

4.6 Actions resulting from the Cape Breton Pilot Project evaluation findings

Based on the Cape Breton Discharge Planning Pilot Project evaluation, the program will be rolled-out across the province. The pilot project review included thirteen recommendations to inform the program roll-out. As noted previously, the implementation process has taken longer than expected. At present, legal counsel for the provincial government and First Nation communities are reviewing the MOU agreement which would detail the operational relationship between each First Nation community and each DHA. The province has developed a specific policy mandating this service be provided by each DHA which will be implemented in late 2010 or early 2011. It was hoped that the MOUs would have been signed and the policy implemented before the formal AHTF project ended. The Aboriginal Continuing Care Policy Forum will assume responsibility to facilitate the signing of the MOUs and supporting program roll-out.

Early on in the evaluation process, Chapel Island (the only community that did not participate in the initial pilot project) approached the Province requesting inclusion in the pilot. An MOU was developed and signed by the Province, DHA and community in 2007.

5.0 COMMUNITY STAKEHOLDER SURVEY RESULTS

An invitation to participate in an on-line *Community Home Care Service Profile Stakeholder Survey* was sent to stakeholders who provided data for the community service profiles. The survey was designed to evaluate three facets of the service profiles:

1) process related questions regarding data collection, profile development and presentation;
2) questions regarding the usefulness of results/project to the community;
3) questions assessing if the project has fostered an increased capacity to address key home care related issues.

While the aggregate service profile results informed the development of the Home Care Framework, the community specific results were intended to provide valuable information for communities to support planning and decision-making regarding their individual home care programs. Each community received a detailed community profile which would be owned by the community to use at its discretion. The short survey consisted of nine questions: two addressing process related issues; three questions evaluating the usefulness of the results, and four questions assessing if the project has fostered an increased capacity to address key home care issues.

Overall the survey results were positive, with the vast majority of respondents indicating that they either strongly agreed, agreed, or somewhat agreed with the survey statements. Survey statements were evaluated on a scale of 1-7 (one being strongly disagree and seven being strongly agree). No respondents disagreed with any of the statements. One respondent answered neutral for the questions regarding increased capacity. One participant also responded neutral to one of these questions. Questions regarding usefulness of the results had an average score of 6.0 out of 7. Questions regarding process had an average score of 5.9 out of 7 and questions regarding increased capacity had an average score of 5.5 out of 7.

Community Informant Survey (total responses: 7)

1. Please rate your response to the following statements on a Scale of 1-7.

	1	2	3	4	5	6	7	Response Total	Response Average

1.1)This project has resulted in an accurate reflection of my community's Continuing Care needs.	0% (0)	0% (0)	0% (0)	0% (0)	42.86% (3)	42.86% (3)	14.29% (1)	7	5.71
1.2)The process of developing my community's service profile was collaborative, respectful and appropriate.	0% (0)	0% (0)	0% (0)	0% (0)	16.67% (1)	50% (3)	33.33% (2)	6	6.17
1.3)The summary report I received about my community's service profile will be useful to local planning.	0% (0)	0% (0)	0% (0)	0% (0)	16.67% (1)	66.67% (4)	16.67% (1)	6	6
1.4)The community service profile will be useful to me in discussing Continuing Care needs with the District Health Authority.	0% (0)	0% (0)	0% (0)	0% (0)	16.67% (1)	50% (3)	33.33% (2)	6	6.17
1.5)My community has a close working relationship with the District Health Authority on issues of Continuing Care.	0% (0)	0% (0)	0% (0)	16.67% (1)	33.33% (2)	50% (3)	0% (0)	6	5.33
1.6)I know who to call to resolve a local home care issue.	0% (0)	0% (0)	0% (0)	33.33% (2)	0% (0)	66.67% (4)	0% (0)	6	5.33
1.7)I know who to call to resolve a local long term care issue.	0% (0)	0% (0)	0% (0)	20% (1)	20% (1)	40% (2)	20% (1)	5	5.6
1.8)I know who to call to organize a discharge plan for a local patient.	0% (0)	0% (0)	0% (0)	0% (0)	50% (3)	33.33% (2)	16.67% (1)	6	5.67
1.9)The project has reduced barriers to accessing services.	0% (0)	0% (0)	0% (0)	0% (0)	50% (3)	33.33% (2)	16.67% (1)	6	5.67

5.1 Process related questions

Participants responded favourably to process related questions. Four of the seven survey participants either agreed or strongly agreed '*the project resulted in an accurate reflection of my community's Continuing Care needs'*. Three respondents somewhat agreed. Six of the seven survey participants either agreed or strongly agreed that '*the process of developing my community's service profile was collaborative, respectful and appropriate'*. One respondent somewhat agreed.

5.2 Usefulness of service profiles

Participants also responded favourably to questions regarding the usefulness of the service profiles. All of the respondents with the exception of one either strongly agreed or agreed that '*the summary report I received about my community's service profile will be useful to local planning'* and '*the community service profile will be useful to me in discussing Continuing Care needs with the District Health Authority'*. One respondent somewhat agreed to the above statements. In regard to the statement about the project's ability to reduce barriers, the responses were slightly less favourable. Three respondents somewhat agreed.

5.3 Capacity to address Home Care issues

The capacity to address Home Care issues received an average score value 5.5 out of 7 – the lowest overall rating of all evaluation fields in the survey, but still remarkably positive. One respondent replied neutral to all the statements falling under this theme. No respondents disagreed with any of the statements. Statements were oriented around knowing who to call to resolve a local home care issue, who to call to resolve a local long term care issue, and who to call to organize a discharge plan for a local patient.

6.0 STEERING COMMITTEE SURVEY RESULTS

The survey was designed to capture the opinion of steering committee members regarding project process and the success of the project to address home care issues and improve the delivery of home care services on-Reserve. Questions regarding project process targeted three themes including: 1) fostering a productive working environment; 2) fostering relationships; 3) fostering results. The survey consisted of nineteen questions, eleven questions regarding project process and eight questions regarding the usefulness of results.

Overall the survey results were very positive. The vast majority of respondents either strongly agreed or agreed with the survey statements. Survey statements were evaluated on a scale of 1-7 (one = strongly disagree and seven = strongly agree). No respondents disagreed with any of the statements. For the nineteen questions, the average score of all respondents (out of seven) ranged from a low of 5.57 to a high of 6.71. The responses tended to be very high, sixteen of the questions had average scores above 6.0. In addition to evaluating survey statements, all survey participants were asked to respond 'yes' or 'no' to the question, *'Has the initiative achieved progress in its goal to increase access to home care services by First Nation people living on-Reserve in Nova Scotia?'.* Respondents answering 'yes' were asked to indicate the critical success factors and respondents answering 'no' were asked to indicate the barriers and limitations that prevented progress. All respondents answered 'yes'.

Steering Committee Survey (total responses: 7)

1. Please rate your response to the following statements on a Scale of 1-7.

	1	2	3	4	5	6	7	Response Total	Response Average
1.1) Draft project documents were helpful in facilitating discussion and decision making.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	71.43% (5)	14.29% (1)	7	**6**
1.2) I had adequate opportunity to provide my input to draft documents.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	14.29% (1)	71.43% (5)	7	**6.57**
1.3) Meetings made an effective use of my time.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	28.57% (2)	57.14% (4)	7	**6.43**
1.4) The process fostered an environment where I felt safe to speak openly.	0% (0)	0% (0)	0% (0)	14.29% (1)	0% (0)	14.29% (1)	71.43% (5)	7	**6.43**
1.5) The process fostered an environment where others could feel safe to speak openly.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	42.86% (3)	42.86% (3)	7	**6.29**
1.6) The process created new opportunities for interjurisdictional dialogue about Aboriginal home care issues on-Reserve.	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	28.57% (2)	71.43% (5)	7	**6.71**
1.7) The process was oriented to finding solutions when issues were identified.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	28.57% (2)	57.14% (4)	7	**6.43**
1.8) The process of developing community service profiles was an effective approach to identifying local home care needs and capacities.	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	57.14% (4)	42.86% (3)	7	**6.43**
1.9) The process has been effective in contributing to the integration of home care services for First Nations living on Reserve.	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	100% (7)	0% (0)	7	**6**
1.10) The process has increased capacity for analysis and resolution of home care issues.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	28.57% (2)	57.14% (4)	7	**6.43**
1.11) The process has increased collaboration and strengthened partnerships.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	14.29% (1)	71.43% (5)	7	**6.57**
1.12) The home care framework will foster a common understanding of current programs, services and responsibility for delivery.	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	57.14% (4)	42.86% (3)	7	**6.43**
1.13) Information in the framework will increase the ability to customize service delivery to local needs and capacities.	0% (0)	0% (0)	0% (0)	0% (0)	42.86% (3)	42.86% (3)	14.29% (1)	7	**5.71**
1.14) The project has built effective partnerships across jurisdictions to address Aboriginal Home Care policy issues.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	42.86% (3)	42.86% (3)	7	**6.29**
1.15) I have a better understanding of jurisdictional responsibilities because of this project.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	42.86% (3)	42.86% (3)	7	**6.29**
1.16) I feel more confident in my interjurisdictional relationships as a result of this project.	0% (0)	0% (0)	0% (0)	0% (0)	14.29% (1)	57.14% (4)	28.57% (2)	7	**6.14**
1.17) I have a better understanding of FN community home care needs as a result of this project.	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	71.43% (5)	28.57% (2)	7	**6.29**
1.18)This project has created greater awareness of how to customize culturally appropriate solutions to providing home care in First Nation communities.	0% (0)	0% (0)	0% (0)	0% (0)	42.86% (3)	42.86% (3)	14.29% (1)	7	**5.71**
1.19)The project has reduced barriers to accessing services.	0% (0)	0% (0)	0% (0)	0% (0)	71.43% (5)	0% (0)	28.57% (2)	7	**5.57**

6.1 Survey results: statements

6.1.1 Process: fostering a productive work environment

Participants responded very favourably to statements regarding project process to facilitate a productive working environment including helpfulness of project documents, opportunity for input, effective use of meeting time, and a safe environment to speak openly. The average score for each statement was above six. As a reminder, a score of six on the scale corresponds with 'agree' and a score of seven corresponds with 'strongly agree'. The scale ranges from one to seven.

6.1.2 Process: fostering relationships

Given that project success depended so heavily on building and nurturing relationships, two statements were geared to evaluate if steering committee members felt the process fostered improved relationships and relationship building. These two statements received the highest average scores of all statements on the survey.

6.1.3 Process: fostering results

Participants responded favourably to statements focused on if the project fostered results including did the process increase capacity to resolve home care issues, lead to the integration of home care services on-Reserve, and support a solutions oriented culture. The average statement score for these questions were all above 6 out of 7.

6.1.4 Success of project

Several statements focused on the project's capacity to facilitate conditions to address home care issues and improve the delivery of home care services on-Reserve including: building effective partnerships; improving the capacity to develop culturally appropriate solutions; increasing awareness of jurisdictional responsibility; increasing awareness of home care needs and, reducing barriers to access services. Again, steering committee members responded very favourably. No one responded "neutral", or disagreed with any of these statements. The only statement where the majority of respondents did not reply agree or strongly agree was in respect to the capacity of the project to reduce barriers to accessing services. Five of the seven respondents for this statement indicated somewhat agree, the other two indicated strongly agree.

6.2 Survey results: comment on overall project success

All survey participants responded ‘yes’ to the question, *‘Has the initiative achieved progress in its goal to increase access to home care services by First Nation people living on-Reserve in Nova Scotia?’*. Five of the seven survey respondents provided written comments identifying critical success factors.

6.2.1 Critical success factors

Several respondents noted that the process has initiated important dialogue. Having everyone at the table and an agreement to maintain a policy forum to facilitate ongoing dialogue around home care services were identified as critical success factors. Several respondents also noted the importance of key documents produced during the project including the Common Definitions Document and Community Service Profiles. One respondent commented in respect to the Common Definitions Document, *“I feel the confusion around Continuing Care and Discharge Planning has been clarified and understandable so we could move forward with everyone concerned on the same page”*. Another respondent commented, *“The produced documents describing Home care on-Reserve across Nova Scotia have been comprehensive and outline services available. The resulting recommendations provide a framework for implementation of strategies to improve Home Care to First Nations Communities.”* Other critical success factors identified by participants include the establishment of MOU's around discharge planning and the resolution of several systemic service access barriers.

7.0 KEY FINDINGS BY DOMAIN

7.1 Planning and Communication (Project Management)

A key aspect of the project was to engage relevant First Nations, provincial and federal stakeholders in an environment to facilitate constructive dialogue and communication around the provision of home care. The project was extended with additional resources from AHTF to investigate long term care issues and best practices in the Aboriginal context. The project recognized from the outset that strong working relationships built on trust and good intention were critical not only for short-term success but sustained success beyond the life of the project.

Performance indicators to evaluate stakeholder engagement and participation include the number of steering committee meetings, representation at steering committee meetings and engagement opportunities with First Nations communities. To evaluate the success of relationship building, steering community members were questioned about the strength of relationships in the steering committee survey.

7.1.1 Stakeholder engagement

The steering committee was made up of the partner organizations that collaborated in the AHTF project proposal. Upon the policy decision by the NSDoH to integrate home care into the management responsibility of DHAs, the steering committee table was extended to include health authority representation. The communication plan was also revised to include DHAs as principal stakeholders.

The steering committee included representation from the Union of Nova Scotia Indians UNSI), the Confederacy of Mainland Mi'kmaq (CMM), Aboriginal Policy Congress of First Nations Chiefs (APC), Nova Scotia Department of Health (NSDoH), Nova Scotia Office of Aboriginal Affairs (OAA), Health Canada, First Nations Inuit Health Atlantic Region (FNIH), Indian & Northern Affairs Canada (INAC), Guysborough Antigonish Strait District Health Authority (GASHA) and the Cape Breton District Health Authority (CBDHA).

The NSDoH proposed a model of co-chairmanship with an Aboriginal lead, which was embraced by the group. Loraine Etter (APC) and Susan Stevens (NSDoH, Continuing Care Branch) were appointed by consensus and were the co-chairs throughout the life of the project. The co-chairs met with the project management team prior to all steering committee meetings to prepare the agenda and meeting

packages. They also collaborated regularly in the management of policy issues requiring navigation between steering committee meetings and were co-presenters at a number of forums, where project updates were requested. They provided detailed activity reports to the steering committee as a standing agenda item of each meeting and ensured that all action items were followed up by designated leads.

There were 12 steering committee meetings held over the course of the project. This followed the initial work-plan, which was approved by the steering committee at the beginning of the project. Steering committee meetings averaged an attendance rate (either in person or by phone) of over 90%. While there was turnover among steering committee members, participating organizations continued to be actively involved over the course of the entire project. The steering committee chairs and project management team ensured that new members were briefed on the history of the project and welcomed to the group.

The project management team collaborated with the project director of the South West Nova Mental Health and Complex Discharge Planning AHTF project. For example, joint project meetings were held in participating communities to avoid over burdening community health professionals. Cross representation on steering committees also allowed for regular updates to their respective projects. This supported relationship building, inter-project communication and avoided duplication.

7.1.2 Community engagement

In addition to multiple contacts by the project management team (including the co-chairs and NS DoH staff conducting site visits, touring facilities, sharing information about the project, gathering input and promoting a better understanding about operational issues), First Nation communities were consulted frequently over the course of the project. These consultations focused on two streams of input in particular: [1] the review of the Cape Breton Discharge Planning Pilot Project, and [2] the development of Community Service Profiles (both home care and long term care).

The Unama'ki communities participated in the Cape Breton Discharge Planning pilot project review. In-person interviews or phone interviews were held with health directors and/or home care staff from all thirteen First Nation communities in the province to develop the community service profiles.

The development of the home care service profiles was an iterative process that included all thirteen governing Bands and involved several conversations with program leaders in each community. The project management team visited all communities with the exception of two. The intended site visits were cancelled due to weather. In these communities the planned interviews were conducted by phone instead. Several site visits to communities in South West Nova Scotia were held in conjunction with planned visits by David Maxwell, project director for the Mental Health and Complex Discharge Planning AHTF project.

Community home care service profile informants were asked to review draft research findings about their own community to ensure accuracy and completeness. Strict attention was paid to the OCAP[1] principles and local data was provided back to each community to support program planning and evaluation at the Band level. The steering committee co-chairs presented a summary of service profile results to community health directors.

Community assets/capacities, as well as gaps in home care policy and service delivery that were identified through the community service profile process, served to inform the development of the Aboriginal Home Care Framework.

Community health providers participated in the development of the long term care service profiles. The process followed the same methodology as the home care service profiles.

In addition to formal engagement activities, the steering committee co-chairs briefed health directors on several occasions regarding project direction, findings, and results.

7.1.3 Strengthened partnerships

As part of the *Steering Committee Evaluation Survey*, steering committee members were asked to rate the degree to which they agreed or disagreed with the statement, *"the process has increased collaboration and strengthened partnerships"*. Five of the seven respondents strongly agreed, one respondent agreed, and one respondent somewhat agreed for an average score of 6.57 out of 7. In addition, steering committee members were asked to rate the degree to which they agreed or disagreed

[1] First Nation '*Ownership, Control, Access and Possession*' of community data (First Nations Health Research and Information Action Plan, Assembly of First Nations; May 2005).

with the statement, *"the project has built effective partnerships across jurisdictions to address Aboriginal Home Care policy issues"*. Four of the seven respondents strongly agreed, two respondents agreed, and one respondent somewhat agreed for an average score of 6.29 out of 7.

7.1.4 Component review

Outcome	Performance Indicator	Status
Active engagement and participation opportunities of First Nations leadership and provincial and federal governments in project.	Number of steering committee meetings (12) Representation at steering committee meetings (90%) # of engagements with FN communities • (4 presentations to FN Health Director meetings • co-chairs, DoH staff community site visits: Membertou, Bear River, Indian Brook, Pictou Landing, Millbrook, Glooscap, Paqtnkek)	√ - Achieved
Strengthened partnerships and communication between First Nations leadership and provincial and federal governments in project.	Steering committee perceptions (survey questions) (Average scores out of seven: 6.57, 6.29)	√ - Achieved

7.2 Collaboration (Trilateral Policy Forum)

The project set out to establish a trilateral policy forum to ensure that collaboration among the project partners to improve home care services on-Reserve would continue after the formal AHTF project ended. The forum offers a structure to involve First Nations organizations and communities in the planning of home care services and long term care on-Reserve. Performance indicators to evaluate ongoing collaboration include the establishment of the Aboriginal Continuing Care Policy Forum (ACCPF) with representation from First Nations, provincial government and federal government, and the establishment of a long term meeting forum and structure with terms of reference in place.

7.2.1 Ongoing stakeholder involvement

All groups that participated on the Home Care AHTF Project Steering Committee have joined the Aboriginal Continuing Care Policy Forum. The project was set up so the steering committee would roll into the policy forum following the completion of the AHTF project. The process has gone smoothly with a first policy forum meeting already held, a Statement of Work call for proposals issued and a consultant hired. The steering committee co-chairs also plan to send invitations to several organizations

with an interest in home care and long term care to join the new Aboriginal Continuing Care Policy Forum.

7.2.2 Forum structure

The Aboriginal Home Care Framework document resulting from this project outlines terms of reference for the Aboriginal Continuing Care Policy Forum. The ACCPF includes First Nation communities, district, provincial and federal representation and facilitates action on multi-jurisdictional issues that will advance improved quality of care and access to services for First Nation people living on-Reserve. The terms of reference outline the purpose and objectives of the group, expected roles of members, meeting structure, and budget responsibility. It is noteworthy that a provincial Aboriginal Health Policy Framework has cited the ACCPF approach as a model for policy and planning engagement.

7.2.3 Component review

Outcome	Performance Indicator	Status
Increased involvement of First Nations in planning of home care services on-Reserves through the establishment of a trilateral policy forum.	# of organizations and key stakeholders engaged in trilateral policy forum from First Nations, provincial government and federal government (15 confirmed members)	√ - Achieved
Development of sustainable relationships and forum structure for ongoing resolution of continuing care issues for First Nations in Nova Scotia	Establishment of a long term forum meeting schedule and forum structure/terms of reference (Outlined in the Aboriginal Home Care Framework)	√ - Achieved

7.3 Implementation of Provincial Home Care Discharge Planning Model

The evaluation of the Cape Breton Home Care Discharge Planning Pilot Project was identified as a key objective of the Nova Scotia Aboriginal Home Care AHTF project. Anecdotal evidence reviewed during the proposal development phase suggested that the Cape Breton Home Care Discharge Planning Model was working very well. Memoranda of Understanding outlining discharge planning procedures and protocols between the Department of Health, the Cape Breton Regional Hospital and four of the five Unama'ki communities was seen to offer a potential model for the entire province. The evaluation focused on documenting a program history, gathering information from the Cape Breton pilot experience to demonstrate what worked and what didn't, and identifying recommendations to support the implementation of a province-wide home care discharge planning model.

The context of this evaluation is important to understand. In the general population, protocols have been developed for continuing care coordination personnel, who work closely with hospital discharge staff to ensure that appropriate services are in place when the individual returns home. Due to a policy gap between federal and provincial jurisdictions, however, the discharge planning needs of First Nation people living on-Reserve have been largely unaddressed.

Performance indicators to evaluate progress toward the implementation of a province-wide home care discharge planning model include the completion of an evaluation of the Cape Breton Home Care Discharge Planning Model signed off on by the steering committee and a list of recommendations to support a province-wide program endorsed by the steering committee.

An MOU template between the province and First Nation communities has been drafted and vetted by Department of Health legal services. Project resources were secured to engage CMM legal services to assist with further template review and revisions through the lens of Aboriginal stakeholder organizations. Completion of this phase of activity is pending, although issues regarding discharge planning and First Nation communities are reflected in the revised policy manual for the provincial home care program, which will be released later in 2010 or early 2011. As such, it is undetermined whether all First Nation communities and all district health authorities will opt, in the final analysis, for an MOU approach to discharge planning, or if policy alone will guide the provision of this service.

7.3.1 Component review

Outcome	**Performance Indicator**	**Status**
Understanding the effectiveness and impact of the Cape Breton home care discharge planning pilot project.	Completion of Cape Breton home care discharge planning evaluation	√ - Achieved
List of recommendations to support the implementation of a provincial discharge planning service model for First Nations on-Reserves.	List of recommendations endorsed by steering committee	√ - Achieved
Provincial roll out of discharge planning model.	Implementation of discharge planning pilot project recommendations.	Pending implementation of the new provincial home care policy and completion of the MOU process

7.4 Development of the Aboriginal Home Care Framework

A critical outcome and deliverable of the AHTF project was to develop a provincial Aboriginal Home Care Framework addressing the delivery of home care services to Aboriginal people living on-Reserve in Nova Scotia. It was recognized from the start of the project that two key elements of a framework must include a detailed inventory of home care services provided on-Reserves in Nova Scotia to understand the specific home care programs being offered locally and a summary of programs and terms to facilitate a shared understanding of the different home care services provided by the Nova Scotia Department of Health (Continuing Care Branch), Health Canada, and Indian & Northern Affairs Canada. As such, developing community service profiles and a common definitions and terms document were identified as performance indicators to evaluate progress towards the development of a home care framework. An additional indicator identified was the satisfaction among stakeholders that the document offered increased understanding of culturally appropriate home care service delivery options.

The official release of the Aboriginal Home Care Framework was not achieved within the timeline of the project. This is due to a number of contributing factors including a three-month delay in the signing of the project Contribution Agreement (with subsequent impacts on the overall project workplan), a longer-than-expected timeframe to complete the community service profiles and additional time required to navigate and complete internal review processes by partner organizations. The complexity associated with Department of Health and provincial government internal review processes cannot be understated when involving policy issues and their potential financial impact of this nature.

The project did, however, successfully develop a framework, which was endorsed by all organizations represented on the steering committee. The document provides detailed home care service profiles for all thirteen First Nation communities in the province. The document also provides everyone involved in home care planning and delivery - in all jurisdictions and in each community - with a common set of definitions so that there is a shared understanding of program scope and purpose. Another outcome of the common definitions section was the identification of additional policy gaps that were addressed (including respite care, alternative level of care charges and caregiver allowance). The document was also designed to serve as a resource guide for all parties with an interest in the design and delivery of home care services for Aboriginal people on-Reserve in Nova Scotia. Furthermore the framework

documents the findings and recommendations of the steering committee of the Aboriginal Home Care in Nova Scotia Project. These recommendations and the data that support them are the basis of the framework for the organization and delivery of home care services to Aboriginal people living on-Reserve in our province.

As part of the steering committee evaluation survey, steering committee members were asked to rate the degree to which they agreed or disagreed with the statement, *'This project has created greater awareness of how to customize culturally appropriate solutions to providing home care in First Nation communities'.* Three of the seven respondents somewhat agreed, three of the respondents agreed, and one respondent strongly agreed for an average score of 5.71 out of 7.

7.4.1 Component review

Outcome	**Performance Indicator**	**Status**
Improved understanding within the provincial government of the local home care needs and service capacity on First Nations Reserves.	Complete home care service profiles for First Nations Reserves	√ - Achieved
Agreed upon common understanding of current policies and responsibilities for service delivery.	'Common understanding' document outlining current policies and responsibilities for service delivery endorsed by tri-lateral forum stakeholders	√ - Achieved
Increased understanding of culturally appropriate home care service delivery options.	Agreement among stakeholders that the process has fostered greater awareness of how to customize culturally appropriate solutions	√ - Achieved
Development of an action plan and recommendations	Agreement of stakeholders on action strategy and associated timelines to monitor progress.	√ - Achieved

7.5 Completion of a Review of Aboriginal Long Term Care Issues

In response to concerns raised at the community level, the steering committee applied for and received additional AHTF funding to examine the provision of long term care for First Nations living on-Reserve in Nova Scotia. With the additional funding, the steering committee committed to conducting baseline research to be used by the Aboriginal Continuing Care Policy Forum to develop recommendations to improve long term care services to First Nation populations in Nova Scotia. The long term care component was not included in the original evaluation plan given its late addition to the project. It is recommended that the Aboriginal Continuing Care Policy Forum, as part of their ongoing evaluation process, evaluate the implementation of recommendations and track improvements in the provision of long term care.

As part of the baseline data collection, questionnaires were sent to community health directors to develop long term care service profiles. In several cases, the health directors passed on the questionnaire to the community home care coordinator to complete. Respondents had a choice to complete the questionnaire directly or contact the research coordinator to complete the questionnaire together over the phone. Twelve of the thirteen First Nation communities in the province completed questionnaires. The community of Paqtnkek did not respond to the community survey. The health director was not able to complete the questionnaire during the data collection period due to scheduling and time commitments.

The level of engagement and detail provided in the service profiles varied by community. In one community, the home care coordinator consulted a group of Elders for input. In several communities, the respondent was relatively new to the position and not actively aware of any pressing long term care issues or details on accessing and using long term care services. In other communities, long term care services are not used and therefore the respondent had little to comment on. The lack of input is also telling with regards to how communities view and understand long term care options for First Nations living on-Reserve.

Best practice research was also completed and utilization data for each FN community gathered and analyzed. Additionally, a common definitions document similar to the one completed for the Aboriginal Home Care Framework was developed to ensure a common understanding of provincial and federal policies. All of this information was used to develop eleven recommendations for future action.

7.5.1 Component Review

Outcome	Performance Indicator	Status
Improved understanding within the provincial government of the local long term care needs and service capacity on First Nations Reserves.	Completion of long term care service profiles for First Nations Reserves.	√ - Achieved
Agreed upon common understanding of current policies and responsibilities for long term care.	Development of a long term care companion summary 'Common understanding' document outlining current policies and responsibilities for service delivery endorsed by tri-lateral forum stakeholders.	√ - Achieved
Increased understanding of culturally appropriate long term care service delivery considerations.	Completion of research into examples of best and promising practices in the provision of long term care to Aboriginal clients.	√ - Achieved
Development of recommendations regarding the delivery of long term care services to Aboriginal people living on-Reserve.	Agreement among stakeholders on recommendations for further action.	√ - Achieved

8.0 DISCUSSION

By all measures, this project was remarkably successful. There were, however, a number of challenges that impacted the workplan, which are noteworthy.

Project Challenges

Community time constraints

The project relied heavily on community input to develop the Cape Breton Discharge Planning Review, the home care service profiles, and the long term care service profiles. To complete these components of the project, the project management team conducted interviews and questionnaires with health directors and home care staff. Additional research gathering included community visits, and several back and forth communications by e-mail and phone. While the success of the project depended on this valuable input (notably community buy in and integrity of research findings), time demands on community stakeholders needed to be considered. In most communities the health professionals wear multiple hats. For example, it is not uncommon for the health director to be the community health nurse and home care director as well.

Integration of home care

The decision to transfer responsibility for home care management and delivery from the Department of Health to DHAs occurred after this project had been approved and required significant adjustments to the workplan, steering committee composition and communication strategy. It added an additional layer of complexity to the work, orientation of new stakeholders and buy in by new management structures that would be inheriting the implications of the policy framework.

AHTF fatigue

Another closely related concern is AHTF project fatigue. Several communities were participating in a number of AHTF projects, with several individuals representing those communities by wearing many hats. The advantage was ‘cross-pollinization’ among AHTF projects. The challenge was having a

limited number of individuals to spread across a significant number of projects, all of which competed for time and attention on top of their existing professional responsibilities. Meetings, research input, and material review require a significant time commitment on already time stressed health professionals. Obviously, the daily health needs of community members take priority over external initiatives.

Skepticism

Several community leaders feel that there are too many studies and too little action. One community, in particular, has an unofficial position to no longer participate in external projects. In the case of this project, strong advocacy by First Nation steering committee members and early evidence of their work influencing policy secured this community's participation in this particular AHTF project.

Data sensitivity

Communities overall are understandably cautious about the use of research findings, data ownership, and investigative protocols. This project addressed these issues directly by making its approach to data collection clear and committing to community ownership of local data. It should be noted that this represented a significant shift in policy by the Department of Health, which normally would own all data, and required internal review and approval for this precedent to be established. In addition, the project team developed individual community service profiles for community use. Providing the data back to communities in a useful format helped solidify participation. The AHTF project reported aggregate results only.

Staff turn-over

The high turn-over among community health professionals presented a real challenge for project continuity. Between the start and end of the project, two-thirds of the community health professionals consulted during the course of the initiative left their respective positions.

Limited best and promising practice inventory

A further challenge was the sparseness of research regarding Aboriginal long term care issues, utilization, models, and needs. Academics, government agencies and practitioners have identified a crucial need for more research and data gathering on First Nations long term care issues in Canada.

Internal review processes

The length of time required by all levels of government to satisfy internal review requirements before approving and officially releasing material was a significant challenge during the project. This resulted in a decision to abandon a data sharing agreement with the Cape Breton First Nation communities because the parameters of the agreement required a provincial approval process that would have taken longer than the project workplan could accommodate. Another example was in the case of First Nations and Inuit Health undertaking policy research relevant to this project, but being unable to share it in a time frame that could inform the development of recommendations. Indeed, the Aboriginal Home Care Policy Framework itself, although signed off by all partners including the Department of Health, has not yet been officially released.

Key Learnings

A number of lessons were learned from this initiative that served to inform future collaborative planning and policy development initiatives in Nova Scotia and across the country. They are summarized as follows:

Co-leadership

Co-leadership is a demonstration of stakeholder commitment to putting the theory of collaboration into practice. It is important for this model to be embedded in terms of reference and for the representative organizations participating in the model to allow sufficient time and provide appropriate supports to individuals to fulfill these roles. The co-chair model with an Aboriginal lead proved very successful. The concept of co-chairmanship between an Aboriginal partner and government partner reinforced notions of collaboration and joint ownership over the project to other steering committee members. The shared leadership also helped build trust among community partners and provincial decision makers because of the credibility and relationships brought by each co-lead to the process. This model, and the terms of reference that will guide the work of the Aboriginal Continuing Care Policy Forum, is cited as

a best practice of multi-stakeholder engagement in the Government of Nova Scotia Aboriginal Health Policy Forum.

Leverage

The project included representation from other related AHTF projects on the steering committee. In addition, representatives from the project management team participated on other AHTF project steering committees. The collaboration among projects helped streamline data collection, share ideas, help establish relationships, make good use of time, and piggy-back on related project resources. For example, travel was shared for data gathering visits to communities participating in the South West Nova Mental Health and Complex Discharge Planning AHTF project. In addition to saving travel dollars, the joint meetings made good use of community members' time. Given the workloads and commitments of health providers, it is critical to avoid duplicate data collection and unnecessary time use. As noted in the evaluation limitations, cross representation of multiple projects has its risks. Among those risks is that a few key individuals are spread too thinly across multiple initiatives. While there is interconnectedness across projects, each of them has their own set of demands and expectations which can exceed the capacity of people and organizations to service.

Data Ownership

One of the first and perhaps most important steps taken by the project was to articulate respect for OCAP principles. This required an important concession by the Department of Health, which typically would own any data collected in a research or program improvement initiative. While developing and signing formal data sharing agreements with the Unama'ki communities proved to be too lengthy a process to be achieved within the limited timeframes of the project, the methodology used to collect and interpret data for the purposes of the community service profiles conformed with the expressed commitment of the steering committee, supported by the Department of Health, that each community is the owner and controller of its own data. This is a vital precedent to be modeled in any future community-based planning process.

Individual community data was rolled up and provided to respective communities to use at their discretion. Providing communities with a useful output to inform local decision-making encouraged participation and reinforced the project's commitment to making the results useful for communities.

Need for common definitions

One of the first revelations around the steering committee table was that a term used in one jurisdiction meant something very different to another. This policy language issue is itself a source of service delivery gaps and confusion in an environment where there are multiple streams of service provision, with funders often regarding themselves to be the provider of last resort. While a common definitions document will certainly help to alleviate basic misunderstandings and clarify who is responsible for doing what for whom, the frequently changing policy landscape does require a mechanism to allow for dialogue between and among policy makers to keep this tool current and familiar.

Using meetings for decisions, not just information

Steering committee meetings were organized and moderated by the co-chairs showing respect for members' time and contributions. Meeting materials were sent in advance to members to ensure adequate time for review making meetings more efficient. Meetings focused on issues requiring debate and decision points making them important for members to attend. The active role in project decisions fostered a sense of project ownership and commitment to success. Outside of the formal meetings, steering committee members were asked to review project materials and reports, provide input regarding any outstanding issues and update their respective organizations regarding project progress.

The value of relationships

The project benefited immensely from a well-functioning steering committee. The appropriate level of representation was at the table to either make decisions or accurately gauge the level of organizational support for policy directions. While the group had a serious agenda, laughter and informal opportunities to engage created a sense of personal connection to the group, which evolved as the project matured. All meetings opened with a prayer to set the tone and create an opportunity for non-natives to participate in traditional Aboriginal protocols. In addition, meeting notes were organized to highlight decisions and action points, in order to track progress and accountability.

The importance of relationships extends far beyond the steering committee table and reaches into every stakeholder organization and participating community. It was often observed that the building of relationships with home care leadership in each community was greatly accelerated by the Ambassadorship and facilitation provided by Michele Landry at UNSI. Because of the close and effective working relationships she had developed with First Nation program representatives across the

province, she bridged these relationships with the project and gave credibility in communities to the work of this initiative.

Demonstrated Action

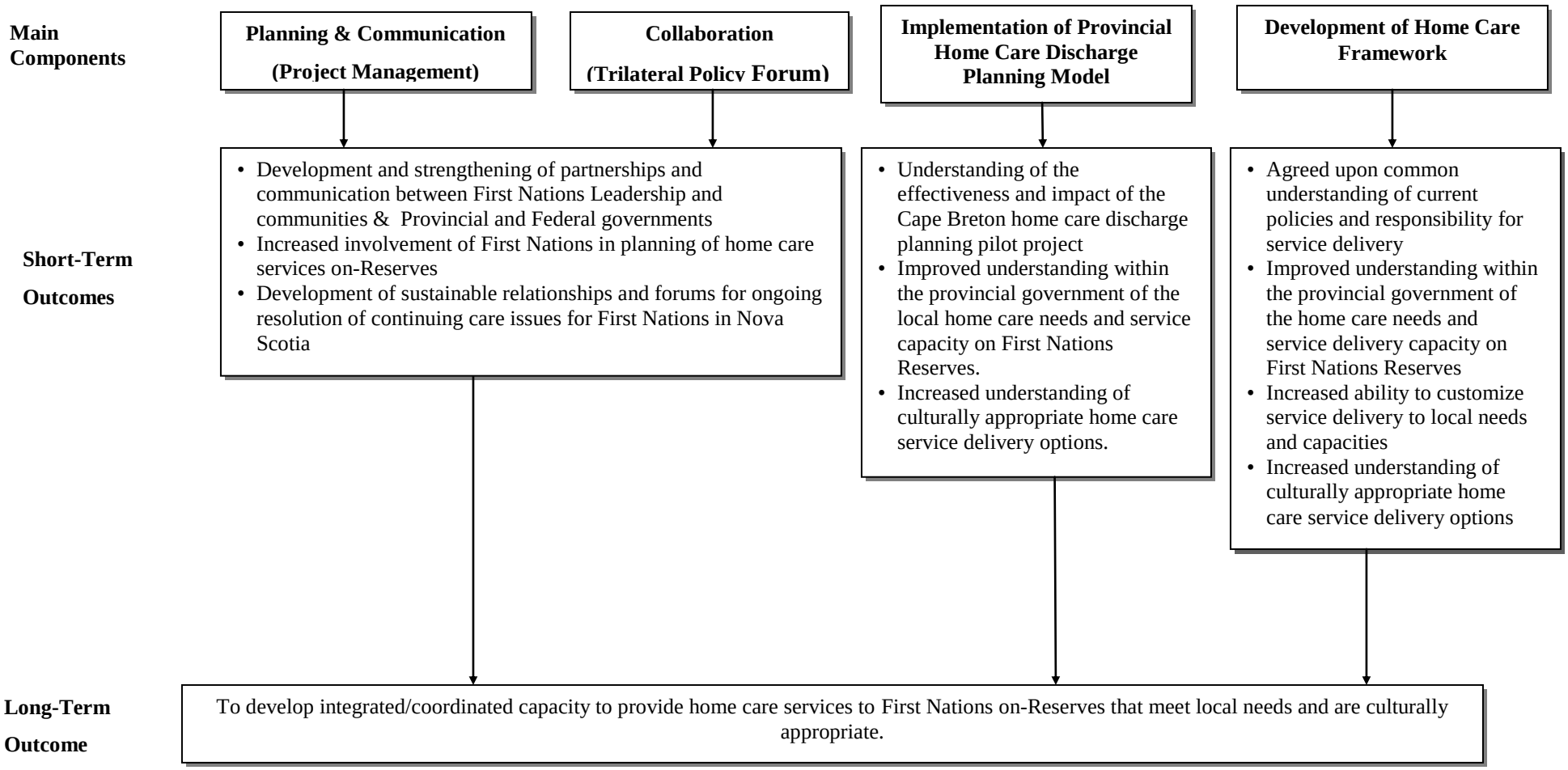
Due to the number of studies and reports that have been commissioned regarding various aspects of Aboriginal health service delivery, it is not surprising that most communities and many policy makers have become skeptical about the likelihood that positive changes will actually be made. This project benefited from having a number of early wins. The Province's decision to make the bed loan program available on-Reserve and suspending the alternate level of care fee for First Nation communities demonstrated responsiveness and action by the province fostering a sense of trust among stakeholders that the project was motivated out of a legitimate concern to improve the delivery of home care services on-Reserve. The quick response to address these gaps in service established credibility and created momentum for the broader planning process.

The project had support from senior provincial Continuing Care policy makers from the outset giving sanction to the work and allowing for quick response to policy changes. Having senior leadership on board is critical to moving projects forward.

In conclusion, the progress that has been made in advancing the issue of improved access to home care services by Aboriginal people living on-Reserve through the AHTF initiative has been remarkable. All of the short-term objectives of the project were achieved. The service profile stakeholder survey results and steering committee survey results indicate that the project has been overwhelmingly successful.

The transformation of the steering committee into the Aboriginal Continuing Care Policy Forum demonstrates a sustained commitment on the part of all stakeholders to continue working together to improve the delivery of continuing care services for First Nation people on-Reserve. The commitment to support the forum over the next two years sends a strong signal to communities that the province and other stakeholders are fully engaged in continued advocacy and joint action.

APPENDIX A - HOME CARE SERVICES DELIVERY AND POLICY INTEGRATION AND COORDINATION



APPENDIX B – COMMUNITY HOME CARE SERVICE PROFILE STAKEHOLDER SURVEY

Please rate your response to the following statements on a Scale of 1-7.

1 – strongly disagree
2 – disagree
3 – somewhat disagree
4 – neutral
5 – somewhat agree
6 – agree
7- strongly agree

Statements:

1. This project has resulted in an accurate reflection of my community's Continuing Care needs.

2. The process of developing my community's service profile was collaborative, respectful and appropriate.

3. The summary report I received about my community's service profile will be useful to local planning.

4. The community service profile will be useful to me in discussing Continuing Care needs with the District Health Authority.

5. My community has a close working relationship with the District Health Authority on issues of Continuing Care.

6. I know who to call to resolve a local home care issue.

7. I know who to call to resolve a local long term care issue.

8. I know who to call to organize a discharge plan for a local patient.

9. The project has reduced barriers to accessing services.

Part II:
Please provide written comments for scores of three or below.

APPENDIX C – STEERING COMMITTEE SURVEY

Please rate your response to the following statements on a Scale of 1-7.

1 – strongly disagree
2 – disagree
3 – somewhat disagree
4 – neutral
5 – somewhat agree
6 – agree
7- strongly agree

Part I - Statements

1. Draft project documents were helpful in facilitating discussion and decision-making.

2. Meetings made an effective use of my time.

3. I had adequate opportunity to provide my input to draft documents.

4. The process fostered an environment where I felt safe to speak openly.

5. The process fostered an environment where others could feel safe to speak openly.

6. The process created new opportunities for interjurisdictional dialogue about Aboriginal home care issues on-Reserve.

7. The process was oriented to finding solutions when issues were identified.

8. The process of developing community service profiles was an effective approach to identifying local home care needs and capacities.

9. The process has been effective in contributing to the integration of home care services for First Nations living on-Reserve.

10. The process has increased capacity for analysis and resolution of home care issues.

11. The process has increased collaboration and strengthened partnerships.

12. The home care framework will foster a common understanding of current programs, services and responsibility for delivery.

13. Information in the framework will increase the ability to customize service delivery to local needs and capacities.

14. The project has built effective partnerships across jurisdictions to address Aboriginal Home Care policy issues.

15. I have a better understanding of jurisdictional responsibilities because of this project.

16. I feel more confident in my interjurisdictional relationships as a result of this project.

17. I have a better understanding of FN community home care needs as a result of this project.

18. This project has created greater awareness of how to customize culturally appropriate solutions to providing home care in First Nation communities.

19. The project has reduced barriers to accessing services.

Part II – Overall project evaluation

Please respond ‘yes’ or ‘no’ to the question:

Has the initiative achieved progress in its to goal to increase access to home care services by First Nation people living on-Reserve in Nova Scotia?

If answering ‘yes’ indicate the critical success factors.

If answering ‘no’ indicate the barriers and limitations that prevented progress.

APPENDIX D – PROJECT FINANCIAL SUMMARY

The evaluators would like to thank the Nova Scotia Department of Health for providing the following financial information as part of their project management reporting:

The Nova Scotia Department of Health provided additional in-kind contributions during the project. The original estimate of $136,000 of staff time/effort was underestimated. While no formal calculations have been done or record kept of actual effort expended, staff estimate the in-kind contribution was at least four times this amount. The increased effort can be attributed to relationship building, visits to FN communities, additional research and analysis required to complete project deliverables and resolution of policy issues raised throughout the project.

NSDoH also contributed additional staff resources not contemplated in the original proposal. Monitoring and Evaluation staff were involved in setting up and collating responses to the on-line evaluation survey tools, as well as providing statistical data throughout the project. NS DoH Communications staff worked on a website for the project and forum.

Additional Resources – Health System

The NSDoH has incurred some limited additional program costs as a result of the policy changes made during the project. This financial information is not available.

Resources to Support Work Post Project

A signed agreement is in place between NS DoH, FNIH-HC and INAC committing to a total of $42,000 in funding ($14,000 per organization) for the Aboriginal Continuing Care Forum over the next two years (2010/11 and 2011/12). In addition, all organizations involved in the AHTF project are continuing their participation in the ACCPF – an in-kind contribution of staff time and travel expenses (for government organizations, FN members will have their expenses covered from forum funds).

	Original Proposal Budget 2007 + Expanded Project Budget 2009				
Category	AHTF $	DoH $	DoH in-kind	APC in-kind	Total
Personnel, Project Team, Consultants	207,750.00	30,000.00	76,000.00	0.00	313,750.00
Supplies and Services					
Travel	12,250.00				12,250.00
Communications	6,950.00	10,000.00			16,950.00
Evaluation	15,050.00				15,050.00
Discharge Planning Evaluation		20,000.00			20,000.00
Staff Training & Development					
Other – Legal Services	10,000.00				10,000.00
Other - CHCA Conference	8,790.00				8,790.00
Total	**260,790.00**	**60,000.00**	**76,000.00**	**0.00**	**396,790.00**

	Estimated Actual Project Expenditures 2007-2010				
Category	AHTF $	DoH $	DoH in-kind	APC in-kind	Total
Personnel, Project Team, Consultants	217,750.00	25,260.00	129,884.62	21,153.85	394,048.47
Supplies and Services					
Travel	11,454.38	3,500.00			14,954.38
Communications	3,265.62	1,202.09			4,467.71
Evaluation	18,900.00				18,900.00
Discharge Planning Evaluation		16,725.00			16,725.00
Staff Training & Development	630.00				630.00
Other - CHCA Conference	8,790.00				8,790.00
Total	**260,790.00**	**46,687.09**	**129,884.62**	**21,153.85**	**458,515.56**

Note: Financial information will be finalized after project end date of November 30, 2010 and therefore these figures may change. The 2 primary DoH staff did not charge travel to the project to save project funds and also efforts were made to combine AHTF travel with other DoH business - $3500 is an estimate of their travel expenses. Consulting fees include project communication efforts. The $4,467.71 Communication line item reflect primarily printing costs. APC co-chaired the project committee, contributing in kind resources not in the original budget.

APPENDIX E – UPDATED WORK PLAN (SEPTEMBER 9, 2010)

Aboriginal Health Transition Fund -Home Care on Reserves Project
Contribution Agreement AT0800074

Specific Objectives	Activities	Person/Organization Responsible	Anticipated Outcome/Milestone	Original Timeline	Completed	Outcome Achieved
1. Develop a Steering Committee	1. Partners to establish a formal steering committee with membership from Continuing Care, DoH Primary Care, CMM, FNIHB,	NS DoH	Steering Committee membership confirmed.	September 2007	February 2008	Yes _X_ No _____
	2. Identify Steering Committee and governance structure (addressing both project operational and policy/strategic functions), meeting schedule, roles and responsibilities and process.	NS DoH	*Terms of Reference, Project Charter and Governance Model.*			
2. Secure Project Management Capacity	*1. Develop RFP.*	NS DoH	*Project Infrastructure Secured*	*September - November 2007*	*November 2007*	Yes _X_ No _____
	2. Select Vendor. (This includes advertising position, hiring process, etc...)					
	3. Formalize contract					
3. Establish a Trilateral Policy Forum	*Establish a sustainability/infrastructure plan for steering committee to continue beyond project end date as a forum where continuing care issues can be discussed and resolved.*	Steering Committee and Project Coordinator	*Terms of Reference and organizational commitment to participate in the Trilateral Policy Forum.*	*November 2007 - August 2009*	*February 2008 - May 2010*	Yes _X_ No____

Specific Objectives	Activities	Person/Organization Responsible	Anticipated Outcome/Milestone	Original Timeline	Completed	Outcome Achieved
4. Develop Processes Plan and Evaluation Framework	*1. Development of framework to ensure gender based analytical approach to project.*	Steering Committee and Project Coordinator	*Established GBA Framework*	*November 2007*	*January 2010*	Yes _X_ *No____*
	2. Develop formal communication, sustainability, and evaluation plan.	Steering Committee and Project Coordinator	*Formal communication, sustainability and evaluation plans.*	*November 2007*	*January 2010*	*Yes _X_ No____*
5. Establishment of a Shared Understanding between the Continuing Care Branch (DoH), FNIHB, and First Nations Health Care Delivery Providers regarding "Definitions" - Common Definitions Document	*Identify current home care definitions, service types, scopes of practice and employment, responsibility for service provision, service delivery mechanisms, and eligibility for service for First Nations people living on Reserve in Nova Scotia. This will include the examination of continuum of serves that are part of both the federal and provincial programs (i.e. self managed care, palliative care)*	*Steering Committee and Project Coordinator with support from Continuing Care Branch staff*	*Common understand of issues around home care to support the next steps of the project.*	*December 2007 - February 2008*	*September 2009*	*Yes _X_ No____*
6. Conduct an Evaluation of the Cape Breton Home Care Discharge Planning Project	*1. Undertake evaluation to determine what worked, what didn't and what aspects are applicable to and needed by other First Nations communities in Nova Scotia.*	*Project Coordinator with Continuing Care Branch policy advisors*	*Recommendations regarding home care discharge processes to serve all First Nations communities that are supported by the Steering Committee.*	*December 2007 - June 2008*	*February - December 2008*	*Yes _X_ No ____*

Specific Objectives	Activities	Person/Organization Responsible	Anticipated Outcome/Milestone	Original Timeline	Completed	Outcome Achieved
	2. Identify approaches to address gaps in service as identified in the needs assessment and Cape Breton discharge planning evaluation and seek feedback from partners and stakeholders.	*Continuing Care Branch staff with support from Project Coordinator*	*Home care discharge planning model is customizable to the needs of each First Nations community.*	*June - September 2008*	*February - December 2008*	*Yes _X_ No _____*
	3. Finalize recommendations/model for home care discharge planning processes to serve all First Nations communities in the province.	*Continuing Care Branch staff with support from Project Coordinator*	*Final report with recommendations completed and approved by all project partners*	*September - December 2008*	*December 2008 - January 2009*	*Yes _X__ No _____*
7. Conduct a needs assessment of home care service needs for First Nations people living on Reserve - Service Profile Document	*1. Undertake needs assessment for each community including analysis of gaps in service and capacity/asset map.*	*Project Coordinator*	*Documented findings to complete need assessment/asset mapping process for each community*	*December 2007 - August 2008*	*September 2009*	*Yes _X_ No___*
	2. Analyze the data gathered to identify gaps and barriers as well as community					
8. Development of a home care framework for First Nations people living on Reserve.	*1. Integrate results from community needs assessment to inform policy discussions.*	*Project Coordinator with support from Continuing Care Branch staff*	*Community needs assessment findings are communicated to key stakeholders.*	*August - September 2008*	*June - December 2009*	*Yes _X_ No____*
	2. Integrate findings from Cape Breton discharge planning evaluation into broader home care policy framework.	*Project Coordinator with support from Continuing Care Branch staff*	*Generalizeable aspects of Home Care Discharge Planning Model identified.*	*August - September 2008*	*June - December 2009*	*Yes _X_ No____*
	3. Develop framework document including recommendations for policy amendments where required.	*Project Coordinator with support from Continuing Care Branch staff*	*Policy issues are identified and contextualized.*	*September - December 2008*	*June - December 2009*	*Yes _X_ No____*

Specific Objectives	Activities	Person/Organization Responsible	Anticipated Outcome/Milestone	Original Timeline	Completed	Outcome Achieved
	4. Solicit input and feedback from steering committee partner organizations.	*Project Coordinator*	*Policy issues are identified and prioritized (where relevant) and communicated to appropriate partner organization for action.*	*Setpember - December 2008*	*June - December 2009*	*Yes _X_ No____*
	5. Develop community dissemination plan to ensure Federal, Provincial, and First Nations decision makers, policy staff, and service delivery staff are up to date on assessment findings, policy discussions and any potential policy changes.	*Project Coordinator*	*Partner organizations understand and accept their roles/responsibilities for next steps.*	*November 2007 - August 2009*	*October - December 2009*	*Yes _X_ No____*
9. Develop a plan to identify next steps and action strategy for framework.	*1. Work with steering committee to outline plan forward.*	*Project Coordinator/Steering Committee*	*Define a plan outlining the next steps to move the identified strategies toward implementation.*	*November 2008 - February 2009*	*December 2009 - March 2010*	*Yes _X_ No____*
	2. Prepare action strategy document to outline steps to move forward the home care framework and recommendations toward implementation.	*Project Coordinator*				
10. Implementation of provincial home care discharge planning for First Nations on Reserve.	*1. Develop an internal plan for DoH to roll out home care discharge planning across the province.*	*Service Delivery Planner/Steering Committee*	*Home care discharge planning for First Nations on Reserves available province-wide.*	*January - March 2009*	*April - June 2009*	*Yes _X_ No____*

Specific Objectives	Activities	Person/Organization Responsible	Anticipated Outcome/Milestone	Original Timeline	Completed	Outcome Achieved
	2. Implement home care discharge planning province wide, including related policy changes, development of MOUs, operational system changes, staff training/education, public awareness, etc.	***Continuing Care Branch staff, DHA staff, Project Coordinator***	***Home care discharge planning for First Nations on Reserves available province-wide***	***April - July 2009***	***Not completed***	***Yes ___ No__X_***
11. Undertake formal evaluation of project.	*1. Complete formal evaluation of program as identified at start of project.* *2. Communicate results to steering committee.*	*Project Coordinator*	*Completed Program Evaluation.*	*June - August 2009*	*January - September 2010*	*Yes _X_ No____*
12. Updated Common Definitions Document to include Long Term Care services	*1. Identify current long term care definitions, service types, scopes of practice and employment, responsibility for service provision, service delivery mechanisms, and eligibility for service for First Nation people living on Reserve in Nova Scotia. This will include the examination of continuum of serves that are part of both the federal and provincial programs.*	*Project Coordinator with Steering Committee and Continuing Care Branch policy staff*	*Trilateral policy Forum has Common Definitions Document which contains full continuum of continuing care services.*	*September 2009 - March 2010*	*January - September 2010*	*Yes _X_ No____*
13. Long Term Care Policy and Service Issues	*Prepare a report with information gathered from FN communities regarding service and policy issues in long term care and develop recommendations for resolution.*	*Project Coordinator*	*Information to inform policy decisions at the federal and provincial level.*	*September 2009 - March 2010*	*January - September 2010*	*Yes _X_ No____*

Specific Objectives	Activities	Person/Organization Responsible	Anticipated Outcome/Milestone	Original Timeline	Completed	Outcome Achieved
14. Long Term Care Best Practice Research	*Undertake a literature review of best practice in LTC related to FN individuals and prepare a report.*	*Project Coordinator*	*Information to inform policy decisions at the federal and provincial level as well as future partnerships with FN communities.*	*January - March 2010*	*January - September 2010*	*Yes _X_ No____*