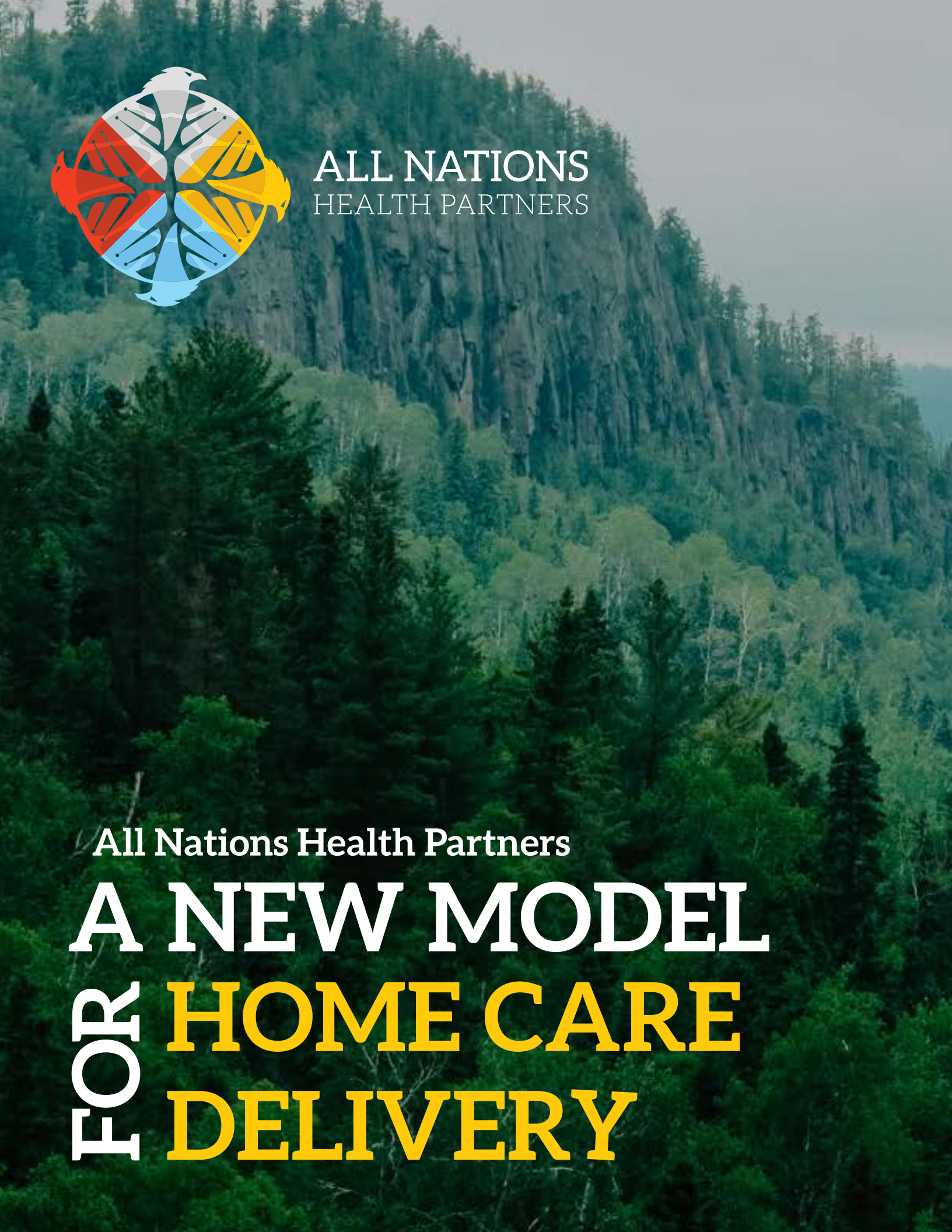


ALL NATIONS
HEALTH PARTNERS

All Nations Health Partners

A NEW MODEL FOR HOME CARE DELIVERY

Table of Contents

Acknowledgements

The All Nations Health Partners (ANHP) wishes to thank all ANHP First Nations communities. Your support and contributions to developing this Phase Two report are greatly appreciated. The ANHP wishes to thank the following First Nations communities:

- North West Angle #33A (Dog Paw)
- North West Angle #33B (Angle Inlet)
- Grassy Narrows
- Niisaachewan
- Animakee Wa Zhing #37A (Regina Bay)
- Animakee Wa Zhing #37B (Windigo Island)
- Iskatewizaagegan #39
- Shoal Lake 40
- Wabaseemoong
- Wauzhushk Onigum
- Naotkamegwanning
- Washagamis Bay

The ANHP also wishes to thank the Sunset Country Family Health Team who provided financial support to development of the Phase Two report, and the ANHP Home Care and Community Services Working Group (HCCSWG) who worked diligently to provide leadership in the development of the report, including:

- Colleen Neil, Sunset Country Family Health Team
- Vicki Barnes, Kenora Chiefs Advisory
- Donna Makowsky, Lake of the Woods District Hospital
- Philina Sky, Waasegiizhig Nanaandawe'iyewigamig
- Jess Rheault, District of Kenora Homes and Community Support Services

The ANHP looks forward to support from Ontario Health (OH) and the Ministry of Health (MOH) both from a financial and reconciliation perspective to advance the direction of Home Care transfer to Ontario Health Teams (OHT).

Executive Summary

As an OHT the ANHP have developed a HCCSWG to guide the redesign of home care services in the ANHP's catchment area.

The purpose of this report is the second phase of preparing the ANHP OHT for their Business Case submission to Ontario Health North (OHN) for the transition of home care services to the ANHP OHT.

Expected levels of home and community support services currently provided by Home and Community Care Support Services North West (HCCSSNW) were calculated using age-standardized rates service utilization levels in the City of Thunder Bay as a benchmark; current levels of services in the ANHP catchment area were found to be much higher in the City of Thunder Bay than ANHP Communities.

This report demonstrates the ANHP population is significantly underserviced for home care services. While the calculations in this report are population-based, the ANHP OHT wishes to express the desire to move to a needs-based funding model for home care services. The population-focused modeling currently in use for the delivery of home care services does not properly account for the unique needs and challenges of ANHP communities, related to the social determinants of health, overall poor health outcomes and the geographical dispersion of the ANHP's mostly rural and remote communities.

In 2015, the Truth and Reconciliation Commission of Canada released a final Calls to Action report.

RECOMMENDATION 19

We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

Our proposal will illustrate how facilitating dialogue, contributing expertise and collaboratively developing systems to produce high quality, robust health data that appropriately respect the governance rights of Indigenous people.

Multi-Sector Service Accountability Agreement (M-SAA) funded services were benchmarked using data from the Local Area Services Plan for Older Adults developed by the North West LHIN (now Ontario Health North).

Federally-funded services directed to specific communities were not considered for reallocation; it was assumed that these would augment community resources rather than be available for reallocation throughout the ANHP catchment areas.

The following summarizes the estimated costs and funding required to operationalize the future state model presented throughout this report.

Direct Staffing & Benefits	$6,805,015
Indirect Services Staffing	$712,481
Medical Supplies[1]	$487,759
Subtotal	$8,005,256
Overhead & Administration	$800,526
Total Projected Expenses	**$8,805,782**
Less Federal Funding	$(1,582,786)
Provincial Funding Reallocation Required	**$7,222,996**

In total, it is expected that services will cost $8,805,782 on an annual basis, off-set by Federal funding of $1,582,786 already in place for existing services **(services which would still be provided to the same communities as per existing contribution agreements with Indigenous Services Canada (ISC)).**

Operationalizing this future state model would require a reallocation of MOH funding from HCCSSNW to the ANHP OHT for $7,222,996. This estimated amount would support Ontario's connected care strategy and set a precedent for OHT development.

This amount does not include startup and transition costs, which would be significant. These costs are estimated to be between $800,000 and $1,200,000, but would be subject to a more detailed costing exercise to be determined in future planning efforts.

The ANHP OHT recognizes that this is the first step in a multi-step process to transfer home and community care services to the ANHP OHT. This report focuses on a locally owned home and community care program with home care coordination, homemaking services, home maintenance services and professional home care services. The ANHP OHT anticipates that the next phase of the transition process will include detailed operational planning and that additional services may be included in future steps (e.g., transportation services, in-home respite services, social services, etc.).

[1] See above supplies section – not including federally-funded supplies provided to communities directly and not expected to be reallocated

Introduction

As an OHT the ANHP's have developed a Home Care and Community Services Working Group (HCCSWG) to guide the redesign of home care services in the ANHP's catchment area.

The HCCSWG Phase One work completed in 2020 outlined the need for the ANHP OHT to focus on system redesign with all partners working collectively.

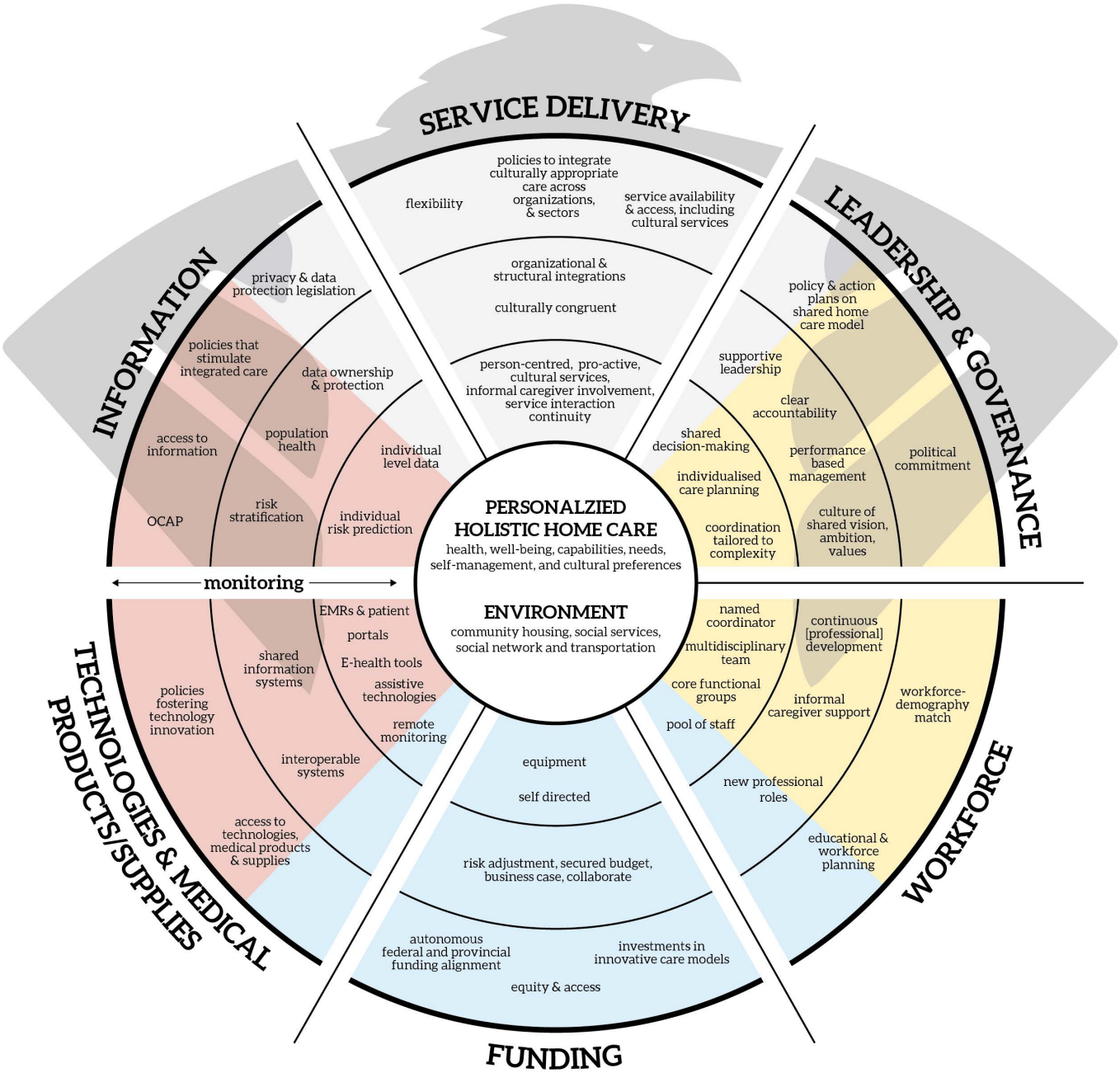
The purpose of this report is to complete the next phase of work as outlined on the pages below. At a high-level, it is intended to prepare the ANHP OHT to submit a Business Case to OHN for transitioning home care services to the ANHP OHT.

This report is considered Phase Two of the HCCSWG work to redesign the delivery of home care services in the ANHP's catchment area.

HOME & COMMUNITY CARE VISION

The ANHP's vision as illustrated below, is to create a community-based framework for a people centered approach that results in a fully integrated model of health care

ANHP Home and Community Care Executive Committee continued the Phase One work[2] and built the home care vision and framework to include: *Service deliver, leadership, workforce, funding, technology & medical products / technology and information and research.* Each layer is more personalized to the individual at the centre of care.



[2] ANHP Community Engagement Report on Home Care and Community Services (Phase One Report)

PREVIOUS WORK

In September 2020, the ANHP released the *ANHP Community Engagement Report on Home Care and Community Services,* which was the Phase One report. The Phase One report was a culmination of a substantial community engagement process to support the ANHP to develop solutions to meet the unique needs of the region as Home and Community Care (HCC) functions transfer to the OHT.

With the vision to "create a community-based framework for a people-centred approach that results in a fully integrated model of health care", this report provides a summary of insights from local experts and community members to develop a more responsive HCC system that is regionally specific, locally owned and culturally congruent.

The results and recommendations from this report aim to assist in developing and implementing the HCC services structure that will meet the unique needs of people living in the ANHP catchment area. The key recommendations highlighted in the report include:

- **Communication and Coordination |** create a foundation of trust that front-line teams can work together and ensure all patients will receive the right care at the right time in the right place
- **Culturally Congruent System Navigation |** create a simplified, streamlined and informed experience with increased transparency and culturally congruent services
- **Transportation Program and Travel Grants |** focus on having multi-point access to care with flexible transportation options that are efficient and on-time
- **Technology and Digital Health |** work towards facilitating improved continuity of care and information sharing that can facilitate bridging remote access challenges and gaps with virtual and digital health opportunities

In addition to the recommendations listed above, this report documents the suggested next steps to develop and deliver a locally-owned HCC service structure. The report also includes suggestions for developing the Service Delivery Plan. The Service Delivery Plan includes developing local health human resources, providing services that meet the unique needs of community members, empowering First Nations to offer on-reserve, and incorporating evaluation measures to refine service delivery over time.

> Culturally congruent care refers to the process of establishing trust and effective communications between the care providers and the client [patient]. The idea is ever-evolving to improve the relationship within the context of cultural competence and safety; providers take the time to improve their quality of communication, leading to trusting relationships and improved quality of life.[3]

In May 2021, the ANHP OHT Home Care and Community Services Working Group developed Phase Two of the HCC service structure for the ANHP OHT with project management support from FSET Inc. and 807 Management Services Inc. Building on the previous work from the ANHP Community Engagement Report on Home Care and Community Services, the ANHP OHT set out to develop a detailed business case report as Phase Two of the ANHP OHT Home and Community Care Service Structure.

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

The final detailed business case report includes the following elements:

- **Identification of future state delivery model options |** includes the development of options as well as refinement and validation of options with key stakeholders
- **Future state costing analysis |** includes determination of current state costs and projection of future state costs for each future state delivery option
- **Future state service data analysis |** includes collation and validation of HCC service level data as well as analysis of data to identify implications for, and projected level of services required for, each future state delivery option
- **Future state service structure development |** includes development and validation of the current state service structure with crucial stakeholders, identification of future state service structure needs and development and validation of future state structure options
- **Identification of Future State Transition Barriers |** includes analysis of barriers such as legislation, health human resources/unions, technological barriers, patient eligibility/assessments, the impact of formal partnerships, etc.)
- **Analysis of Future State Transition – Risk Assessment and Barriers |** includes the calculation of various risks (e.g., political, economic, social and technological factors) and a risk mitigation strategy for the preferred future state model

PROJECT GOALS, OBJECTIVES, AND SCOPE

GOALS AND OBJECTIVES

The purpose of this project was to create a high-level plan outlining actionable options for transitioning the operations of HCC from Ontario Health to the ANHP OHT. This report was intended to analyze and make recommendations related to the following:

- The creation of models to evaluate options for the transfer of operations of all existing HCC services provided in the ANHP catchment area (specific services are discussed in the scope section),
- Evaluation of the current intake and assessment practices of HCC and make recommendations for improvements within the current legislative framework and to the legislative framework for future patient care improvements,
- Evaluate the level of current-state service provision and provide recommendations from a health-equity lens,
- Develop plans that are costed at a high-level related to the operation of HCC services by the ANHP OHT.

SCOPE

The following is a listing of services that are in scope for the project:

SERVICES	ONTARIO HEALTH (DIRECT)	ONTARIO HEALTH (MSAA)	FEDERAL
Personal Care and Homemaking	✓		
Nursing ○ Telehome care ○ In-home nursing ○ Rapid response	✓		
Mental Health Nursing (schools)	✓		
Case Management	✓		
Allied Health ○ Occupational Therapy ○ Physiotherapy ○ Speech-Language Therapy ○ Social Work ○ Nutrition | Dietary	✓		
Home Maintenance		✓	
Homemaking		✓	
Visiting and social safety		✓	
Home and community care (Federal on reserve)			✓

WHERE DOES HOME CARE CONNECT

All Nations OHT understands home care and community care as a critical component of the patient medical home. The medical home is a way for providers and colleagues at other organizations to work together to provide holistic, comprehensive, and compassionate care to meet the All Nations OHT population's health care needs.

OUT OF SCOPE

Areas of HCC not addressed above were out of this project's scope. These out-of-scope items include other Ontario Health Insurance Plan (OHIP) – funded services such as home visits by physicians.

HCC resources also provide assessment, placement, and wait-list management services for long-term care in Northwestern Ontario. These services were excluded from this review, and the process was assumed to continue to be managed centrally through Ontario Health North.

APPROACH & METHODOLOGY

ONTARIO HEALTH TEAMS AND ONTARIO HEALTH NORTH

BACKGROUND

On February 26, 2019, the Ontario government introduced The People's Health Care Act, 2019, This Act supported the establishment of local OHTs to connect health care providers and services around patients and families. It integrated multiple existing provincial agencies into a single health agency – Ontario Health (OH). This plan included the reorganization of the North West Local Health Integration Network (LHIN) who in 2016 had assumed the operations of HCCS when they amalgamated with the Northwest Community Care Access Centre (CCAC). The North West LHIN has since ceased operations and has been succeeded by Ontario Health North (OHN) – a regional office of OH. OHN has a mandate to plan and coordinate the health care system while in contrast, a new entity, Home and Community Care Support Services Northwest (HCCSSNW) has taken over direct care provision concerning the homecare services previously administered by the CCACs.

Ontario's new plan aims to improve access to services and patient experience by organizing health care providers to work as one coordinated team, focused on patients and specific local needs. Improvements also aim to a more easily navigated system with easy transitions from one health provider to another. Ontario strategy envisions integrating multiple provincial agencies and specialized provincial programs into a single agency providing a central point of accountability and oversight for the health care system. This plan would improve clinical guidance and support for providers, and enable better-quality care for patients.

At maturity, OHTs are expected to be managed health care organizations, delivering the following services:

- primary care (including inter-professional primary care and physicians)
- secondary care (e.g., in-patient and ambulatory medical and surgical services (includes specialist services)
- **home care**
- **community support services**
- mental health and addictions services
- health promotion and disease prevention services
- rehabilitation and complex care
- palliative care (e.g., hospice)
- residential care and short-term transitional care (e.g., in supportive housing, long-term care homes, retirement homes)
- long-term care home placement
- emergency health services
- laboratory and diagnostic services
- midwifery services, and
- other social and community services and other services, as needed by the population.

ANHP was in the first cohort of approved OHTs announced on December 19, 2019. As such, this report is intended to aid in the development of a business case to take over the operations of Home Care and Community Support Services (HCCSS) and develop a new integrated service delivery model for these services.

DATA REQUEST FROM OHN

To inform the report's development and the resulting business case and future state service delivery model, a request for information related to HCCSNW operations was made to OHN in September 2021.

The following is a summary of the data request made to OHN.

DATA REQUEST ELEMENT	RATIONALE | NEED
1. Financial and statistical details of the HCC within Ontario Health related to the care of the ANHP attributable population & catchment area. This request includes administration resources that are available for transfer.	We need to know the details of the available resources available for redistribution / transfer to the ANHP to operate HCC. We seek details such as wage rates, position information, hours worked and/or FTE totals, and any other information that will assist with budgeting.
2. Any documentation of the process(es) related to HCC in the ANHP area, including: a. Process mapping for services referred to the community from a hospital discharge b. Process mapping for services referred to remote First Nations communities from a hospital discharge c. Process mapping for services referred to community from community referral, and d. Process mapping for services related to remote First Nations communities from a hospital discharge	We understand that these may exist in some recent form, possibly as a result of the Resource Mapping and eReferral project. Any other explanatory information such as process checklists, assessments and documentation would also be helpful.
3. Contract details with service providers for the 2018/19 and 2019/20 fiscal years, including: a. Nursing b. Occupational Therapy c. Personal Support Services d. Physiotherapy e. Social Work f. Speech-Language Pathology g. Combined homemaking and personal support h. Mental health and addictions nursing visit i. Nurse Practitioner palliative j. Any other relevant contract types	Details of contracts for the two years of 2018/19 and 2019/20 (i.e., price, resource specifications, terms, etc.) as applicable to service provision by the ANHP OHT.
4. MIS trial balance data for the Legacy CCAC/Home & Community Care operations from the Ontario Health Reporting Standards (OHRS) for the 2018/19 and 2019/20 fiscal years	MIS trial balance data for the two years of 2018/19 and 2019/20 will provide insight into operational overhead costs for the ANHP OHT.

Since that time, the ANHP Home and Community Care Executive Committee (HCCEC) has been meeting regularly with OHN representatives to gain access to complete the data request; however as of this report, no data have yet been provided. As a result, this project was completed using data available to the ANHP through other means described below. Services data were relied upon heavily and assumptions needed to be made where specific information was unavailable. These assumptions and methodological decisions have been described throughout the report where applicable.

SERVICE LEVEL ESTIMATIONS | PROVINCIALLY FUNDED SERVICES

As a baseline, a population-based analysis of existing services was used to estimate the required level of services for the ANHP catchment area related to the Provincially-funded services.

HEALTH EQUITY

For many years, the perception has been that communities in the ANHP catchment area, especially First Nations communities, have been underserviced for many reasons, including the longstanding expectation that health services in First Nations' communities are the responsibility of the Federal government. This perception and barrier has emerged as a significant health equity issue that needs to be addressed from a reconciliation standpoint in recent years. Provincial governments have a clear constitutional responsibility to care for the health needs of all provincial residents, including First Nations peoples.

RECOMMENDATION 18

We call upon the federal, provincial, territorial and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the healthcare rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

Our proposal will illustrate how:

- Reframing the discussion of Indigenous health inequities and differences in care from “patient blaming” to “system enabling”;
- Acknowledging the presence of underlying ideologies of racism and colonization;
- Recognizing that widespread apathy and disdain can be common when addressing First Nations, Métis and Inuit health gaps;
- Ensuring messages related to education, research and service delivery are consistent with the Commission’s message that the health gaps are the result of policy choices past and present.

BENCHMARK RATES FOR PROVINCIALLY-FUNDED HOME CARE SERVICES

For this analysis and the resulting business case, a benchmark utilization rate for the entire population of the ANHP's catchment was established related to Provincially funded healthcare resources. In consultation with the project working group, a benchmark service level was established based on the age-standardized rate of services provided in the City of Thunder Bay. The benchmark rates calculations are shown below in the current state service levels analysis section.

Current hours of services provided were downloaded from the Intellihealth Ontario system for the most recent fiscal year available. Services were grouped by service type, municipality (using the MOH residence coding system and cross-referenced to census subdivisions (CSD), and five-year age group of the service recipient. A standard utilization rate by service was calculated for the City of Thunder Bay, and this rate was applied to other communities to calculate an "expected" rate of service. In many cases, this rate was much higher than current services rates–a phenomenon attributed to health equity issues. The "expected" service levels were then used to form the basis of the future state service delivery model.

COMMUNITY SUPPORT SECTOR | MSAA-FUNDED SERVICES

In addition to home care services funded through the legacy home and community care model (formerly funded through the Community Care Access Centre Model), the MOH funded some home care services via a transfer-payment model to community providers. These transfer-payment agreements are knowns as M-SAAs. In-scope M-SAA-funded services include home maintenance, homemaking and visiting and social safety programs.

Planning estimates for these services are included in the Local Area Services Plan (LASP) for older adults, a demand/capacity service level planning model developed originally by the North West Local Health Integration Network and still maintained today. The planning model is evidence-based and is vital from a health equity standpoint since it is based on a rate per population 65 and older.

It cannot be stressed enough how crucial Supportive Housing is in establishing a robust All Nations OHT Home Care program. All Nations Health Partner, Kenora District Services Board (KDSB) is instrumental to the strategy of housing and aging in place. KDSB is the largest provider of housing to seniors in the Kenora District. The partnership with ANHP's home care will strengthen our communities' ability to care for seniors and elders. KDSB is actively working on several supportive housing projects.

RECOMMENDATION 20

In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and manage the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

Our proposal will illustrate how:

- An immediate review of Health Canada's First Nations and Inuit Health Branch programming, with a renewed emphasis on primary care services instead of preventative and public health care;
- Implementation of Jordan's Principle across health services (Jordan's principle is a patient-first principle that calls for the government - federal or provincial - of first contact to pay for a service for a First Nations child ordinarily resident on-reserve. Governments are then to settle responsibility for costs later. The intent is to prevent First Nations children from being denied prompt and equal access to benefits or protections available to other Canadians as a result of their First Nations status); and,
- Engaging all levels of government to ensure a seamless transition between federally and provincially-funded healthcare that is patient and family-centred.

SERVICE LEVEL ESTIMATIONS | FEDERALLY FUNDED SERVICES

The Federal government directly funds some home care services in First Nations communities through agreements with community band administrations. Service levels and services offered differ significantly by community.

Indigenous Services Canada (ISC) uses the following funding formula for Home and Community Care for First Nations communities. The formula takes into consideration the size of the population, the remoteness of the community and the level of need. The amount of funding received for Home and Community Care in First Nations communities is very limited overall.

A. An amount for Direct Program Services

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

- X Personal Care Requirements = 2.4% (total on reserve population x 2.4% x .5 hr/client x 26 weeks
- X Diabetes/Arthritis/Cardiovascular rate = 8% (total on reserve population x 8% x 32% x .5 hr/client x 52 weeks
- X Early Hospital Discharge/Post Hospitalization (20% of on-reserve population x 35% x 2 hrs/client)
- X 10% of total nursing time for nursing management

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

- X Personal Care Requirements = 2.4% (total on reserve population x 2.4% x .60 hr/client x 52 weeks
- X Diabetes/Arthritis/Cardiovascular rate = 8% (total on reserve population x 8% x 32% x .5 hr/client x 52 weeks
- X Early Hospital Discharge/Post Hospitalization (20% of on-reserve population x 35% x 2.5 hrs/client)
- X 10% of total nursing time for nursing management

Program Support Services @36000 for Type 1 and Type 2 communities or $30000 for Type 3 and 4 communities (.35 hours of service x total population x hourly wage for Type of Community)

Case Management, Coordination Services & Case Assessment Services

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

- X Client Assessment 2 hrs/client x 350 clients = .59 FTE
- X Care Planning @ 1 hr/client x 350 clients - .197 FTE
- X Care coordination/Client @ 1 hr/client x 350 clients = .197 FTE

A. An amount for Operating Costs (30% of A); C. Adjustment for Remoteness (25% of B for Community Types 1 and 2) Total funding for each HCC program is A+B (30% of A) + C * (25% of B) = Total Funding (note; * is for Type 1 and Type 2 Communities)

The service delivery plans for each community occurred via a survey. These services were considered to be available to augment the community health services plan.

Stakeholders

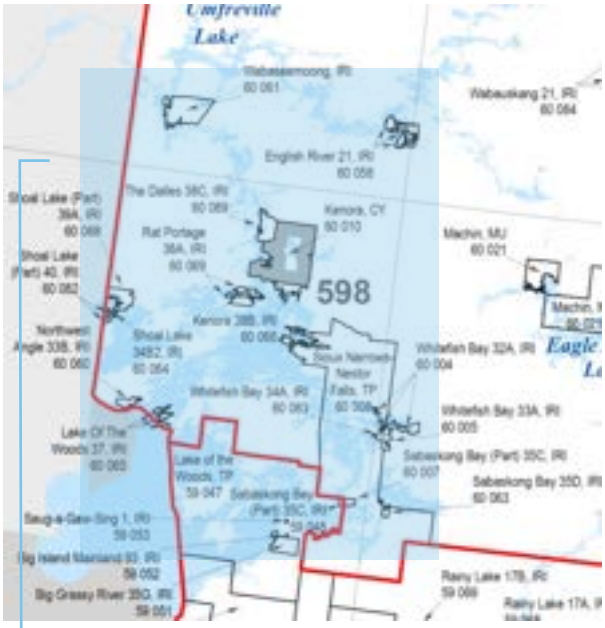
ANHP CATCHMENT AREA

The ANHP serves a catchment area located in the Kenora District. The City of Kenora is the largest community in the catchment area, with several smaller and remote communities included.

Many health, population and demographical data sources rely on the Census Division and Subdivision methodology and boundary classification system. The figures below are key to interpreting the catchment area of the ANHP and providing a basis for assessing the population estimates and projections. Figure 1 is the official ANHP map for planning purposes. Figure 2 shows the most recent Census Subdivision (CSD) Reference map for the area, which can be used to reconcile with the Ontario Ministry of Health's Residence Coding System for healthcare data. The two maps are shown side-by-side at similar scales to help understand the two classification systems of community names.

Figure 1 | Official ANHP Catchment Area Map

Figure 2 | ANHP Communities per Statistics Canada Census Methodology and Nomenclature



The summary below reconciles the communities included in the ANHP catchment area.

CATCHMENT AREA COMMUNITIES

RESIDENCE CODE	COMMON | FORMAL NAME
(4291) KENORA	Kenora
(4299) KENORA	Reddit & Minaki (Unorganized Kenora)
(4263) SHOAL LAKE 34B2	Shoal Lake 40
(4292) SIOUX NARROWS-NESTOR	Sioux Narrows & Nestor Falls
(4237) ENGLISH RIVER 21	Grassy Narrows
(4241) WABASEEMOONG	Wabaseemoong
(4268) THE DALLES 38C	Niisaachewan (Dalles)
(4264) SHOAL LAKE 39A	Iskatewizaagegan #39 (Shoal Lake 39)
(4265) SHOAL LAKE 40	Shoal Lake 40
(4254) NORTHWEST ANGLE 33B	Northwest Angle No 33B (Angle Inlet)
(4247) LAKE OF THE WOODS 37	Animakee Wa Zhing 37B (Windigo Island)
(4275) WHITEFISH BAY 32A	Naotkamegwanning (Whitefish Bay)
(4276) WHITEFISH BAY 33A	Northwest Angle 37A (Dog Paw)
(4277) WHITEFISH BAY 34A	Animakee Wa Zhing 37A (Regina Bay)
(4258) RAT PORTAGE 38A	Obashkaandagaang & Washagamis Bay
(4243) KENORA 38B	Wauzhushk Onigum

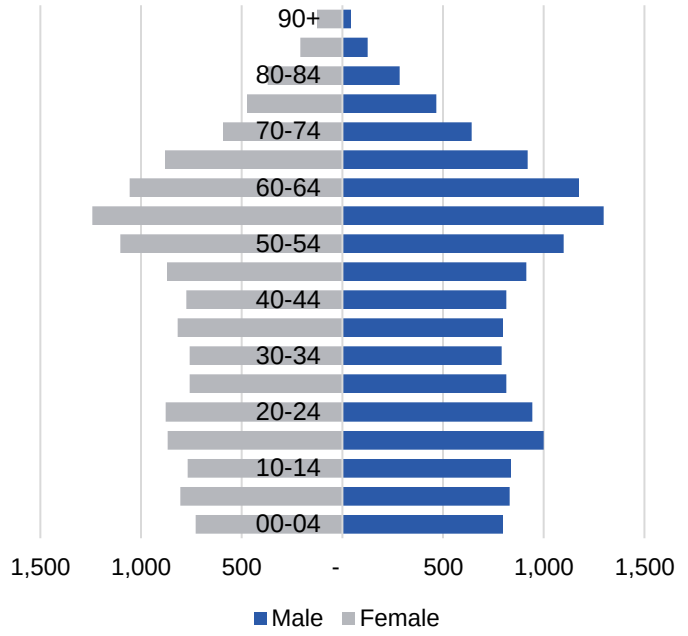
For the success of this project, it is critical to understand the relationship between Statistics Canada CSDs, the Ministry of Health Residence coding system (which aligns with CSD) and the more commonly used names of communities, including traditional names for First Nations Communities.

The Kenora Unorganized CSD presented a problem for this analysis. The area comprised of the Kenora unorganized CSD is a large geographical area that extends well beyond the borders of the ANHP catchment area. For this report, the entire population of this area was included in the definition of the population figures. The rationale for Inclusion of Kenora Unorganized CSD population:

- This area is sparsely populated outside of the major municipalities and towns, the largest of which in the area is Kenora which is within the ANHP catchment area
- The OHT attributed population analysis included 4483, or 60% of the estimated 7,475 residents of this CSD based on health utilization (see below for discussion). Therefore, the majority of health utilization by residents in this CSD was related to OHT member organizations.
- The total population helps offset known deficiencies and understatement of census data concerning First Nations communities (see below for discussion).

POPULATION ANALYSIS & PROJECTIONS

FIGURE 3: Population Age and Gender* Distribution – 2016 Census



** Gender is as defined by the Ministry of Health and reported in the Intellihealth Ontario database*

Figure 3 shows the estimated age and gender distribution for the ANHP catchment area based on the 2016 census data.*

The total estimated population in 2016 was 28,672, 5,135 (18%) of which were 65 years old or older.

Population projections are available at the District level only. The ANHP Catchment area is included in the Kenora District and comprises approximately 40% of the population.

Figure 4 shows the projected population for the Kenora District over the next 20 years. Overall, the population is expected to age sharply, with the population presenting as 65 years old and older expected to increase by 45%. At the same time, the population less than 65 years of age is expected to stay flat, leading to an overall population increase of just under 7%.

By 2040, the population aged 65+ is expected to account for 21% of the total population of the Kenora District. This percentage is up from an estimated 14% in 2016 compared to 18.6% in the ANHP Catchment area specifically for 2016.

FIGURE 4: Population Projections – Kenora District

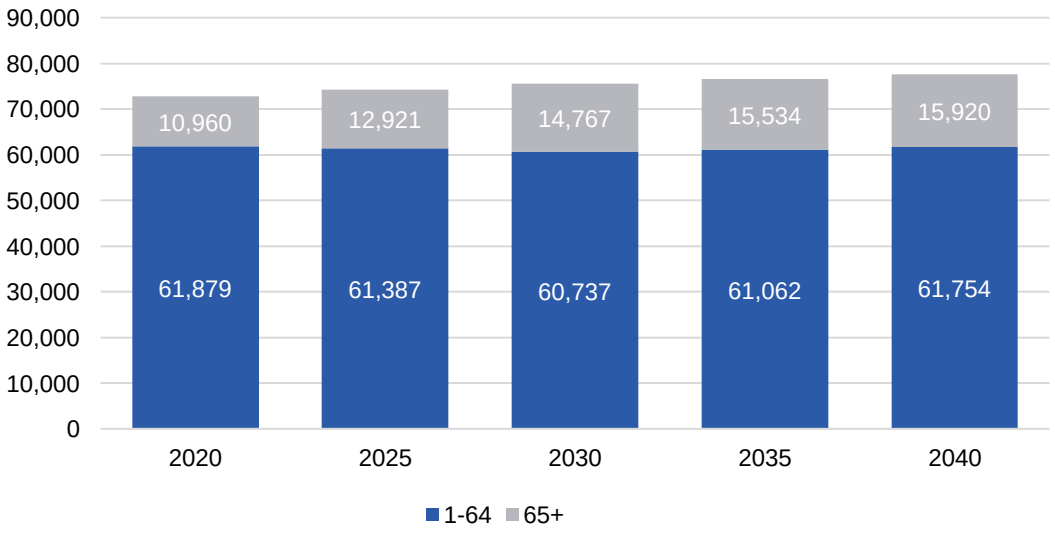
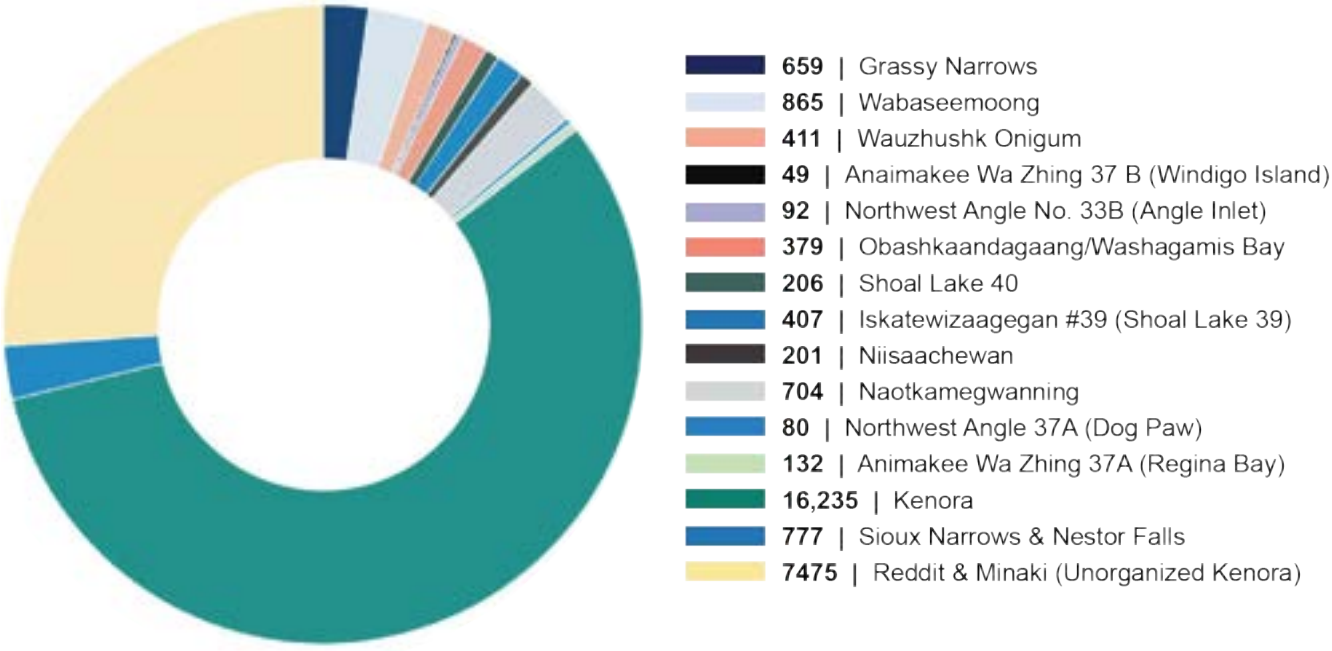


Figure 5: Population by Community, ANHP (2016 Estimates)



The majority of the population resided in the Kenora area (57%) and the Kenora unorganized area (26%). According to official population estimates, 4,185 (14.6%) resided in First Nations communities, with Wabaseemoong being the largest of the individual communities with an on-reserve population officially estimated as 865.

The MOH uses census data (2016 census) to derive the office population estimates and projections. There are known issues with census data concerning First Nations communities, and population estimates were cross-referenced to Federal government data from community profiles with the results shown in the table below. In many cases, significant differences were observed.

Table 1: Provincial vs. Federal Population Estimates for First Nations Communities

COMMUNITY		POPULATION		
		MOH Official Estimates	Federal Community Profiles	Difference
(4237) ENGLISH RIVER 21	Grassy Narrows	659	1,015	54.0%
(4241) WABASEEMOONG	Wabaseemoong	865	1,015	17.3%
(4268) THE DALLES 38C	Niisaachewan (Dalles)	201	190	-5.5%
(4264) SHOAL LAKE 39A	Iskatewizaagegan #39 (Shoal Lake 39)	407	368	-9.6%
(4265) SHOAL LAKE 40	Shoal Lake 40	107	305	185.0%
(4254) NORTHWEST ANGLE 33B	Northwest Angle No 33B (Angle Inlet)	92	262	184.8%
(4247) LAKE OF THE WOODS 37	Animakee Wa Zhing 37B (Windigo Island)	49	n/a	-
(4275) WHITEFISH BAY 32A	Naotkamegwanning (Whitefish Bay)	704	765	8.7%
(4276) WHITEFISH BAY 33A	Northwest Angle No 37A (Dog Paw)	80	n/a	-
(4277) WHITEFISH BAY 34A	Animakee Wa Zhing 37A (Regina Bay)	132	202	53.0%
(4258) RAT PORTAGE 38A	Obashkaandagaang & Washagamis Bay	379	184	-51.5%
(4243) KENORA 38B	Wauzhushk Onigum	411	393	-4.4%

OHT ATTRIBUTED POPULATION

As Ontario has rolled out the OHT strategy, analysis has been provided to reflect an "attributed" population to use for planning purposes. Attributed populations are based on the health utilization of OHT partner organizations, not based on the physical geography of communities. As OHT member organizations are approved through the OHT development process, health utilization of area residents is used to determine population numbers for planning services related to the OHTs and identifying catchment areas.

This strategy has been adopted across Ontario; however, it makes more sense in urban areas where geographical boundaries cannot reliably be used to plan healthcare utilization and predict demand and supply for health programming. For example, residents of Richmond Hill may routinely travel to Toronto for health care services for many reasons, such as the availability of transit services, perception of quality, wait times in local health care providers, etc. Travel times from Toronto to Richmond Hill are not significant enough to be a barrier to patient mobility in these areas.

In Northwestern Ontario, travel times between communities are long, and travel can be difficult, especially during the winter, significantly more prolonged and harsher than in Southern Ontario. The official attributed population data provided to the ANHP by the MOH shows an attributed population of 28,801, which is very similar to the estimated population used in this report of 28,672.

COMMUNITIES & RESOURCES

There are several different models related to the provision of HCC in First Nations Communities in the current state. See below for a summary of the current state models by the community.

Table 2: Current State of HCC Resources in ANHP First Nations Communities

COMMUNITY	ONTARIO HEALTH	COMMUNITY LED (HC)	KCA (HC) & NUR	WNHAC (HC)	CONTRACT NURSING	HEALTH RECORD
Kenora	✓					CHRIS
Reddit	✓					CHRIS
Minaki	✓					CHRIS
Sioux Narrows	✓					CHRIS
Nestor Falls	✓					CHRIS
Grassy Narrows		✓			Health Can	
Wabaseemoong			✓		Health Can	Telus PSS / ISC
Niisaachewan (Dalles)			✓			Telus PSS / ISC
Iskatewizaagegan #39				✓	WNHAC	Telus PSS / ISC
Shoal Lake 40			✓			Telus PSS / ISC
Northwest Angle No 33B (Angle Inlet)				✓		Telus PSS / ISC
Animakee Wa Zhing 37B (Windigo Island)				✓		Telus PSS / ISC
Wauzhushk Onigum			✓			Telus PSS / ISC
Washagamis Bay			✓			Telus PSS / ISC
Animakee Wa Zhing 37A (Regina Bay)				✓		Telus PSS / ISC
Northwest Angle No33A (Dog Paw)				✓		Telus PSS / ISC
Naotkamegwanning (Whitefish Bay)			✓			Telus PSS / ISC

Services Analysis

CURRENT SERVICE LEVELS

HOME AND COMMUNITY SUPPORT SERVICES NORTHWEST

Data for the most recent year available (2019/20) were obtained from the Intellihealth Ontario system for analysis. Intellihealth Ontario is a business intelligence system owned and maintained by the Ontario Ministry of Health and contains vital health data information made available for health data analysis and evaluation purposes. Data are de-identified and linked to several health and demographics databases through the use of unique encrypted identifiers.

Table 3 and Table 4 show the services provided and the services hours (respectively) in the Ontario Health North health planning region for the most recent fiscal year available (2019/20).

The vast majority of services and service time were provided in the City of Thunder Bay Sub Region. The City of Thunder Bay had approximately 50% of the Ontario Health North West Region; however, it accounted for over 75% of the total services and service time. This was despite the fact that the population in much of the ANHP catchment area was older and had a higher population 65 years and older as a percentage of the total population. As shown in Figure 6 and Figure 7, the ANHP areas, particularly the Kenora area, stood out as having an older population than much of Ontario.

Figure 6: Percentage of the Population 65+, 2016 Census

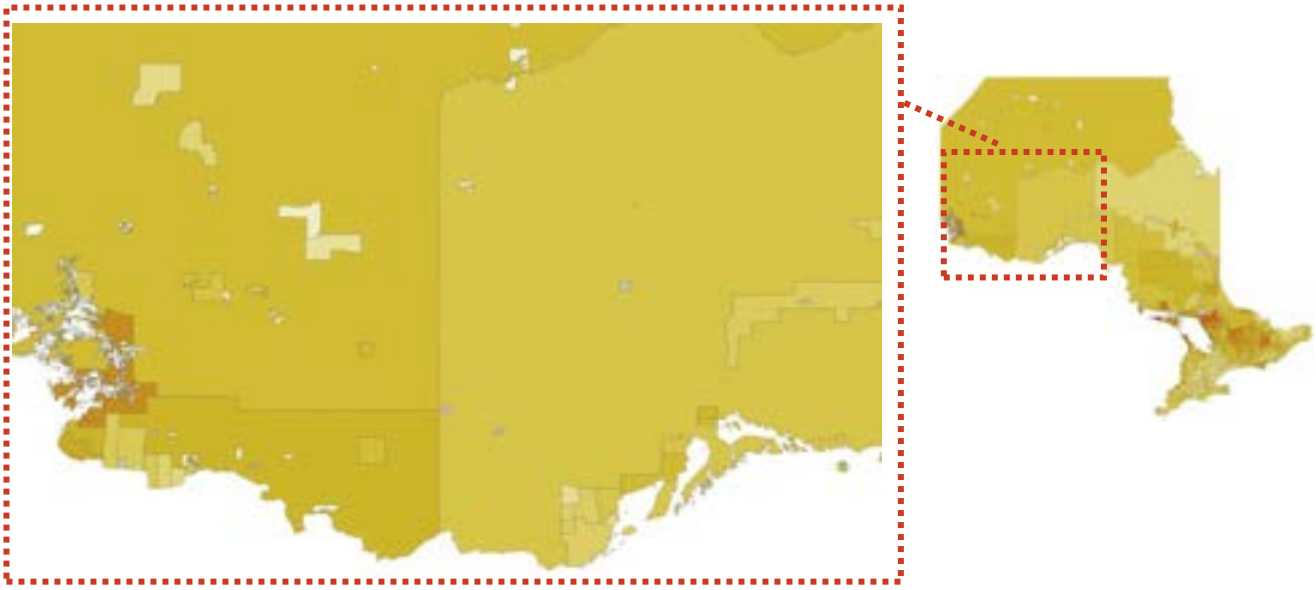


Figure 7: Median Population Age, 2016 Census

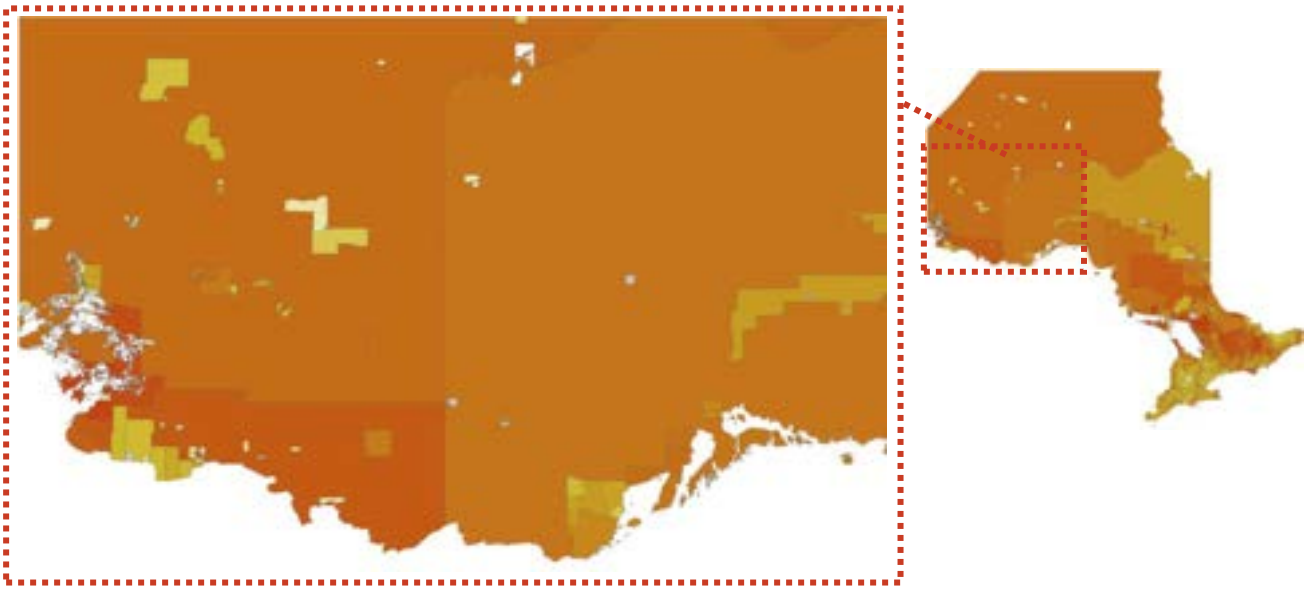


Table 3: Home and Community Care Services (# of), 2019/20, North West Ontario Health Planning Area

SERVICES (# OF)	CITY THUNDER BAY	DISTRICT KENORA	DISTRICT RAINY RIVER	DISTRICT THUNDER BAY	NORTHERN	TOTAL
(01) NURSING-VISIT	154,242	15,919	7,658	3,729	3,407	**184,955**
(02) NURSING-SHIFT (HOUR)	3,609		36	7	142	**3,794**
(04) NUTRITION/DIETETIC	505	58	13	13	7	**596**
(05) PHYSIOTHERAPY	9,556	1,654	783	541	355	**12,889**
(06) OCCUPATIONAL THERAPY	5,726	778	406	450	242	**7,602**
(07) SPEECH LANGUAGE THERAPY	1,804	107	38	47	23	**2,019**
(08) SOCIAL WORK	1,486	78	45	92	19	**1,720**
(10) CASE MANAGEMENT	38,662	7,089	4,568	2,636	1,535	**54,490**
(11) PERSONAL SERVICES (HOUR)	622					**622**
(13) COMBINED PERSONAL SUPPORT AND HOMEMAKING SERVICES (HOUR)	520,079	82,126	41,559	32,848	4,407	**681,019**
(15) RESPITE (HOUR)	73			8		**81**
(16) MENTAL HEALTH AND ADDICTION NURSING VISIT	3,344	1,605	46	840	445	**6,280**
(17) NURSE PRACTITIONER PALLIATIVE VISIT	1,739	496	679	11	108	**3,033**
(18) RAPID RESPONSE NURSING VISIT	2,097	688	338	4		**3,127**
(23) Telehome care	2,122	237	247	86		**2,692**
(24) Primary Care	1,151			1		**1,152**
(99) OTHER	127			7		**134**
Grand Total	**746,944**	**110,835**	**56,416**	**41,320**	**10,690**	**966,205**
% of Total Services / Service Time	**77.3%**	**11.5%**	**5.8%**	**4.3%**	**1.1%**	

Table 4: Home and Community Care Services (Total Hours), 2019/20, North West Ontario Health Planning Area

SERVICES (HRS)	CITY OF THUNDER BAY	DISTRICT OF KENORA	DISTRICT OF RAINY RIVER	DISTRICT OF THUNDER BAY	NORTHERN	TOTAL
(01) NURSING-VISIT	154,242	15,919	7,658	3,729	3,407	**184,955**
(02) NURSING-SHIFT (HOUR)	12,821		146	41	1,201	**14,209**
(04) NUTRITION/DIETETIC	505	58	13	13	7	**596**
(05) PHYSIOTHERAPY	9,556	1,654	783	541	355	**12,889**
(06) OCCUPATIONAL THERAPY	5,726	778	406	450	242	**7,602**
(07) SPEECH LANGUAGE THERAPY	1,804	107	38	47	23	**2,019**
(08) SOCIAL WORK	1,486	78	45	92	19	**1,720**
(10) CASE MANAGEMENT	38,662	7,089	4,568	2,636	1,535	**54,490**
(11) PERSONAL SERVICES (HOUR)	2,304					**2,304**
(13) COMBINED PERSONAL SUPPORT AND HOMEMAKING SERVICES (HOUR)	380,365	74,823	32,448	25,419	4,288	**517,342**
(15) RESPITE (HOUR)	370			19		**389**
(16) MENTAL HEALTH AND ADDICTION NURSING VISIT	3,344	1,605	46	840	445	**6,280**
(17) NURSE PRACTITIONER PALLIATIVE VISIT	1,739	496	679	11	108	**3,033**
(18) RAPID RESPONSE NURSING VISIT	2,097	688	338	4		**3,127**
(23) Telehome care	2,122	237	247	86		**2,692**
(24) Primary Care	1,151			1		**1,152**
(99) OTHER	77			7		**84**
Grand Total	**618,370**	**103,532**	**47,415**	**33,935**	**11,630**	**814,882**
% of Total Services / Service Time	**75.9%**	**12.7%**	**5.8%**	**4.2%**	**1.4%**	

ESTIMATED SERVICE GAPS

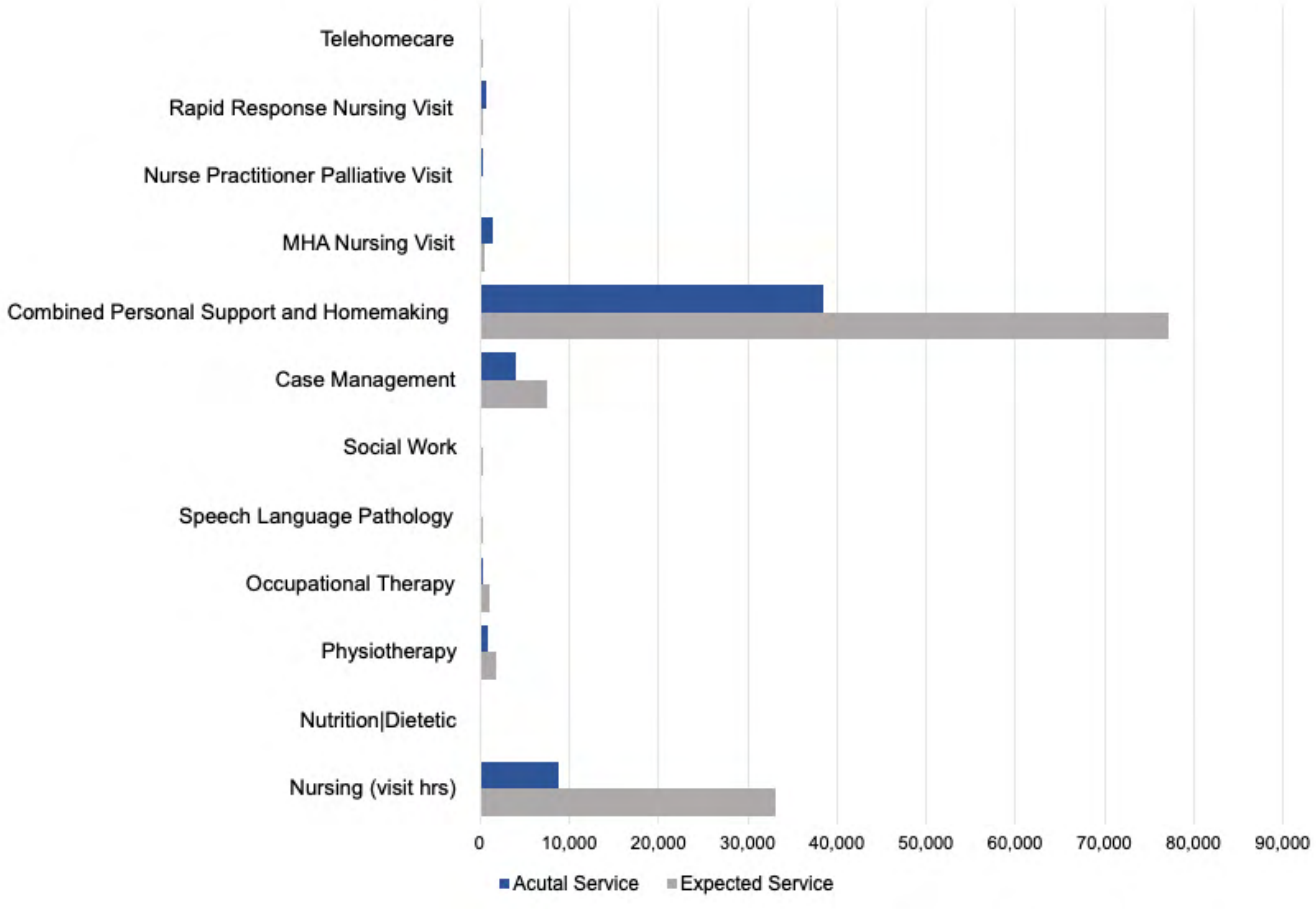
HOME AND COMMUNITY CARE

ANHP AREA SUMMARY

Home and community care service data for 2019 was used to estimate service deficits (and surpluses) in the ANHP catchment area. Service data by modality and 5-year age group were used for this estimation. Services were benchmarked using the Thunder Bay municipality as a baseline – assuming the City of Thunder Bay represented the most appropriately-resourced area in the Ontario Health North western region. There are currently no evidence-based levels of care planning models based on leading practices in Ontario. This is a shortcoming of Ontario's homecare system observed in the 2015 Auditor General's review of homecare services and persists to this day. One of these plans aims to provide a consistent and equitable level of service in the ANHP catchment area.

Figure 8 shows the *observed* vs. *estimated* service levels for Home and Community Care Services in the ANHP Catchment area, based on the 2019 fiscal year.

Figure 8: Observed Service Levels vs. Estimated (2019) – ANHP Catchment



There was a significant observed service gap for most service areas when ANHP catchment area service volumes were compared to service levels by 5-year age group in the City of Thunder Bay municipality.

These results are further summarized in Table 5 below. Across all service types, the estimated service deficit varied widely but was estimated between 40% and 70%. Three service types showed a higher than expected service level – Mental Health and Addition Nursing Visit, Rapid Response Nursing and Nurse Practitioner Palliative Visits.

Table 5: Summary of Estimated Service Gaps – Home and Community Care (2019, all ANHP Catchment Area)

SERVICE	EXPECTED SERVICE LEVELS	OBSERVED SERVICE LEVELS	ESTIMATED DEFICIT (SURPLUS)	% OF EXPECTED
Nursing (visit hrs)	33,131.8	8,947.0	24,406.8	73.7%
Nutrition | Dietetic	108.1	25.0	84.1	77.8%
Physiotherapy	1,820.4	1,049.0	859.4	47.2%
Occupational Therapy	1,168.0	451.0	741.0	63.4%
Speech Language Pathology	342.0	39.0	308.0	90.1%
Social Work	317.1	68.0	253.1	79.8%
Case Management	7,607.5	4,068.0	3,754.5	49.4%
Combined Personal Support and Homemaking	77,364.3	38,598.5	39,083.8	50.5%
MHA Nursing Visit	619.6	1,479.0	(794.4)	(128.2%)
Nurse Practitioner Palliative Visit	302.6	404.0	(61.4)	(20.3%)
Rapid Response Nursing Visit	403.2	688.0	(249.8)	(62.0%)
Telehomecare	434.4	113.0	331.4	76.3%
AVERAGE				**33.1%**

Table 5 shows the actual expected total levels of service (total estimated hours of service) by service type. The most significant service types of nursing visits, combined personal support & homemaking and case management services were all well below expected values (gaps between 50% and 70% of expected).

Case management, personal support and homemaking service volumes were approximately 40% lower than expected in the ANHP catchment area. Service gaps were higher in several allied health services such as occupational therapy, nutrition, social work, and speech language pathology – between 50% and 78% higher.

Three areas had higher than expected service levels - Mental Health Nursing Visits (school aged children), Rapid Response Nursing and the Nurse Practitioner Palliative Visits.

RECOMMENDATION 21

We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional and spiritual harms caused by residential schools and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

Our proposal will illustrate how:

- Advocating for parallel support of Indigenous traditional medicine approaches to healing;
- Working with traditional healers to develop respectful ways to teach learners as well as practicing health care providers on how to work with traditional healers or people who are using traditional healing methods - this may include accreditation; and,
- Developing community partnerships between First Nations communities and health organizations to ensure the inclusion of traditional healing in the primary care models in ways that are respectful, responsive, and directed by First Nations communities and traditional healers.

FIRST NATIONS COMMUNITIES

Three First Nations Communities only recorded home and community care volumes: Grassy Narrows, Wabaseemoong, Iskatewizaagegan #39. Figure 5 shows Home and community care services in the three first nations communities (detailed above), which recorded services. Results should be interpreted with caution due to these communities' small population, which results in less reliability for expected service volume calculations. As per official Ministry of Health estimates, the total population in these communities was 1,931, or 7.1% of the total population in the catchment area.

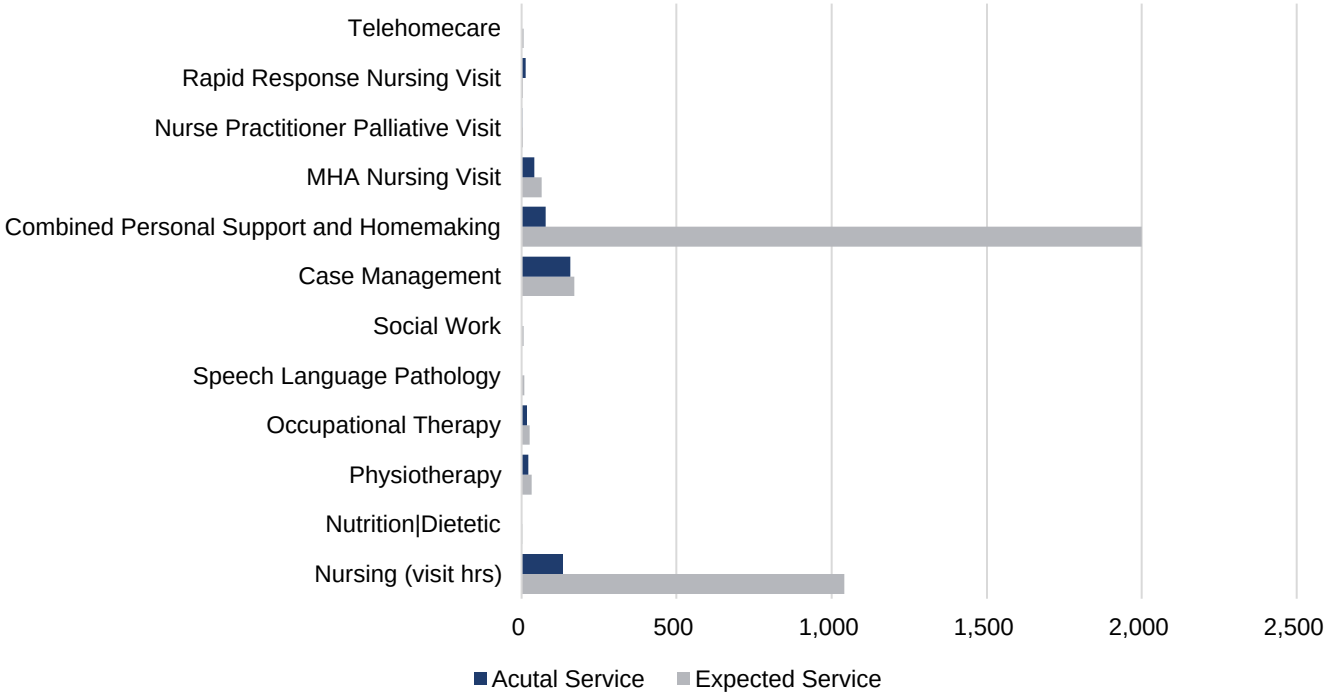
In most service areas, the service volumes observed were close to expected service volumes for these three communities. Notable exceptions include some allied health professions, including speech-language pathology and social work, where no services were provided. In contrast, physiotherapy and occupational therapy services were close to expected.

It is notable that while case management services were higher than expected, personal support combined volumes were lower than expected, suggesting a disconnect between the management of services and actual service provision in the community.

These figures reflect that historically services in First Nations communities have been provided at different rates and through other service delivery models than non-First Nations Communities.

In the past, the North West LHIN provided services using M-SAA-funded provided through organizations such as Kenora Chief's Advisory. These services were not funded according to a population-based methodology or demand-based model.

Figure 9: Observed Service Levels vs. Estimated (2019) - Grassy Narrows, Wabaseemoong, Iskatewizaagegan #39



LEGISLATIVE FRAMEWORK & KEY CONSIDERATIONS

LEGISLATIVE UPDATES

On February 25, 2020, the government introduced Bill 175, the Connecting People to Home and Community Care Act, 2020. It received Royal assent on July 8, 2020. Ontario Health is focused on modernizing home care service delivery with five key areas of focus:

- **COVID 19** | Fund and implement targeted initiatives in HCC as part of the government's broader COVID-19 response plan
- **Modernize Legislation and Regulations |** Create a new and modernized legislative framework for home and community care to enable Ontario Health Teams and Health Service Providers to assume responsibility for delivering home and community care within an integrated and person-centred service model.
- **Improve Accountability in Delivery |** Review, update and provide redesign ideas for home care service provider organizations for procurement and contracting models.
- **Establish Transitional and Permanent Governance |** Refocus LHINs as interim organizations responsible for maintaining home care delivery and long-term care placement functions. New name: Home and Community Care Support Services (HCCSS). Plan for end-state Ontario Health takes accountability for HCC, and services are delivered through Ontario Health Teams
- **Develop a Framework for HCC Transition |** Construct a strong foundation for service continuity with Home and Community Care Support Services. Set parameters for the phased transition of HCC to Ontario health Teams and establish clear roles and responsibilities for the ministry, Ontario Health and Ontario Health Teams during the transition. Evaluate tests of change to prepare for full provincial scale.

SUMMARY OF APPLICABLE CHANGES TO LEGISLATION

PREVIOUS FRAMEWORK	PROPOSED FRAMEWORK
Requires all care coordination functions (intake, assessing and determining eligibility, care planning, service allocation and case management) to be performed by an approved agency.	Adaptable care coordination functions can be embedded in front-line care within Ontario Health Teams, promoting integration between sectors, reducing duplication and ensuring care is more responsive to patient needs.
Home and community care services (which are called 'community services' under HCCSA) comprise four groups of services: ○ professional services ○ personal support services (PSSs) ○ homemaking services ○ community support services (CSSs)	Refrains from sorting services into 'home care' and 'community care' categories in regulation The following is a listing of changes proposed in the new legislation: ○ It keeps the four current groups of services (professional, personal support, homemaking, and community support services) and the individual services currently listed under each group (e.g., nursing, assisting a person with activities of daily living, etc.) ○ Two legacy homemaking services would be discontinued: ironing and mending. ○ Introduces a new group (Indigenous Services) that includes Traditional Healing and Indigenous Cultural Support Services. ○ Indigenous Cultural Support Services would replace Aboriginal Support Services, a current community support service ○ Psychological services area added as a new professional service ○ New community support services: bereavement services; behavioural supports; and education, prevention, and awareness services pertaining to home and community care services, mental health and addictions, chronic disease management, aphasia and communication disorders, and vocational training and education services ○ Renames "caregiver support services" as "caregiver support and respite services." ○ Retains "security checks or reassurance services" as a community support service ○ Services previously identified as potential new services (aphasia services, diabetes education, and pain and symptom management) have now been confirmed as being within the scope of other listed services, e.g., new education, prevention, and awareness services. At maturity, under the new regulations, Health Service Providers could be funded to provide any combination of these services, and Ontario Health Teams would be funded for all of them.
Places restrictions on changing care plans without formal re-assessments, limiting the ability to make changes to care plans that meet patient needs.	Flexibility in care planning requirements to support more responsive care delivery based on patient outcomes
Reinforce a per hour/visit-based approach to the delivery of care.	Flexibility for autonomous and innovative care models is needed by providing care virtually and removing the emphasis on visit-based care.
Places restrictions on the number of services provided, reducing the capacity to care for certain clients.	No service maximums enable care provision based on identified needs and resources.
Provides limited clarity/oversight to enable new settings and methods of delivering care.	An oversight model will be provided for residential congregate services, which would support patients with needs too high to be met at home - but do not require the intensive level of care provided by a hospital or long-term care home.

KEY CONSIDERATIONS FOR ANHP OHT

The new legislative framework provided by Bill 175 provides the opportunity for ANHP to address several notable shortcomings of the current health system delivery model for home and community care. While the proposed legislation makes possible improvements to many of the challenges inherent in the HCC Service Delivery Model, not all issues will be addressed through the legislative changes.

The following is a brief listing of key considerations for the ANHP in developing a new service delivery model for their catchment area:

- **Existing RAI Home Care assessment is a barrier for First Nations health partners and home care clients |** RAI assessments are time-consuming and require extensive training to complete. Specialized software is also required in most cases to facilitate the process. As a result, assessment, eligibility and services planning approaches are different for First Nations providers and clients, resulting in gaps in care.

  The new legislative framework appears to allow more flexibility for assessments, making it possible for the new integrated ANHP home and community care support services delivery frameworks to be more seamless and efficient, utilizing assessment tools that work for everyone.

- **Eligibility remains with OHIP card |** the proposed legislation does not change eligibility criteria for provincially-funded services. This new legislation could continue to be a barrier for residents living in First Nations communities. The ANHP will need to develop systems and assessment processes to ensure non-insured residents of the catchment area receive the same care as insured residents.

- **Technology Barriers and Alignment of Health Data Collection and Use |** The proposed legislation does not address issues related to the use of health data and integration between federal and provincial systems, which are different and do not currently integrate. Privacy legislative frameworks are different at the federal and provincial levels, making it challenging to share client data. This disconnect results in inefficient and ineffective health service delivery, such as clients providing duplicate assessment information.

  ANHP will have to work collaboratively with Federal and Provincial health authorities to overcome health Information Technology, privacy and security issues.

- **More Integration with Primary Care is Required |** The proposed legislation indicates that more integration with Primary Care is required for Ontario Health Teams, including ANHP. Care coordination is expected to be more integrated with primary care and other health providers through integrated care records, integrated care delivery and improved referral networks.

  The ANHP OHT focused efforts on a community health record can significantly aid operating Home and Community Care.

- **Elimination of Service Maximums |** The proposed Care Coordination model from Ontario Health indicates additional responsibilities and monitoring financial information and comparing to the services being provided, with no service maximums. Service maximum and rationing of care have always been a vital aspect of the legacy home and community care operations, with strict limits on service. This report has estimated service levels based on age-standardized rates from Thunder Bay, which is the Community in Northwestern Ontario with the highest current rates of home care utilization. However, there is a risk that this level of service is not adequate to meet the actual needs of the ANHP population.

  ANHP can mitigate that risk somewhat by implementing the future state service delivery model to streamline the assessment process. As well, ANHP should look to find more opportunities in the future to shift care coordination resources to care provision.

- **Uncertainly Surrounding the OHT Model at Maturity |** The Ministry of Health has yet to determine or prescribe the details of how home and community support services will transfer to OHTs.

  There is an opportunity for ANHP OHT to fully design the Home Care framework and collaboration models with communities and CSS. The guidance provided has indicated that "*…to support this transition, the ministry will work with Ontario Health, HSPs, OHTs, and Home and Community Care Support Services to develop a staged implementation plan, including complementary policies and management tools for care coordination (e.g., service allocation, wait listing).*"

Options Analysis

The ANHP Home and Community Care Executive Committee has identified system and service models to evaluate future HCCS. It is essential to define and analyze all potential governance and service delivery models under consideration by the ANHP HCCS Working Group and then analyze them in detail to determine the optimal governance structure and service delivery model for the ANHP. The governance models define how the resources for HCCS will flow between involved organizations, including the "who" and the "where" of service delivery. Conversely, the service delivery model will define how services will be delivered in the new ANHP Home and Community Care System.

GOVERNANCE MODEL OPTIONS

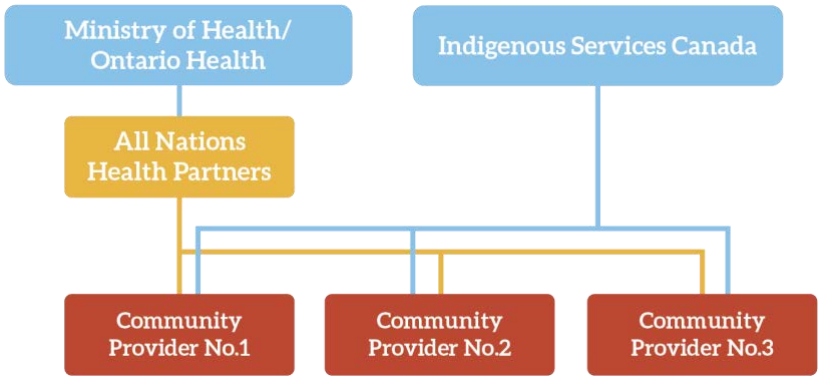
There are two primary governance models under consideration for the ANHP Home and Community Care Executive Committee, including the Modified Current State model and the Managed Health Care Model – both of which are defined below.

GOVERNANCE MODEL 1 | MODIFIED CURRENT STATE

The Modified Current State model has the ANHP (or an alternative, designated Paymaster) receiving HCCS funding from the Ministry of Health/Ontario Health and Indigenous Services Canada (ISC).

The ANHP would direct funding to community service providers responsible for local community service delivery. While the local service providers are responsible for carrying out services, the ANHP would be ultimately accountable for the system-level performance of the HCCS and the performance of each community service provider. Each organization, however, would remain independent and finally be responsible from a governance perspective to its governors, trustees, council or other leadership structure.

Figure 10: Modified Current State Governance Model



The accountability and performance of the community service providers would be managed through accountability agreements between the ANHP and each community service providers; this would be similar to the current MSAA agreements between providers and OHN.

ADVANTAGES	DISADVANTAGES
• Simple transition from current Ontario Health North governance model • No new governance structure required • Collaborative governance • Less complicated, the smaller organization required	• Less standardization across all communities • More complicated distribution and management of resources • Harder to enact real change and system redesign • Siloed and more challenging to administer and drive positive change

GOVERNANCE MODEL 2 | MANAGED HEALTH CARE

The Managed Health Care governance model is similar to the Modified Current State model. It envisions the ANHP (or an alternative, designated Paymaster) receiving HCCS funding from the Ministry of Health/Ontario Health and ISC.

Under this model, governance would be provided by the ANHP board. Accountability would flow down to regional offices managed by management personnel but governed by the ANHP Board of Directors. This model would ensure strategic alignment across the region, with one health care provider setting a consistent direction in all communities.

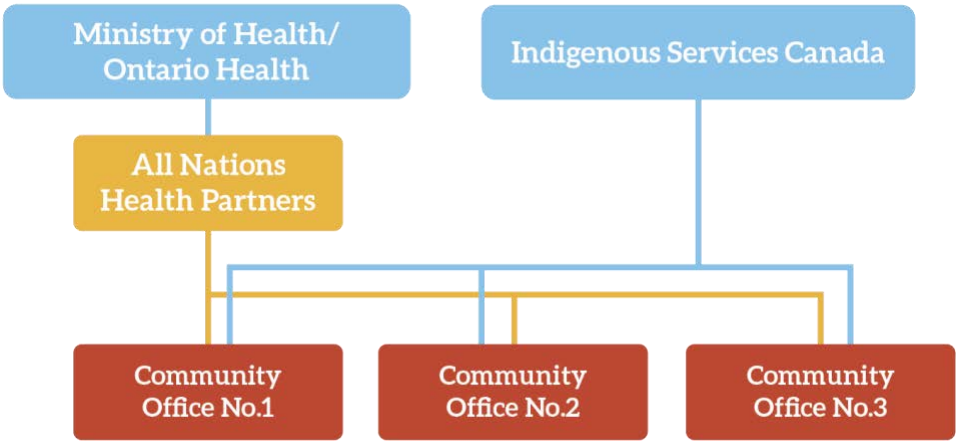
RECOMMENDATION 22

We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Our proposal will illustrate how:

- Advocating for parallel support of Indigenous traditional medicine approaches to healing;
- Working with traditional healers to develop respectful ways to teach learners as well as practicing health care providers on how to work with traditional healers or people who are using traditional healing methods - this may include accreditation; and,
- Developing community partnerships between First Nations communities and health organizations to ensure the inclusion of traditional healing in the primary care models in ways that are respectful, responsive, and directed by First Nations communities and traditional healers.

Figure 11: Managed Health Care Governance Model



ADVANTAGES	DISADVANTAGES
• One clear and consistent strategic direction across all ANHP Communities • Standardized approach and delivery models • Resources shared by one organization across all communities • More feasible to design innovative regional service delivery models based on resources shared across communities and providers.	• Less autonomy and voice at the community level • More complex, a larger organization is required • Requires agreement by all communities on a shared organizational and governance approach • Requires new funding model, organization structure and governance approach

SERVICE DELIVERY MODELS

Historically, most home care services in Ontario have been delivered via contractual relationships with third-party, for-profit providers. These service contracts have been in place for many years, and these contracts were established through requests for proposal processes that were ceased in the early 2000s.

Contacts between these providers and Ontario Health North have been transferred from the old Community Care Access Centres to the Local Health Integration Networks and Ontario Health North.

Once they assume operations, two options for future state service delivery have been proposed for the ANHP.

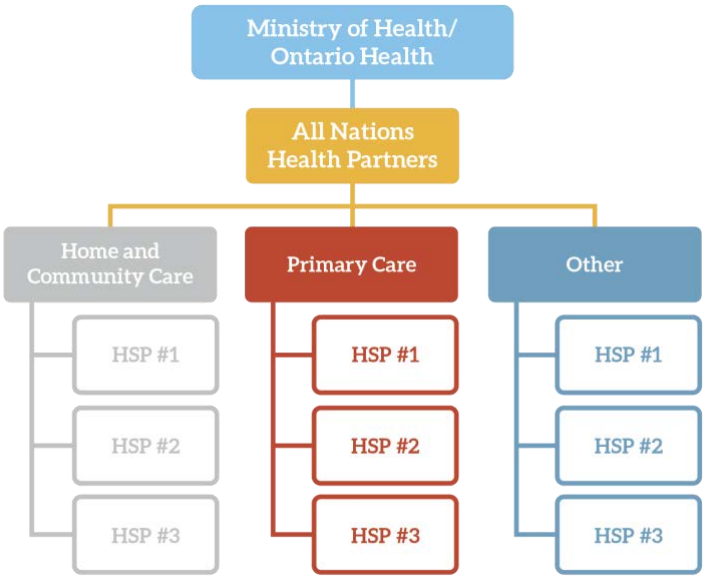
SERVICE DELIVERY MODEL 1 | MODIFIED STATUS QUO

The first service delivery model is called a modified status quo because, similar to the current model, it relies on contracts and transfer payments to provide services to patients and families. Service providers would be contracted and managed through contract terms, specifying service requirements, rather than having staff managed directly by the ANHP.

A benefit of this model will be the ability to reduce the risk to the ANHP concerning labour stability and supply by making that a function of contracting. It also allows the ANHP the flexibility of working with organizations "on the ground," which could be especially beneficial in areas such as remote First Nations communities, where community health organizations understand best the unique needs and challenges in their communities.

Disadvantages include the lack of direct control and staff engagement provided through many different providers. Issues such as training and organizational culture would be difficult to control, manage and standardize.

Figure 12: Service Delivery Model 1 | Modified Status Quo



ADVANTAGES	DISADVANTAGES
• Simple transition from current Ontario Health North service delivery model • Retains existing infrastructure, staffing • Continued contractual obligation with providers, transferring the risk of staffing to contracted providers • Potentially more cost-effective – service provider rates of staffing are assumed to be cheaper	• Less standardization across all communities • More complicated distribution and management of resources • Harder to enact real change and system redesign • Less integration and control of services at the provider and community level • Continued profit component to costs where for-profit service providers are utilized

SERVICE DELIVERY MODEL 2 | INTEGRATED SERVICES MODEL

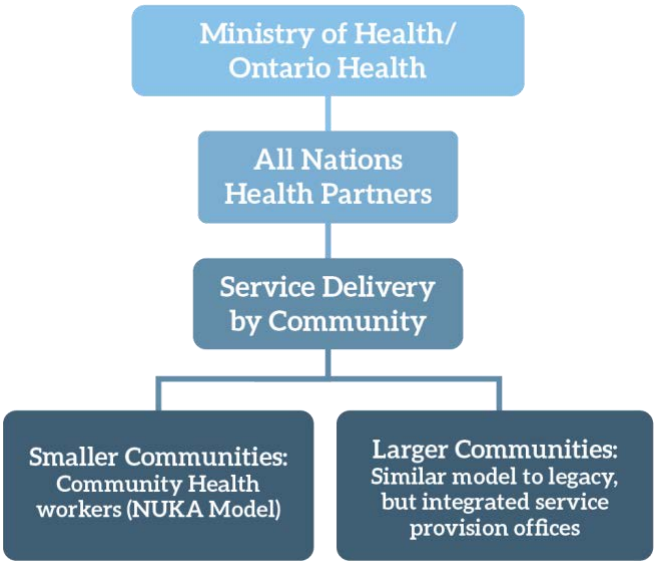
The integrated services delivery model differs from the modified status quo option. It considers the entire ANHP catchment area as one program area rather than a separate delivery zone for each community. This model can provide more flexibility to the service delivery and staffing model.

Instead of having a separate service delivery plan involving more or less discrete levels of staff between communities, staffing roles can be different for each community. Larger communities may staff with traditional roles, while smaller communities have more generalist workers with specialized workers providing support at a distance through periodic travel and/or through telemedicine and videoconferencing.

This proposed model is successfully employed by the Southcentral Foundation in Alaska, more commonly referred to as the NUKA model. Instead of specialist roles in small, remote communities, generalist community health worker roles are residents of the community with specific generalist training and central support. This model helps create a more stable workforce and ensures a sustainable community presence.

This service delivery model is best suited to working in a managed healthcare model (governance option 2) where the same organization provides services in each community. This model allows for seamless policies, procedures and infrastructure (including information technology and systems) to support the smaller community programs. It is possible under both models of governance to make this work. Success will require strong partnerships supported by memorandums of understanding, contracts, and other enablers such as shared coordinator roles, policies, procedures, and systems to enable the integrated services model to work under the modified current state governance model.

Figure 13: Integrated Services Delivery Model



ADVANTAGES	DISADVANTAGES
• More integrated service delivery model • ANHP in control of service provision, more room for flexible, innovative and patient-centred service delivery • Eliminates profit component from costs	• Potentially more costly • Risk of staffing transferred to ANHP, in an era where health human resources are more difficult to recruit and retain

PREFERRED MODELS OF GOVERNANCE AND SERVICE DELIVERY

Throughout the summer and fall of 2021, the HCCS met regularly to review the work included in this report and provide guidance in developing a future state business model. Based on the discussion of the options above and the analysis performed to date, the HCCS unanimously endorsed moving to the second service delivery model presented, the Integrated Services Model.

The group also felt strongly that the ANHP was working towards providing care under a Managed Health Care governance model and however that work was still ongoing. This model was endorsed as the preferred model of governance for this report and the development of the resulting business case and future state services delivery model.

As a result, the final section of this report focuses on developing an Integrated Service Delivery Model governed by a Managed Health Care organization.

CURRENT SERVICE DELIVERY PROCESSES

To provide clarity on the current state and to inform the future state of the service delivery models, the future state processes were mapped by the HCCEC during the project. Services were summarized into four functions:

1. Discharge from Hospital to Community – non-First Nations Communities
2. Discharge from Hospital to Community – First Nations Communities
3. Community referral – non-First Nations Communities, and
4. Community referral – First Nations Communities

First Nations and non-First Nations communities had to be analyzed separately since they had completely different processes. This separate and isolated process is something that the HCCEC felt very strongly needed to change. There needs to be a standardized approach to service delivery, designed and adopted across the entire ANHP catchment area in the future.

The ANHP HCCEC engaged with key stakeholders to map home and community care referral pathways as they exist in the current state. The pathways include the community referral process for First Nations communities and non-First Nations communities and the process for discharging from hospital to Community for First Nations and non-First Nations communities. The pathways were captured in a flowchart (where applicable) and validated by the ANHP HCCEC.

When the current state of the home and community care referral pathways were captured and validated, the ANHP HCCEC developed a future state referral pathway. This pathway depicts how the community referral and hospital discharge process will function in the future state of the ANHP OHT.

CURRENT STATE REFERRAL PROCESS (NON-FIRST NATIONS COMMUNITIES)

The current state referral process for non-First Nations ANHP communities is depicted below Figure 14. This process includes both the community referral process and the hospital referral process. Clients are referred via the community either by phone, fax or walk-in and then present to the intake cue (based in Fort Frances).

Clients in the hospital are referred via the HCC intake resource in-hospital – usually within 24 hours of the initial hospital stay. Whether the client is referred via community or hospital, the client is triaged and assessed according to the existing HCC process. From there, the service initiation request is sent (via CHRIS) to a service provider who accepts or rejects the request. If the client is denied at that point, they are referred to an overflow provider to receive service. The service provider will manage client services and reassess the client as needed, based on their level of need. The client remains in this service cycle until a long-term care bed is secured.

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

While the process for referrals is well-defined for non-First Nations communities, there are many challenges in practice. Once the client is referred to a service provider, there is no mechanism to ensure service occurs in real-time. The reconciliation process to determine whether or not services were initiated is a 30-day process or more. Another common challenge in the process is a general lack of timely re-assessments. Clients are often not receiving re-assessments within the expected timeframe based on their level of need. Finally, there is a stacking issue, as more clients enter the process than exit. As the client caseloads progressively build up over time, the ability to care for those patients becomes increasingly diminished. A major contributing factor to this stacking issue is a relative shortage of LTC beds and lengthy wait-lists for those beds in ANHP communities.

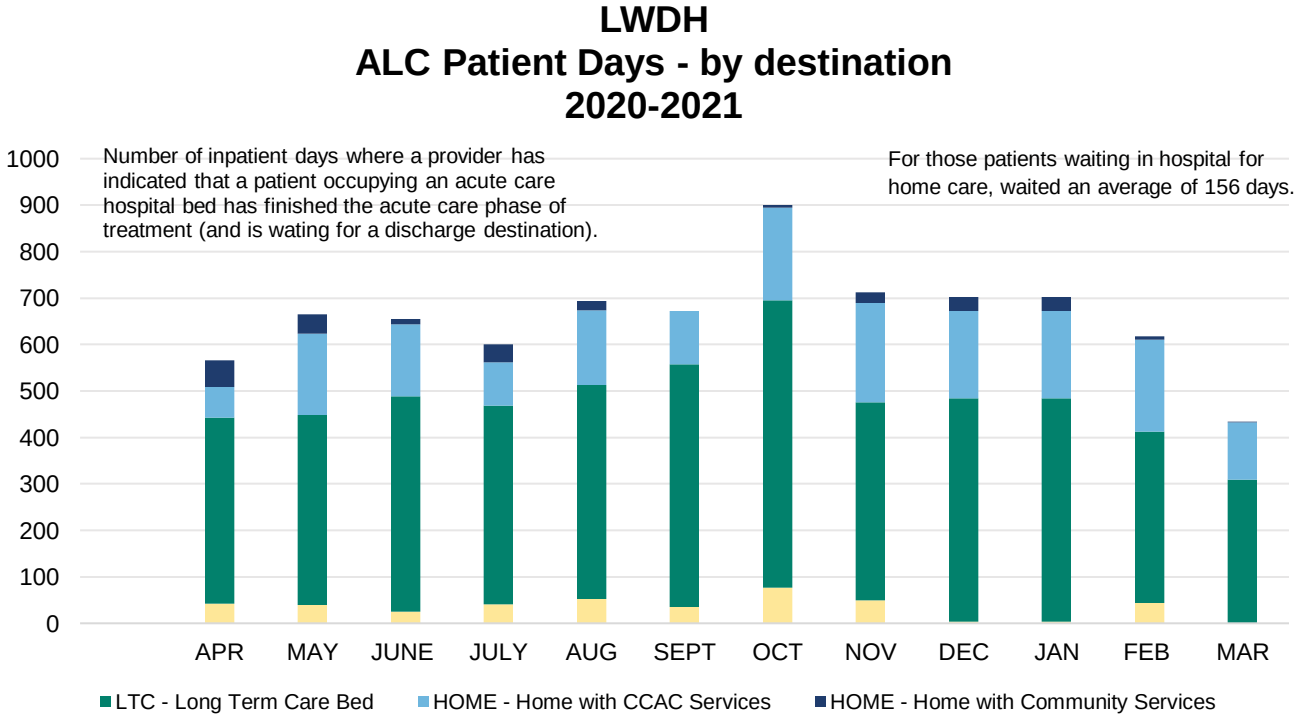
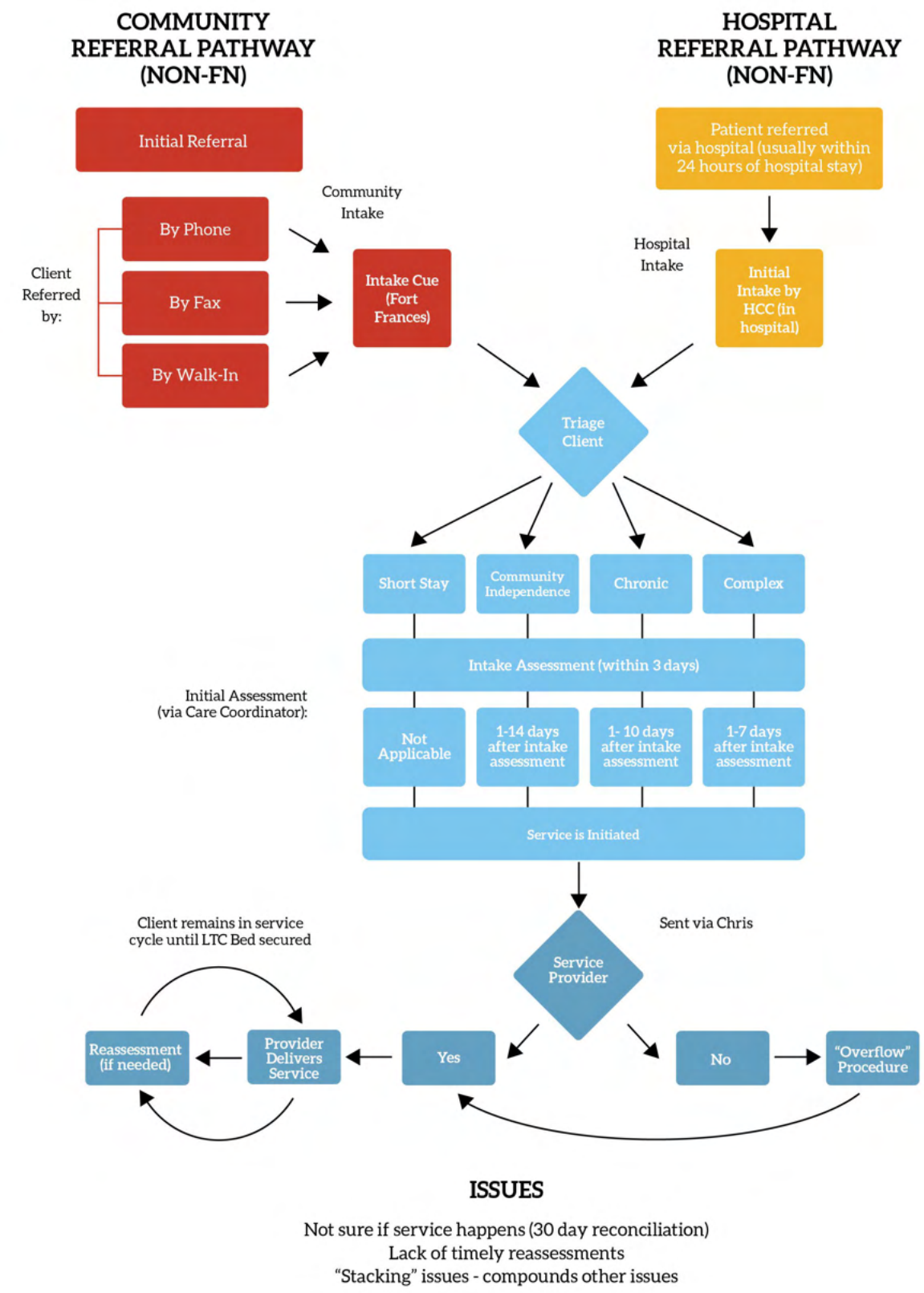


Figure 14: Current State Referral Process (Non-First Nations communities)



CURRENT STATE REFERRAL PROCESS (FIRST NATIONS COMMUNITIES)

For First Nations communities within the ANHP OHT, there is not a standard referral process in place. The home and community care services in place for ANHP First Nations communities are primarily driven by the program initiated by Indigenous Services Canada, which was intended to supplement the home and community care services delivered via the province for on-reserve communities.

The process of delivering home and community care varies from Community to Community for ANHP First Nations communities, although there are some common elements. Home care delivered in the community is based on the nine essential elements of the federally funded program. Each community manages the intake process for its program. While the intake process is not formalized through all home care programs in the region, there is a structure to intake different from the province and even other First Nations communities. Anyone can refer to the program, and there are no exclusion criteria enforced of potential clients. Once clients enter the program, they tend to remain in the program over the long term. The process of organizing and tracking clients within the program is intermittent, primarily driven by personnel rather than process. There are times when tracking measures are well-coordinated and other times when tracking measures are lacking.

There are several challenges with the delivery of home and community care services in ANHP First Nations communities, including:

- **Third-party providers |** There are instances where third-party providers refuse to provide services in remote First Nations communities, citing challenges related to safety and transportation.
- **Staffing |** Communities noted significant challenges and/or an inability to recruit and retain qualified staff to work in their communities.
- **Supply availability |** There are challenges to secure medical and dressing supplies, and there is not the critical mass to warrant stockpiling supplies.
- **Lack of program understanding |** Other service providers, lack a factual knowledge of which services can and cannot be done on-reserve, which leads to coordination challenges and inefficiency.
- **Service delivery |** Many of the programs are delivered at the community nursing station, which has limited days and hours of operation, requires nurses working outside of their scope of practice, has insufficient medical transportation services available, etc.
- **Provincial/Federal coordination |** There are challenges related to coordination of services between the Federal government and the Ontario Ministry of Health.

"It took a long time for my husband to be assessed and qualify for a wheelchair. At first, when he arrived home, we would roll him onto a sheet and I would drag him to the bathroom and together we would pull him up to go to the bathroom. I don't think that was safe, it was hard and I was scared I would hurt myself. But then we qualified for and received a basic wheelchair from home care. It came time to go for a follow-up, I had help from the PSW and we struggled to get him down a make shift ramp and into the wheelchair and as we hobbled it through the ruts left on our gravel driveway from spring freeze/thaw the wheel fell off. It turns out we do not qualify for another wheelchair for two more years! But the first one didn't last because it wasn't strong enough to get him through our driveway, never mind being able to take a walk with him outside for fresh air. I feel isolated and we don't go out because it's too hard, and if I fall and can't move, what if I can't reach our phone, we only have a landline, then we will be lying there until someone finds."

- Elder, Natotkamegwanning First Nation (Phase One Engagement)

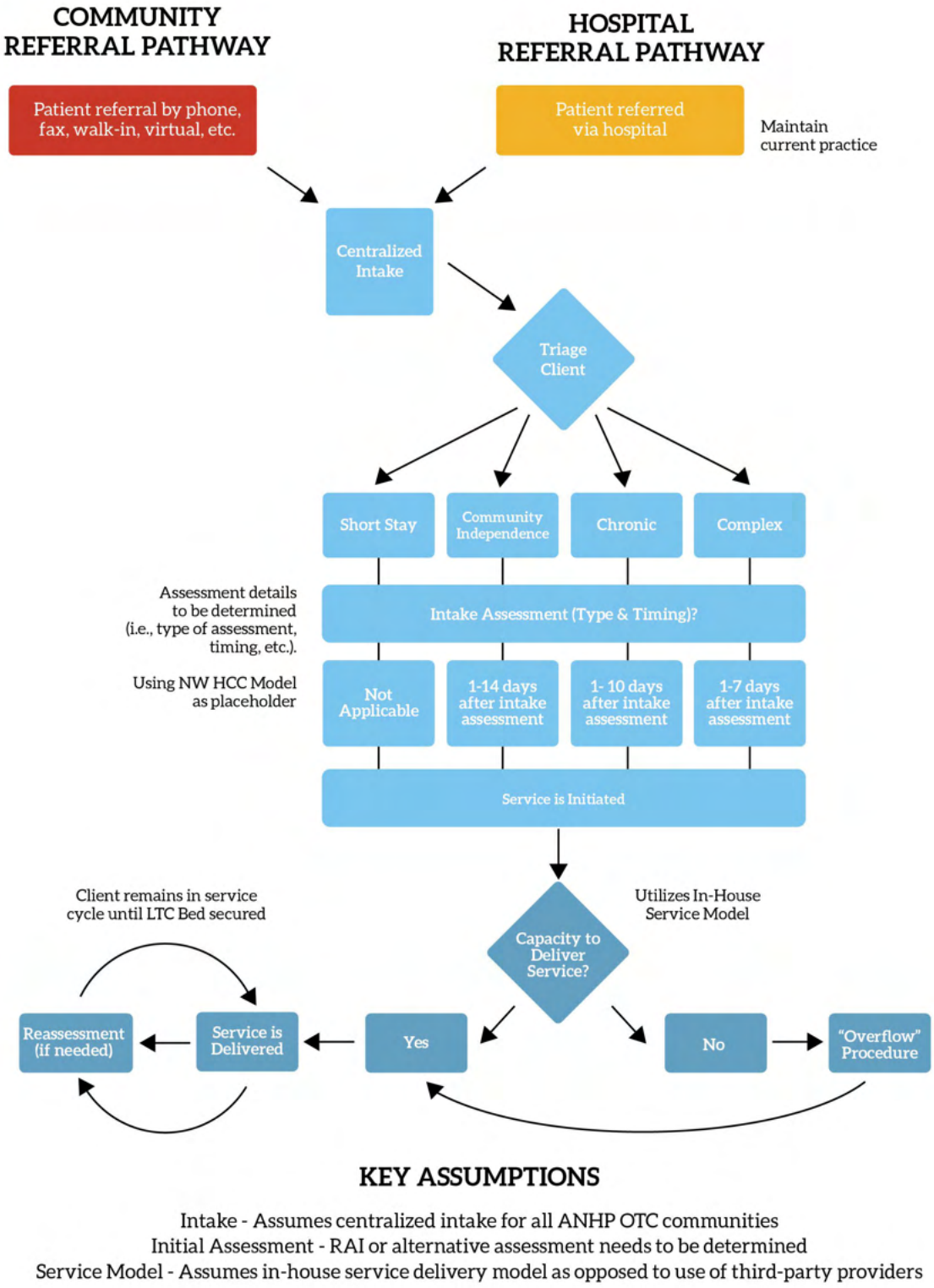
FUTURE STATE REFERRAL PROCESS

The proposed ANHP future state referral process for Home and Community Care Services is depicted below Figure 15. It should be noted that the future state referral process is a conceptual model only and is based on the current state process for non-First Nations communities. The future state model will be refined in subsequent stages of the HCCS planning process. **All participating communities will be included in its development to ensure that the model is equitable and feasible for all ANHP communities.**

The model depicted in Figure 13 is very similar to the existing model for non-First Nations ANHP communities regarding how potential clients are initially referred, assessed and serviced. However, they are some significant differences being contemplated:

- **Centralized Intake |** The first primary difference with the proposed future state model is incorporating a proper centralized intake for all potential clients, whether they present via the community or hospital. The specifics around the centralized intake model still need to be determined at this point.
- **Initial Assessment |** The ANHP OHT will continue using an initial assessment tool for clients. However, the assessment tool may potentially change from the RAI assessment tool currently in use. The ANHP OHT will evaluate available intake assessment tools and choose an assessment that best meets the needs of all ANHP communities.
- **Service Model |** The service model, is the third significant area where the process will change. Rather than using third-party providers, the ANHP OHT will provide Home and Community Care services in-house. While the specifics of the in-house service delivery model need to be determined, in-house service delivery is expected to address many of the challenges that exist with the use of third-party service providers, including the quality and timeliness of services.

Figure 15: ANHP Future State HCCS Referral Process



Future State Business Plan

ASSUMPTIONS

The future state business plan has been created building on the discussion in the preceding sections of this report. The plan assumes the following:

KEY ASSUMPTIONS

- A Managed Health Care model of governance
- An Integrated Service Delivery model
- Transfer of existing resources from Ontario Health North and/or Home and Community Care Support Services North West
- Wage rates comparable to the Hospital and Long-Term Care Sector

HOME AND COMMUNITY CARE SERVICES

The future state business plan envisions the services currently provided by HCCSSNW being provided by ANHP. The proposed model includes a move away from the contracted care model currently in use for much of the current services delivered instead of moving to an organizational model where health care workers are employees of the organization. This model could also work with a modified status quo service delivery model where local organizations and/or First Nations Administration Offices were instead contracted to provide healthcare workers through transfer payment agreements with the ANHP.

Due to the lack of data provided by OHN and HCCSSNW as requested, specific details regarding the current operations were unavailable. Costs were projected using the extrapolating expected staffing requirements from the expected care analysis completed in the preceding sections of this report. Expected hours of care were derived from service hours where available and visit numbers in other instances. Where only visit numbers were available (as was the case for most service categories), an average visit was assumed to be an hour.

RECOMMENDATION 24

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

The ANHP have established a Health Human Resource Working Group who are tasked to:

- Increasing the number of admissions and graduations of First Nations, Métis health professionals into our area;
- Assessing, developing, and resourcing pipeline activities to successfully achieve a representative workforce;
- Exploring partnership opportunities to improve the retention of Aboriginal health care providers in Aboriginal health regardless of the location of practice;
- Recommending that all health care professionals who have contact with learners should receive cultural safety training and that a variety of methods and opportunities should be available; and,
- Further developing remediation processes for clinical teachers that are safe for learners who experience or witness culturally unsafe care or teaching.

Other expenses were extrapolated and estimated through a review of the audited financial statements of the various organizations that delivered home and community care services throughout the years, including the Northwest CCAC, OHN and HCCSSNW. Costing estimates and assumptions were validated as often as possible through discussions with these organizations' current and former staff members with subject matter expertise.

To aid in costing, services were grouped into categories representing job roles to allow for certain positions' wage rates to be estimated. The following is a summary of these wage rate estimations:

Table 6: Positions and Wage Rates Used in the Business Case

ROLE	SERVICE TYPES*	EST WAGE RATE
Community Registered Nurse (RN)		
	(01) NURSING-VISIT	
	(02) NURSING-SHIFT (HOUR)	
	(18) RAPID RESPONSE NURSING VISIT	
	(23) Telehomecare	
	(24) Primary Care	
Total Community RN	**Community RN**	**$44.00**
Care Coordinator		
	(10) CASE MANAGEMENT	
Total Care Coordinator	**Care Coordinator**	**$28.00**
Personal Support Worker (PSW)		
	(11) PERSONAL SERVICES (HOUR)	
	(13) COMBINED PERSONAL SUPPORT AND HOMEMAKING SERVICES (HOUR)	
	(15) RESPITE (HOUR)	
	Homemaking	
	Visiting and Social Safety	
Total PSW	**Personal Support Worker**	**$23.00**
Allied Health		
Dietician	(04) NUTRITION/DIETETIC	$41.00
Physiotherapist	(05) PHYSIOTHERAPY	$43.00
Occupational Therapist	(06) OCCUPATIONAL THERAPY	$43.00
Speech Language Pathologist	(07) SPEECH LANGUAGE THERAPY	$45.00
Social Worker	(08) SOCIAL WORK	$41.00
Other Services		
RN	(16) MENTAL HEALTH AND ADDICTION NURSING VISIT	$44.00
Nurse Practitioner	(17) NURSE PRACTITIONER PALLIATIVE VISIT	$60.00
Community Worker	Home Maintenance	$23.00

** Service types are as defined per the Home Care Database (Sourced from Intellihealth Ontario)*

The cost of employee benefits was added to the estimated staffing costs using an estimated benefits rate of 25%.

COMMUNITY SUPPORT SECTOR | MSAA-FUNDED SERVICES

Community Support Sector-funded services were included in the analysis by utilizing service benchmarks and costing from the LASP, which, as discussed above, is a population-based planning model for these services.

RECOMMENDATION 23

We call upon all levels of government to:

- Increase the number of Aboriginal professionals working in the health care field.
- Ensure the retention of Aboriginal healthcare providers in Aboriginal communities.
- Provide cultural competency training for all healthcare professionals.

LASP estimates are based on population figures for those aged 65 and older. The ANHP catchment area population estimates were used to estimate funding available for these services.

CSS SERVICE	POPULATION 65+	UNITS OF SERVICE* PER 65+	UNITS OF SERVICE BASED ON POPULATION	COST PER UNIT OF SERVICE	MODELLED FUNDING
Homemaking	5,135	0.8	3,851	31.1	$119,762
Home Maintenance	5,135	2.0	10,270	32.3	$331,364
Visiting and Social Safety	5,135	1.3	6,419	37.8	$242,820
TOTALS					**$693,946**

** Units of service are as defined in the LASP*

The resulting funded amount of $693,946 was added to the estimated home care service levels and assumed to be available for redistribution in the new integrated service delivery model.
This funding assumes not redistributing from current health service providers funded to provide Homemaking, Home Maintenance and Visiting and Social Safety programs through M-SAA-funded programs in the ANHP catchment area. These include the following service providers, who are each ANHP partner organizations:

- Kenora Chief's Advisory
- aasegii hig Nanaandawe'iyewigamig
- Board of Management of the District of Kenora Home for the Aged (The)

The current total MSAA funded programming these organizations offer (as of the date of this report or the most recent MSAA available) is shown below. **Note the total current funded amount of $699,316 is close to the expected funding amount of $693,946 added to the business case modelling.**

ORGANIZATION	CSS SERVICE	MODELLED FUNDING
First Nations Community Directed	Homemaking	$45,490
	Home Maintenance	$359,490
	Visiting and Social Safety	$11,655
	Subtotal	**$416,635**
Waasegiizhig Nanaandawe'iyewigamig	Homemaking	$-
	Home Maintenance	$52,107
	Visiting and Social Safety	$2,590
	Subtotal	***$54,697***
Board of Management of the District of Kenora Home for the Aged (The)	Homemaking	$143,500
	Home Maintenance	$28,500
	Visiting and Social Safety	$55,984
	Subtotal	***$227,984***
TOTAL		**$699,316**

FEDERAL FUNDED SERVICES

Information regarding federally-funded home care services provided to First Nations-specific service providers and communities directly was gathered from discussions with providers and community leaders using a standardized information gathering template. The community summarized information regarding federal funding and added to the available funding per community directly. The following summarizes the amounts of funding added to the business case:

Table 7: Federally-Funded Programming Summary

STAFFING ROLE | COMMUNITY	ISC HOME SUPPORT FIRST NATIONS			ISC HOME CARE FIRST NATIONS	ISC HCCS WNHAC
	HOME SUPPORT TOTAL	COMMUNITY COORDINATOR	HOMEMAKING PROGRAM	ISC HOME CARE FUNDING	PERSONAL SUPPORT
Grassy Narrows	$86,323	$15,615		$204,004	
Wabaseemoong	$90,980		$45,490	$253,557	
Animakee Wa Zhing 37B (Windigo Island)	$35,576				$45,000
Northwest Angle No 33B (Angle Inlet)	$35,576				$45,000
Iskatewizaagegan #39 (Shoal Lake 39)					
Shoal Lake 40	$54,697	$8,923		$90,578	
Niisaachewan (Dalles)	$54,607	$8,923		$75,874	
Naokamegwanning (Whitefish Bay)	$13,670	$14,100			
Northwest Angle 37A (Dog Paw)					$45,000
Animakee Wa Zhing 37A (Regina Bay)					$45,000
Obashkaandagaang & Washagamis Bay	$54,068	$15,411		$83,205	
Wauzhushk Onigum	$35,576			$126,033	
SUBTOTALS	**$461,073**	**$62,972**	**$45,490**	**$833,251**	**$180,000**
TOTAL					**$1,582,786**

**Communities self-direct homemaking, PSW and Community Coordinators*
**For KCA serviced communities contract nursing.*

FUTURE STATE MODEL

Funding levels from the provincially and federally funded programs described above were combined into one total allocation to develop a future state service delivery model for the ANHP. Home care services make up the majority of the services available for use. A draft allocation was calculated per community based on the expected demand calculated by analyzing population estimates by 5-year age groups.

Envisioned staffing resources by funding type are summarized in Appendix A. The total expected staffing resources to be allocated is $6,805,015. This total was based on federal and provincial allocations:

- $5,222,239 in aggregate from Provincially funded sources, including MSAA and Home and Community Care funded resources, and
- $1,582,786 in federally-funded services, including ISC-funded home care provided through WNHAC and KCA

Federally-funded services directed to specific communities were not re-allocated – it was assumed that these would augment community resources rather than be available for reallocation throughout the ANHP catchment areas.

DIRECT SERVICES AND RELATED EXPENSES

All direct services, other than those federally-funded and directed to specific first-nations communities, including all provincially-funded services, were allocated to communities based on the "expected" service levels established through the processes described in preceding sections in great detail. Expected services were grouped into staffing roles by the community. Benefit costs were estimated at 25% of estimated gross wage expenses.

DIRECT SERVICES STAFFING | SMALLER VS. LARGER COMMUNITIES

Traditional staffing roles were utilized in the larger communities, most notably Kenora. In the smaller communities, the draft allocation reflects "Community Worker" roles. These staffing roles are intended to provide generalist rather than specialist care to maximize the services provided to communities and improve staffing stability. These roles are akin to the award-winning "Nuka" model of care developed but the Southcentral Foundation in Alaska, USA, for care in remote and rural communities. This model was discussed above.

The draft allocation prioritizes full-time positions in rural and remote communities to increase the staffing pool's stability. Full-time positions help with recruitment and retention efforts in smaller communities by making these positions more attractive to non-residents of the community. RN positions in communities were prioritized for full-FTE allocations due to the specialty training and credentials required. Community Workers are more likely to be filled by local candidates, and therefore these positions were allocated in 0.25 FTE increments.

SUPPLIES COSTS

Supply costs have been estimated using information from the publicly available audited financial statements of the former North West LHIN and North West CCAC. Figures from the last available North West CCAC financial statements were used to generate client services supplies since categorization of supplies changed after the merger with the North West LHIN in 2017. These supply costs only pertain to the provincially-funded portion of care, and Federally-funded supplies would be assumed to be unchanged and provided to the funded communities directly.

It is important to note inequity among medical supplies between the federal and provincial program. It is ANHP OHTs desire to have medical supply parity for all clients.

Table 8: Supply Cost Estimates for ANHP

	2015-16	2014-15
Purchased Supplies	$2,600,792	$2,495,792
Other Client Supplies	$1,204,840	$1,190,308
TOTAL	**$3,805,632**	**$3,686,100**
Per capita cost	$15.87	$15.37
ANHP ESTIMATE	**$454,942**	**$440,653**
WITH INFLATION AT 1% PER YEAR	**$487,759**	

Supply costs related to client services related to the ANHP's are estimated at $490,000. This estimate appears to be reasonable. The total of medical supplies and equipment from the North West LHIN's 2020/21 financial statements was $4,158,999, which is very close to the total from 2015-16 with seven years of inflation at 1%. A review of service volumes overall in the North West LHIN area showed that service volumes had fallen by 3%; however, nursing services increased by 9% over the same period, which offset the overall decline.

OTHER EXPENSES AND OVERHEAD

CARE COORDINATION | INDIRECT CLIENT SERVICE

Care coordination estimates have been included in the portion of the direct costs above based on the statistics that HCCSSNW keeps. These statistics reflect only direct client interactions, and indirect client services and care coordination activities are estimated at 40% of the total direct service time.

Total estimated FTE for Care Coordinators based on direct client interaction statistics is 5.5 FTE. Including the premium for indirect client services, a further 2.2 FTE would be required. Total care coordination staff is estimated at 7.7 FTE. Per discussion with HCCSNW staff, current staffing is approximately 75 FTE Care Coordinators, 25 Team Assistants and 8 Managers in total. Table 9 shows how that staffing level translates to the ANHP staffing on a per-capita basis to estimate the FTE requirement.

Table 9: Indirect Client Services Staffing Estimates

	NORTH WEST LHIN	ANHP ESTIMATE	WAGE RATE ESTIMATE	COST ESTIMATE
Total Population	239,834	28,672		
Share of Population		12.0%		
Staffing				
Care Coordinators	75.0	9.0	$35	**$765,253**
Team Assistants	25.0	3.0	$25	**$182,203**
Managers	8.0	1.0	$60	**$140,400**
Less Care Coordinators included in Direct				**$(375,375)**
TOTAL INDIRECT SERVICES STAFFING				**$712,481**

OVERHEAD AND ADMINISTRATION EXPENSES

To oversee operations, ANHPs will require reasonable funding to support overhead and administration expenses related to the operations of Home and Community Care Support Services. These expenses have been estimated at a high level for this report using information from audited financial statements of the legacy North West CCAC and North West LHIN operations[4].

Table 10: Estimated Administration and Overhead Expenses

	2015-16	2014-15
Purchased Supplies	$37,515,884	$34,857,273
Other Client Supplies	$14,176,423	$12,998,449
TOTAL	**$51,692,307**	**$47,855,722**
Administration and Overhead Expenses	$4,832,620	$5,172,944
Administration & Overhead | Percentage of Total	**9.3%**	**10.8%**

As shown in Table 10 in past years, the North West CCAC operations were able to function with overhead administration and expenses at approximately 10% of client services costs. Operationally 10% was known internally and externally as a critical target for CCACs to meet. After 2015/16, the CCACs merged operations with the North West LHIN. Since that time, it has been impossible to distinguish the HCC operations from other LHIN operations; therefore, the target of 10% is recommended for the purposes of this report.

[4] As of this report date, the current provider, HCCSSNW has not yet published audited financial statements or any other financial reporting and/or made them available to the public. Data were requested from OHN, however they were not provided.

FUTURE STATE MODEL COST ESTIMATE | SUMMARY

The table below summarizes the estimated costs and funding required to operationalize the future state model presented throughout this report. In total, it is expected that services will cost $8,805,782 on an annual basis, offset by Federal funding of $1,582,786 already in place for existing services **(services which would still be provided to the same communities as per existing contribution agreements with ISC).**

Table 11: Summary Home and Community Care Estimated Costs and Funding Required

Direct Staffing & Benefits	$6,805,015
Indirect Services Staffing	$712,481
Medical Supplies[5]	$487,759
Subtotal	$8,005,256
Overhead & Administration	$800,526
Total Projected Expenses	$8,805,782
Less Federal Funding	$(1,582,786)
PROVINCIAL FUNDING REALLOCATION REQUIRED	**$7,222,996**

Operationalizing this future state model would require a reallocation of Ontario Ministry of Health funding from HCCSSNW to the ANHP OHT for $7,222,996. This future state would support Ontario's connected care strategy and set a positive precedent for OHT development.

This amount does not include start up and transition costs, which would be significant. These costs are estimated to be between $800,000 and $1,200,000 but would be subject to a more detailed costing exercise to determine future planning efforts.

[5] See above supplies section – not including federally-funded supplies provided to communities directly and not expected to be reallocated

Appendices

APPENDIX A: RESOURCE ALLOCATION SUMMARY

	Provincial											*Federal - Home Support Budget (2021-22) - First Nations*				*ISC Home Care - First Nations*				WNHAC HCCS Inventory	Total Funding Available
Staffing Role | Community	Community RN	Care Coordinator	Personal Support Worker	Dietician	Physiotherapist	Occupational Therapist	Speech Language Pathologist	Social Worker	Mental Health RN	Nurse Practicioner	Community Worker	Home Support Total ($)	Community Coordinator ($)	Homemaking Program ($)	HS Workers (FTE)	ISC Home Care Funding ($)	Nurses (FTE)	PSW (FTE)	Home Care Coordinator (FTE)	Personal Support (Federal)	
Suggested Resources | Wage Rates	$ 55	$ 35	$ 29	$ 51	$ 54	$ 54	$ 56	$ 51	$ 55	$ 75	$ 29										
Grassy Narrows	$ 20,086	$ 2,097	$ 22,391	$ 67	$ 613	$ 489	$ 180	$ 123	$ 94	$ 120	$ 1,323	$ 86,323	$ 15,615	$ -	3.00	$ 204,004	1.50	-	1.00	$ -	**$ 353,523**
Wabaseemong	$ 25,839	$ 2,643	$ 28,155	$ 72	$ 763	$ 624	$ 231	$ 149	$ 110	$ 158	$ 1,265	$ 90,980	$ -	$ 45,490	4.00	$ 253,557	1.50	-	1.00	$ -	**$ 450,034**
Animakee Wa Zhing 37B (Windigo Island)	$ 1,425	$ 189	$ 2,084	$ -	$ 59	$ 43	$ 6	$ -	$ 6	$ 8	$ 115	$ 35,576	$ -	$ -	1.00	$ -	-	-	-	$ 45,000	**$ 84,510**
Northwest Angle No 33B (Angle Inlet)	$ 4,252	$ 536	$ 5,511	$ 10	$ 177	$ 124	$ 17	$ 41	$ 28	$ 45	$ 690	$ 35,576	$ -	$ -	2.00	$ -	-	-	-	$ 45,000	**$ 92,006**
IIFN 39 (Shoal Lake 39)	$ 11,908	$ 1,222	$ 13,021	$ 41	$ 366	$ 296	$ 101	$ 72	$ 55	$ 60	$ 518	$ -	$ -	$ -	-	$ -	-	-	-	$ -	**$ 27,658**
Shoal Lake 40	$ 5,049	$ 578	$ 6,385	$ 5	$ 188	$ 129	$ 23	$ 21	$ 33	$ 45	$ 920	$ 54,697	$ 8,923	$ -	2.00	$ 90,578	0.25	-	1.00	$ -	**$ 167,573**
Niisaachewan (Dalles)	$ 7,403	$ 781	$ 8,323	$ 10	$ 247	$ 183	$ 62	$ 46	$ 39	$ 60	$ 863	$ 54,607	$ 8,923	$ -	2.00	$ 75,874	0.25	-	1.00	$ -	**$ 157,420**
Naokamegwanning (Whitefish Bay)	$ 25,102	$ 2,804	$ 30,400	$ 72	$ 871	$ 645	$ 225	$ 159	$ 160	$ 203	$ 2,473	$ 13,670	$ 14,100	$ -	1.00	$ -	-	-	-	$ -	**$ 90,882**
Northwest Angle 37A (Dog Paw)	$ 2,695	$ 263	$ 2,720	$ -	$ 65	$ 54	$ 6	$ 10	$ 17	$ 8	$ 115	$ -	$ -	$ -	-	$ -	-	-	-	$ 45,000	**$ 50,950**
Animakee Wa Zhing 37A (Regina Bay)	$ 3,724	$ 350	$ 3,899	$ -	$ 81	$ 65	$ 17	$ 10	$ 11	$ -	$ 58	$ -	$ -	$ -	-	$ -	-	-	-	$ 45,000	**$ 53,213**
Obashkaandagaang & Washagamis Bay	$ 17,628	$ 1,988	$ 20,139	$ 51	$ 656	$ 489	$ 118	$ 144	$ 143	$ 158	$ 1,898	$ 54,068	$ 15,411	$ -	2.00	$ 83,205	0.50	-	1.00	$ -	**$ 196,095**
Waugushk Onigum	$ 12,194	$ 1,267	$ 13,935	$ 26	$ 376	$ 312	$ 113	$ 82	$ 50	$ 68	$ 690	$ 35,576	$ -	$ -	1.00	$ 126,033	1.00	-	-	$ -	**$ 190,720**
Shoal Lake 40	$ 3,278	$ 364	$ 4,005	$ -	$ 113	$ 91	$ 11	$ 15	$ 22	$ 15	$ 288	$ -	$ -	$ -	-	$ -	-	-	-	$ -	**$ 8,202**
Kenora	$ 1,125,344	$ 173,464	$ 1,644,026	$ 3,295	$ 64,694	$ 40,221	$ 13,039	$ 10,066	$ 10,852	$ 20,490	$ 180,435	$ -	$ -	$ -	-	$ -	-	-	-	$ -	**$ 3,285,924**
Sioux Narrows & Nestor Falls	$ 63,569	$ 8,589	$ 82,702	$ 185	$ 3,198	$ 2,086	$ 568	$ 579	$ 556	$ 998	$ 12,133	$ -	$ -	$ -	-	$ -	-	-	-	$ -	**$ 175,161**
Reddit & Minaki & Wauzhushk Onigum	$ 528,523	$ 69,136	$ 666,879	$ 1,630	$ 25,365	$ 16,926	$ 4,427	$ 4,669	$ 4,439	$ 7,673	$ 91,483	$ -	$ -	$ -	-	$ -	-	-	-	$ -	**$ 1,421,147**
																					$ 6,805,015

APPENDIX B: A PEOPLE-CENTRED APPROACH TO CARE

ALL NATIONS
HEALTH PARTNERS

FSET

807 MANAGEMENT SERVICES

March 2022