SERVICE Delivery Plan

3A

Health Canada / Santé Canada

ᐃᓄᑦ ᑕᐱᕐᓂᑦ ᓄᓇᑦ
INUIT TAPIRIIKSAT KANATAMI
Inuit Tapiriit of Canada

Our Mission is to help the people of Canada maintain and improve their health.

Health Canada

Également disponible en français sous le titre Guide de planification - Soins à domicile et en milieu communautaire des Premières Nations et des Inuits.

This publication may be provided in alternate formats upon request.

For additional copies, please contact:

Medical Services Branch National Clearinghouse
Postal Locator 1920 A
Tunney's Pasture
Ottawa ON K1A 0L3

This document is available on the Health Canada website: http://www.hc-sc.gc.ca/msb and the Assembly of First Nations website: www.afn.ca

Cat. No. H34-105/2000-3-1E
ISBN: 0-662-28519-0

TABLE OF CONTENTS

ABOUT THIS HANDBOOK

Purpose

Handbook 3A provides information on developing a Service Delivery Plan for the Home and Community Care Program.

The Handbook is intended for community/tribal council/ regional Inuit association planners and regional First Nations and Inuit organizations.

Using this Handbook

This Handbook is a guide. The steps outlined in the Handbook do not need to be followed in every way. Its goal is to support – not replace – the essential process of determining what will work best in your community. Importantly, the Handbook promotes the integration of community beliefs and values into the design of the program. In this regard, *select the examples and suggestions in the Handbook that reflect the values in your community and are most appropriate for meeting your community's particular needs*.

The aim of the planning and development process is:

- to build an effective Home and Community Care Program;
- to provide services that meet the needs of community members;
- to ensure that the services can be provided as long as they are needed; and
- to establish a foundation for making the program better as the years go by.

The planning and development process for your Home and Community Care Program is designed to be community based and community paced.

This process is an ever evolving process that will ensure that home and community care services will continually seek new and innovative ways and means of responding to the identified needs in each First Nations and Inuit community.

INTRODUCTION

A Service Delivery Plan should outline how your Home and Community Care Program will be managed, the goals and objectives of your Program, how the essential services will be delivered in your community, the staff required to deliver the services and the budget required.

The Service Delivery Plan you develop should be based on the Home and Community Care service needs and priorities you identified through your Community Needs Assessment.

The Service Delivery Plan will be reviewed by a review process established in your region/ territory for adherence to regional criteria, if established, complementing the national program criteria. The national Program Criteria document is available in the Planning Resource kit under the tab “Supporting Documents”.

ESTABLISH YOUR MANAGEMENT STRUCTURE

First Nations and Inuit Home and Community Care Programs will be operating throughout Canada in individual communities, through First Nations Tribal Councils, or through regional organizations. Most of the infrastructure will likely be at the community level, however, there will be a need for infrastructure at a larger First Nations or Inuit level to provide the support that smaller communities cannot otherwise obtain.

Here are some options you may want to consider as you decide what type of management structure will likely work best for you:

- **Delivering the services at the community level**

  For large communities this would mean that the community, likely through the community leadership, would be responsible for the governance and management of the program. The community administration would hire, orient and supervise the staff, administer the budget, deliver the services, monitor and evaluate the program.

- **Delivering the services at the (First Nations) Tribal Council level**

  This means that the Tribal Council would be responsible for the governance and management of the program. The Tribal Council would hire and orient the staff, provide the program supervision, administer the budget, deliver the services, and monitor and evaluate the program. The community may also have community-based workers to deliver some of the services.

- **Delivering the services through an Agency**

  Many small communities simply do not have the infrastructure and/or resources to draw from to run a comprehensive program on their own. One option for small communities (e.g. communities with a population of 500 or less who are not affiliated with a Tribal Council or Regional Association) is to "pool" together to form a Home and Community Care Agency that would oversee and manage the program or to have an established Agency (e.g. provincial/territorial agency or private home care agency) provide the services on their behalf.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A DESCRIPTION OF:

- the type of management structure established
- the mandate and authorities of your management structure

ESTABLISH THE GOALS AND OBJECTIVES OF YOUR PROGRAM

As with any program, you will want to establish goals and objectives for your Home and Community Care Program. These goals and objectives should support your Vision, Philosophy and Mission Statements (refer to the Getting Started Handbook for more information on writing your Vision, Philosophy, and Mission Statements).

The goals and objectives will be used for measuring how well your program is doing. By establishing outcomes against each of your goals and related objectives, you can assess whether home and community care services are meeting the need, whether changes need to be made to the program, and the impact the program is having on the health of community members.

Set Goals

Goals are broad statements that describe what programs or activities should achieve.

Goals reflect your program purpose and priorities.

Goals must start with an action verb.

Goals are easily understandable.

Set Objectives

Objectives state exactly what a program should do. They are identifiable and measurable actions to be completed by a specific time. When objectives are stated in measurable time related terms, the evaluation of the effectiveness of your activities is easily evaluated.

Objectives must be closely tied to your goals. The objectives are steps to reach the goals.

These are some of the questions to ask yourself when writing your objectives:

- What do you want to accomplish?
- What will be done?
- How will it be done?
- When will it be finished?

Examples of Home and Community Care Programs Goals and Objectives are attached as Appendix A.

Write Your Goals and Objectives

Review the Vision, Philosophy and Mission Statements of your program. All goals and objectives must fit within the Vision, Philosophy and Mission of the program.

Start with these questions to obtain an overview of the state of your program.

- What is the role of your program?
- What are your main services?
- Who are your clients?
- What is unique about your services?
- What are your services intended to achieve?

Then do the following:

- Identify the long term goal(s) for your program
- Identify the objectives of each program area (the program areas are the building blocks that make up the overall program). These are steps to reaching the program goal.
- Identify the activity(ies) of each program area.
- Determine how you will know when the objectives are met (performance indicators).
- Collect the data.

Identify the Activity(ies)

An activity is something that is done to help meet program objectives. As stated on the previous page, list the broad program areas that you intend to provide and their objective. Identify the activity(ies) for each program area and objective. For example, activities might relate to personal care, home nursing, information and counselling sessions, etc.

Set Performance Indicators

The program indicators and data will be described fully in Handbook 6 - Evaluation

Performance indicators are signs, events or statistics that measure the success of programs or activities in meeting their objectives. Each program area should include one or more success indicators. The greater the number of indicators, the more "rulers" available for measuring the effectiveness of the program activities in improving the health of community members.

Indicators can be:

- quantitative measurement on numbers or statistics
- qualitative measure of satisfaction or opinions
- long term that may take years to show progress
- short term that may be measured in months or a year.

Collect Data

Data is information on the performance indicators you have identified. This data needs to be collected to determine the effectiveness of the program activities.

Example:

PROGRAM AREA	OBJECTIVE	ACTIVITY	PERFORMANCE INDICATOR	DATA
Home Nursing: Adult Diabetes	To increase knowledge of persons with diabetes of how to monitor their blood glucose.	Individualized teaching and guidance for clients to monitor, record and interpret their own blood glucose.	Number of persons with diabetes taught and who demonstrate the ability and knowledge to correctly monitor and interpret their own blood glucose.	Client charts. Client booklets in which blood glucose is recorded.

IN YOUR SERVICE DELIVERY PLAN DESCRIBE:

- the goals and objectives of your program
- the activities and performance indicators against which your goals and objectives can be measured
- the data to be collected (refer to Information and Data Collection section of this Handbook)

DESIGN THE SERVICES THAT MEET THE NEEDS

Prioritize the Needs

Using the analysis of the information collected in your community needs assessment, prioritize your community's needs.

Some criteria you may want to use in establishing the priority of the needs you have identified are:

- the number of people experiencing the need and affected by it (e.g. this would not only include the person who needs the care but also how it affects the family members);
- the acuteness of the need (e.g. a need for in-home nursing care following surgery; the need to stabilize a person's diabetes);
- access to alternate programs and services for meeting the needs (e.g. is there an outreach support system or service that is accessible that could adequately meet the need instead of developing a service in the community); and
- the reasonable expectation that individuals with disabilities or chronic illnesses can live in their home community.

Conduct Research into Services that Other Communities Provide

Gather information about the kinds of home and community care services that are provided elsewhere. Some sources of such information are:

- other First Nations communities and Inuit settlements. A description of existing Home and Community Care Programs across the country is available in the Planning Resource Kit under the tab "Supporting Documents".
- your local or regional health board – this will give you information about the services that the provincial/territorial and municipal/regional governments fund in your area.

You will also be able to get information by talking to people on the phone and reviewing printed information in reports, brochures and pamphlets. In some cases, it may also be appropriate to actually visit a community where they are providing services that sound particularly interesting to you.

The main purpose of the information you gather is not simply to copy another community's ideas but to stimulate new ideas and options that will work in your community. Discuss the information within your planning team and with your management structure as a whole.

Put in Place the Essential Services

The First Nations and Inuit Home Care Framework and the Home and Community Care Program Criteria document identify a number of essential elements and services required in the foundation of an effective Home and Community Care Program. These services must be in place prior to expanding the continuum of care to other community services. The essential services are:

- Program Management and Supervision
- Managed Care: Case Management and Referrals and Linkages
- Client Assessment
- Home Care Nursing
- Home Support Services: Personal Care and Home Management
- In-Home Respite Services
- Medical Supplies and Equipment
- Information and Data Collection

It is important to keep in mind that even though you may not be able to implement all the services at once, they should be included in your plan. Also the way in which the services are delivered is to be determined by your management structure on the basis of your identified needs.

Strategies for small communities:

- **share the services with other communities**
- **purchase the services from a provincial/territorial, regional/municipal or private agency**
- **"pool" together to form your own agency**
- **have the services delivered through a (First Nations) Tribal Council or Regional (Inuit) Association**

Telehealth is an example of an emerging field that has the potential to benefit the home and community care provider and the client. The Planning Resource Kit contains a document on "Telehealth for Home and Community Care in First Nations and Inuit Communities" which describes how telehealth could be used to enhance home and community care in remote and rural communities. The document also describes the basic steps involved in setting up a telehealth system related to home care by taking you through a step by step assessment process.

Program Management and Supervision

The home care services need a high degree of management and supervision because the service is constantly changing in response to the client's needs, resulting in frequent admissions and discharges. As a result of the dynamic nature of the program, home and community care requires close supervision and management to make sure that services are provided in a consistent, fair, timely and unbiased manner and that staff are supported in their jobs.

IN YOUR SERVICE DELIVERY PLAN:

- Establish an organizational chart which clearly defines the lines of authority and supervision, and the staff relationships with each other to the client care

Put together a description of:

- who will provide the professional supervision for nursing procedures and personal care
- the lines of authorities between staff and the overall management structure
- the relationship between the program and community leadership

Managed Care

Managed care is widely understood to mean when the right care is provided by qualified and competent health team members, at the right frequency and duration that will best support that person. It can be said that managed care goes beyond First Nations and Inuit home and community care services (with client consent), to link with other care and service providers outside the community. The goal is to make sure there is no gap in the service provided to the client regardless of who or what agency provides the care.

In order to deliver an effective Home and Community Care Program, every effort should be made to link and coordinate other programs and services such as the Department of Indian Affairs and Northern Development's Adult Care Program (In-Home Component) and the Building Healthy Communities' Home Nursing Program.

There are two key elements within the managed care process:

- **Case Management**. Case management in home care is a process where the care provider assesses the client's needs, plans the services required, implements the services, and reviews and evaluates the care provided and the client's response to the care provided.

  The goal for case management is to coordinate the multiple services a client may be receiving, in his or her home, to ensure quality and consistency. The Home Care Nurse or the Home Care Coordinator usually assumes the case management role. While providing care in the home, the Coordinator has a unique view of a client's on-going home and community environment. The Coordinator is responsible to communicate the knowledge gained to the physician and other care providers to ensure that safe, effective and appropriate care is provided.

Case management includes the following functions:

- assessment of the client's need;
- review of care;
- care planning directed towards goal achievement;
- skilled intervention;
- teaching (instruction, demonstration and return demonstration);
- coordination of community-based health care services;
- accurate documentation of client's response to care so that the care plan can be adjusted;
- efficient use of resources;
- referrals for supplies and services;
- facilitate communication between care providers in alternative settings;
- offer services throughout the continuum of care; and
- admission and discharge planning.

- **Referrals and Linkages to Services and Other Care Providers**

  Linkages need to be developed for expert support for the many unusual situations and demands that home care staff will be faced with in carrying out their duties. Linkages also need to be made to help with communication and to make sure that the best possible care is being provided to the client. Experts in wound management, rehabilitation services, pharmacists, and nursing procedure experts are examples of some of the expertise and outside services that may be required to support the community based activities.

Consider linking with other communities for expert support and services such as a Diabetes Educator, Dietitian, Rehabilitative Services, etc.

The goal of linkages and managed care is that the client can pass from one health or social service to another without difficulty, and the information from one service will follow the client to the next service.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A PROCESS OUTLINING HOW YOU WILL:

- organize, coordinate and manage cases for optimum care needs
- ensure there is no gap in the service provided
- establish client referrals and linkages to other services, programs, care providers and agencies
- ensure the services continue to be timely and appropriate
- discontinue services that are no longer needed, or safe to provide in the home, or are no longer affordable within the community program. In the event the care is no longer safe or affordable to provide, outline the steps you would take to ensure needs of clients continue to be met.

Client Assessment

The purpose of the client assessment is to make sure that home and community care services are based on the individual's service needs in terms of his/her physical, mental, emotional and spiritual health, and that they are fair and unbiased for all community members. This is a "client-centered process" in which the client and the family (or informal care giver) is involved in identifying the health problems and determining what home and community care services will best support them. *It is recommended that client assessments be performed by a registered nurse. If this is not possible, the person performing the assessments should have the appropriate training and have access to nursing advice and support.*

During the assessment process information is collected and recorded about the person's condition and circumstances. The assessor must identify the person's needs and find out how these needs are currently being met. In order to perform a comprehensive assessment, the use of an assessment tool is recommended (see Handbook 4 for samples). The assessor will then focus on those needs which are not being met. The information collected is used to develop a "care plan".

It is important to remember that home and community care is not intended to replace the support of the family or community but rather assist the family (or informal care giver) in providing care.

The care plan may outline the health need or "problem", the "goal" for the care, "how long" the service is planned for, what the client and supports will do for themselves, what home care will do, and what referrals have been made. The care plan is mutually agreed upon and will identify:

- the health/functional needs or problems;
- what you want to achieve (the outcome);
- which needs will be addressed by whom and the role of home care, client and family;
- how the service will be provided (e.g. how often and for how long, and length of task);
- the plan of how and when the outcome will be reached; and
- referrals made.

The plan for care is dynamic and will be updated as the care needs are met or as the client’s condition changes.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A PROCESS OUTLINING:

- how clients will enter into the home care program
- how clients will be assessed to determine if there is an "assessed need"
- how home and community care services will be identified to support those "assessed needs"
- how a plan of care will be developed that will address:
    - health/functional needs/problem
    - goal of care
    - start dates and duration of services
    - expected outcomes of care
    - family/friend or informal care giver involvement
    - referrals/linkages with other services/programs/ agencies (see Managed Care)
- how clients will be discharged from the program

Describe:

- who will carry out the client assessment
- who will develop the care plan
- the criteria for receiving services
- the planned protocol for the assessment review processes and approval of care plans

Home Care Nursing

Home Care Nursing are those services which are delivered in the home of the client or in a central location in the community. It can include activities such as acute care nursing (for example complex dressings and home renal dialysis), monitoring a person's medication, wound management, teaching clients to care for themselves, therapeutic diet support, managing chronic diseases (for example providing services for diabetics and their families), and adult care clinics. In addition to these activities, home care nursing responsibilities often include the supervision and teaching of the home health aides (or personal care workers) providing personal care.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A DESCRIPTION OF:

- how home care nursing will be provided
- what services will be available and how many hours a week
- how the home care nurse and community nursing functions will differ
- how staff providing the home care nursing functions will be supervised
- how the transportation for home care nursing staff will be provided
- what ongoing professional training, development and peer support will be available

Outline a process for:

- developing, putting in place and monitoring your nursing policies and procedures

Home Support

Two key elements of home support are:

- **Personal Care** – under the supervision of a registered nurse, this includes assisting with activities of daily living such as bathing, helping someone get dressed, mobility assistance, etc.
- **Home Management** – this includes light housekeeping, laundry, meals prepared in the client's home, etc. These services are generally delivered through funding from the Department of Indian Affairs and Northern Development's Adult Care Program (In-Home Component).

Home support services are best provided by a person who has received training and certification for home management and personal care work. For the purpose of this Handbook, home health aide/personal care worker will be used to refer to a worker with this type of training. The role of a Home Health Aide/Personal Care Worker is to help with the care and teaching of the client based on the care plan and as assigned by the Home Care Coordinator.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A DESCRIPTION OF:

- what home support services will be provided (describe the home management services, personal care services and any other services available)
- how home management services and personal care services will be provided
- the relationship between the existing adult care workers (funded through DIAND) and potential new home care staff
- how the services provided by the existing and potential new workers will be coordinated
- how existing and potential new workers will be supervised
- how the adult care workers/home care staff and community health representative functions will differ

In-Home Respite

In-Home Respite may be provided for high needs clients who are presently cared for in the home by a family or other community member and requires supervision because they cannot be safely left alone at home. A Home Health Aide/Personal Care Worker could be assigned to stay with the client for a period of time, or could be scheduled to come in at periodic intervals during the time the caregiver is away from the home. The goal of this service is to provide a "respite" or provide safe care of client for a short time to support the caregiver so that she/he can continue to provide care for the client and therefore delay or prevent the need for institutional care. There is usually a limit to the time allowed for in-home respite so that one client does not take a disproportionate (that is more than their share) amount of time and leave other clients without services.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A DESCRIPTION OF:

- how in-home respite services will be provided
- how you will establish the limits to the amount of care provided

Medical Supplies and Equipment

Medical supplies and equipment are needed to provide good health care in the home and to promote the independence of the client. Often mobility equipment such as walkers and wheel chairs are needed only for a short time during the rehabilitative phase of recovery; at other times the need for supplies and equipment is long term. Home and community care must have access to such supplies in the client's name in order to provide the services to help the client regain his/her independence. Dressing supplies, medications, and mobility aids are examples of supplies needed.

There is often an urgency when supplies and equipment are needed. The Home and Community Care Program may need to find ways to keep a supply on hand so that the support can be provided when needed.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A PROCESS OUTLINING:

- how medical supplies and equipment will be provided
- how you will link with the Non-Insured Health Benefits Program
- how you will link with other programs such as the Drug Distribution Program, local Red Cross agency, etc.

Information and Data Collection

The Home and Community Care Program must be able to monitor the changing health and social needs of the community and adapt services and programming in response to those needs. The program must also be able to make improvements as required and implement quality control activities. The information and data collection tools should include monthly statistical reports and program monitoring reports that can feed into an annual review. The data collected should indicate whether the services are meeting the clients needs and should be used to initiate planning for improving the care (quality improvement process).

Refer also to the reporting requirements identified in the contribution agreement with your funding agency or contact the program coordinator in your region/territory.

IN THE SERVICE DELIVERY PLAN, PUT TOGETHER A PROCESS OUTLINING:

- how client records will be maintained
- how the program will monitor its effectiveness and make improvements if required
- how the program will implement quality control activities

Other Home and Community Care Services

Once the essential services are in place, take a look at your funding level to determine if you can expand your Home and Community Care Program beyond the essential services to include other home and community care services.
For example:

- rehabilitation and therapy services (physical, speech, dietary, respiratory and others);
- adult day program;
- home-based services for long term psychiatric clients and clients experiencing mental or emotional illness. These services might include traditional counselling and healing services, medication monitoring;
- support services to maintain independent living which may include assistance with special transportation needs, grocery shopping, accessing specialized services, interpretative services, and therapeutic bath;
- home-based palliative care services;
- social services directly related to continuing care issues; and
- specialized health promotion, wellness and fitness.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A DESCRIPTION OF:

- which, if any, supportive services will be delivered
- how the supportive services will be delivered

PLAN THE RESOURCES YOU WILL NEED FOR THE PROGRAM

Identify your Human Resource (Staff) Needs

The number of staff you need will depend on the number of people you are serving at any given time and the amount of service you provide. The skills and knowledge of staff will, of course, depend upon the types of services you intend to provide. In some cases you may require a program manager or home care coordinator. If the functions of your program manager or home care coordinator include supervision of home nursing services this person must be a registered nurse.

Some jobs require licensing by a professional group (e.g. registered nurses, physiotherapists, etc.)

Many of the services require a variety of skills that are not subject to licensing. These are skills that are developed through a variety of post-secondary education courses, accredited training programs, in-service seminars and on-the-job training.

IN YOUR SERVICE DELIVERY PLAN, PUT TOGETHER A DESCRIPTION OF:

- all your staff needs (existing and new) by:
    1) type (refer to Appendix C for Service Providers within a Home and Community Care Program)
    2) education requirements
    3) experience requirements
- the responsibilities of each staff

Outline a process for:

- developing work descriptions
- staff orientation
- linking your existing and new staffing requirements with the Training Plan (refer to Handbook 3C)

Plan Your Budget

Developing your budget comes only after you have planned your services, identified the staff and operating needs you will require to deliver the services.

Depending on the available funds, you will need to prioritize how much service you can provide and how many staff you can support.

There will need to be flexibility in planning your budget. A portion of your budget may need to be set aside for high needs care. Some high needs demands are not predictable. There may be one or two years of average needs followed by a year of extreme needs. Some needs are not predictable and each year the home and community care services required will be different. A plan needs to be in place to cover the high needs periods.

It is important that your management structure put in place safeguards to protect the use of human, physical and financial resources of the program. This will help to make sure that the delivery of services is the first priority. These are a few of the processes you may want to consider:

- prepare a budget for your program and set up good accounting procedures;
- develop and implement policies for the efficient use of supplies and equipment;
- make sure the services that are being provided are based on health and functional needs;
- set priorities for care which ensures that clients with the greatest need receive the care;
- monitor service to prevent one or two high needs clients to deplete the entire budget; and
- make sure staff are provided with the training, equipment and supplies needed to provide quality services.

IN YOUR SERVICE DELIVERY PLAN, IDENTIFY:

- the timelines for putting in place the services (based on available resources)
- the funding available from all sources
- your budget breakdown by:
    - salaries and benefits
    - medical supplies and equipment
    - operating expenses
    - transportation expenses
    - amount for high need care (if applicable)

SUMMARY CHECKLIST

ACTIVITIES	PERSON RESPONSIBLE	DATE COMPLETED
Establish your Management Structure		
Establish your Program Goals and Objectives		
Design the Services that Meet the Needs		
Prioritize the Needs		
Research Services that Other Communities Provide		
Put in Place the Essential Services		
Other Home and Community Care Services		
Plan the Resources You Will Need for the Program		
Identify Your Human Resource (Staff) Needs		
Develop Your Budget		

Appendix A - Goals and Objectives

Goal

To assist clients to live in the community as independently as possible, preserving and encouraging enhancement of the support provided by the family and community.

Objectives

- Provide a single access point for both health services and support services for individuals needing home and community care.
- Integrate health promotion goals and practices in care plans and in the provision of care.
- Provide clients with a consistent, comprehensive and client centered assessment of need, utilizing other health disciplines when required.
- Develop a client-centered, mutually agreed upon care plan, defining service delivery and expected outcomes.
- Teach clients, families and others to provide care to promote self-reliance and efficient use of resources.
- Encourage visits to the Health Centre/Nursing Station for provision of the treatments whenever possible.
- Coordinate services required by clients, including assisting clients to gain access to related services to meet identified needs.

- Maximize the use of volunteers in meeting identified needs by encouraging expansion and/or formation of volunteer organizations, creating links with them and other agencies in the community.
- Develop, monitor and revise standards of care on an ongoing basis to ensure clients receive appropriate services.
- Begin discharge planning immediately on admission.

Goal

Work in partnership with other service providers to increase the effectiveness of community care and to eliminate gaps and duplication of services.

Objectives

- Develop collaborative working relationships with community health, mental health, social services, physicians and other service sectors to eliminate duplication of services and to improve the client's ability to gain access to needed services.
- Promote effective and efficient use of acute care resources by working with the hospital sector to prevent unnecessary admissions and to promote early discharge.
- Identify client care resources to assist persons to stay within their social milieu.

Goal

Manage services effectively and efficiently, demonstrating accountability for the use of public funds.

Objectives

- Collaborate to clarify the responsibilities of the various agencies (e.g. Medical Services Branch, Department of Indian Affairs and Northern Development, Provincial/Territorial Government, First Nations/Inuit community) in providing home and community care services in a timely and cost-effective manner.
- Establish funding and service policies which define relationships in the First Nations/Inuit community.
- Develop the capacity to evaluate program effectiveness by capturing relevant information.
- Develop and implement methods to determine the relative priority of client needs based on assisting persons who are the highest risk.

Appendix B - Sample Home and Community Care Plan Template

First Nations and Inuit Home and Community Care Service Delivery Plan

Name of community:

Date:

Program Vision, Philosophy, Mission Statement

Insert your Program Vision, Philosophy of Care and Mission Statement which you developed at the beginning of the planning process. Refer to Handbook 1 – Getting Started for more information on this step.

Community Description

Provide a brief description of your community or insert the relevant information from your Community Needs Assessment Summary Report.

Program Overview

Provide an overview of your Home and Community Care Program as described in the Service Delivery Plan.

Management Structure

Describe your management structure and its mandate and authorities.

Goals and Objectives

Insert the Goals and Objectives of your Home and Community Care Program. Refer to Appendix A for examples.

Identify the activities, performance indicators, and data to be collected to support your goals and objectives. See example below.

PROGRAM AREA	OBJECTIVE	ACTIVITY	PERFORMANCE INDICATOR	DATA
Home Nursing: Adult Diabetes	To increase knowledge of persons with diabetes of how to monitor their blood glucose.	Individualized teaching and guidance for clients to monitor record and interpret their own blood glucose.	Number of persons with diabetes taught and who demonstrate the ability and knowledge to correctly monitor and interpret their own blood glucose.	Client charts. Client booklets in which blood glucose is recorded.

Essential Services

Provide a description of each of the following essential services as outlined in the Handbook:

Program Management and Supervision

Managed Care

- Case Management

- Referrals and Linkages to Services and Other Care Providers

Client Assessment

Home Care Nursing

Home Support Services

- Personal Care Services

- Home Management

In-Home Respite

Medical Supplies and Equipment

Information and Data Collection

Other Home and Community Care Services

Provide a description of which, if any, other home and community care services you will be providing.

Human Resource (Staff) Requirements

Provide a description of your human resource (staff) needs as outlined in the Handbook.

Budget

Insert your detailed budget as outlined in the Handbook.

Appendix C - Service Providers within a Home and Community Care Program

The Human Resources Development Centre's National Occupational Classification (NOC) is a comprehensive classification system of occupations. NOC classifies and describes occupations according to skill level (amount and type of education and training) as well as type of work performed.[1] Occupations within a home care program are described in NOC as follows:

Home Care Nursing

Registered Nurses

Provides direct nursing care and health education to individuals in hospital, nursing homes, extended-care facilities, rehabilitation centres, doctors offices, clinics, companies and private homes or they may be self-employed. Completion of a university, college or other approved registered nursing program is required. Post-RN programs are available at various universities whereby a diploma RN can obtain a baccalaureate. Additional academic training or experience is required to specialize in a specific area of nursing such as community health (public health), home care nursing, and other specialty areas. Licensure by a provincial or territorial governing body is required.

1 obtained from http://www.doch.schdist57.bc.ca

Registered Nursing Assistant/Licensed Nurse

Provide nursing care for patients and assist registered nurses, physicians or other health team members. They are employed in a variety of settings, including hospitals, clinics, doctors' office, extended-care facilities, rehabilitation centres, industry, private homes and community health centres. Completion of a college or other approved program as established by provincial or territorial departments of health and education, and by individual hospitals or community college. Provincial licensure is mandatory for certified nursing assistance in NS and SK, LPNs in MB and BC, RNAs in NFLD, NB, ONT. (Registered Practical Nurses) and AB; in Quebec, membership in the professional corporation of nursing assistants is mandatory.

Personal Care Worker/Home Health Aide

Personal care workers/home health aides provide personal assistance and support services for elderly, disabled, acute or chronically ill people who require short term assistance or ongoing support.[2] Education requirements vary province to province.

2 ibid

Homemaker

Provide care for people in their own homes during periods of recovery, disability or family disruption. Work under the direction of a home care agency or medical personnel. This care may include bedside care meal preparation, and child care. Education requirements vary, and usually some secondary school education and provincially approved training course are required. Homemakers assist with the activities of daily living, e.g. routine house cleaning, laundry, ironing and mending, handy person services for home chores, budgeting, banking, paying bills, shopping for essentials, meals, menu planning and meal preparation. No formal education requirements however basic arithmatic skills and the ability to communicate effectively is advisable.

Once the program foundation is established, other training that might be considered could include:

Rehabilitative Assistants

Physiotherapy Assistant also called physical therapy aides or rehabilitation aides or attendants, under the supervision of physiotherapists assist in the implementation of treatment programs designed to improve or maintain clients's abilities to function independently.[3]

Occupational Therapist Assistant, also called rehabilitation/therapy aides or attendants, under the supervision of an occupational therapists assist in the implementation of treatment programs designed to develop, improve or maintain clients' abilities to function independently.[4]

General high school diploma and further training in various educational settings.

[3] ibid

[4] ibid

Appendix D - Sample Budget Checklist

Salaries and Benefits	*Monthly Budget*	*Yearly Budget*
Staff 1		
Staff 2		
Staff 3		
Casual Staff for High Needs Clients		
Benefits		
Total Salaries and Benefits		
Supplies		
Medical Supplies and Equipment		
Office Supplies		
Total cost of supplies		
Operating Expenses		
Staff Development		
Insurance		
Professional Fees		
Telephone		
Cartage		
Administration Costs		
Total Operating Expenses		

Transportation Expenses	*Monthly Budget*	*Yearly Budget*
Employee travel		
Vehicle Lease		
Licence and Insurance		
Fuel and Maintenance		
Total Transportation Expenses		
Contingency Fund for High Need Clients		
Total Amount for High Need Clients		
Funding From Other Sources		
Building Healthy Communities Home Nursing*		
DIAND Adult Care Program (In-Home Component)*		
Other Community Based Funding		
Provincial/TerritorialFunding		
Total Funding Revenue		

**** for those communities who are eligible and received this funding***