TD 150-19(2) TABLED ON JUNE 12, 2020

Northwest Territories
Health and Social Services

Prepared by: MNP LLP

Government of Northwest Territories

NWT Home and Community Care Review

Final Report

September 26, 2019

Best health | Best care | Better future

| www.hss.gov.nt.ca

TABLE OF CONTENTS

Executive Summary i

Introduction i
Purpose and Scope of the Review i
Review Approach ii
Conclusions iii
Recommendations vi

1. Introduction 1

1.1 Home and Community Care in the NWT 1
1.2 Purpose and Scope of the Review 4

2. Approach and Methodology 6

2.1 Report Limitations 9

3. Current State Assessment Findings 11

3.1 Supply-Side Analysis 11
3.2 Effectiveness of HCC Service Delivery Across the NWT 28
3.3 Usage of Forms, Policies, and Procedures 33
3.4 Efficiency of HCC Service Delivery Across the NWT 43

4. Future Requirements and Projected Demand for NWT HCC Services 46

4.1 Service Delivery Improvements 46
4.2 Perceived Service Delivery Gaps for HCC Clients 49
4.3 Projected Demand for HCC Services in the NWT 54

5. Jurisdictional Analysis 65

5.1 Home and Community Care Services Across Canada 65
5.2 Models, Standards and Practices in Select Jurisdictions 71

6. Conclusions and Recommendations 85

6.1 Key Conlusions and Themes 85
6.2 Recommendations 88

Appendices 101

Appendix A – Review Matrix 101
Appendix B – Interview Guides 106
Appendix C – Form Inventory and Category Defintions 118
Appendix D – Key Assumptions for Projection Model 1 127
Appendix E – Key Assumptions for Projection Model 2 130
Appendix F – Key Assumptions for Recommendation 9 133

LIST OF TABLES

Table 1: Overview of NWT HCC Program 2

Table 2: Summary of Key Informant Interviews 8

Table 3: Summary of HCC Staffing Complements by Funding Source (2014/15 to 2017/18) and 2018/19 Projection 14

Table 4: Ratio of HCC Staff to Population by Community and HSSA/Region 18

Table 5: Utilization of NWT HCC Services by HSSA, Region and Community 19

Table 6: Estimated Client Caseload in 2017/18 Based on Revised Data 22

Table 7: Breakdown of HCC Service Hours by Type of Service by HSSA/Region 24

Table 8: Breakdown of HCC Service Hours by Activity by HSSA/Region 25

Table 9: Summary of Annual HCC Referral, Admission, and Discharge Data by Community and HSSA/Region 27

Table 10: NWT HCC Program Variance Analysis 44

Table 11: Population Growth by Age Group in the NWT from 2008 to 2018 55

Table 12: Population Growth of 60 Plus Age Demographic by Community from 2007 to 2017 56

Table 13: HCC Client Age Distribution by Community 57

Table 14: Population Age Projections by Age Group and HSSA/Region to the Year 2035 58

Table 15: Comparison of Maximum Home Support Hours of Service in Canadian Jurisdictions 65

LIST OF FIGURES

Figure 1: Approach to Review 6

Figure 2: NWT HCC Program Areas of Review 7

Figure 3: Comparison of HCC Services by NWT Region 12

Figure 4: Trends in HCC Client Numbers by HSSA and Region 20

Figure 5: Trends in HCC Client Numbers for NTHSSA – Yellowknife Region and NWT Overall 21

Figure 6: Trends in Hours of HCC Service by HSSA and Region 23

Figure 7: Types of Documents Used by Different HSSAs/Regions in the NWT 34

Figure 8: Level of Spending and Budget per HCC Client by HSSA and Region in 2017/18 ... 45

Figure 9: Projected Demand for HCC Services by Age Group and HSSA/Region in the NWT under Projection Model 1 61

Figure 10: Projected HSW Staffing Requirements by HSSA/Region under Projection Model 1 62

Figure 11: Projected Nursing Staff Requirements by HSSA/Region under Projection Model 1 62

Figure 12: Projected Demand for HCC Services by Age Group and HSSA/Region in the NWT under Projection Model 2 63

Figure 13: Projected HSW Staffing Requirements by HSSA/Region under Projection Model 2 64

Figure 14: Projected Nursing Staffing Requirements by HSSA/Region under Projection Model 2 64

Figure 15: Comparison of HCC Services Available by Canadian Jurisdiction 66

Figure 16: Summary of Client Fees for HCC Services in Different Jurisdictions 68

Figure 17: Summary of HCC Services Provided by a Sampling of Indigenous Health Authorities Across Canada 70

Figure 18: Recommended Projected Demand Model for HCC Services by Age Group and HSSA/Region in the NWT 93

Figure 19: Projected HSW Staffing Complements by HSSA/Region from 2020 to 2035 94

Figure 20: Projected HCC Nurse Staffing Complements by HSSA/Region from 2020 to 2035 95

Figure 21: Projected Additional Funding Required for Additional HSW/Nursing Staff 96

GLOSSARY

ADL	Activities of Daily Living
CCAP	Continuing Care Assessment Package
CCB	Continuing Care Branch
CHN	Community Health Nurse
CSA	Community Services Agency
DHSS	Department of Health and Social Services
DHW	Department of Health and Wellness (Nova Scotia)
DSL	Designated Supported Living
EMR	Electronic Medical Record
EMS	Emergency Medical System
FNIH	First Nations and Inuit Health
FNIHB	First Nations and Inuit Health Branch
FNIHCC	First Nation and Inuit Home and Community Care Program
FT	Full-Time
FTE	Full-Time Equivalent
GNWT	Government of Northwest Territories
HC	Home Care
HCA	Home Care Attendant
HCC	Home and Community Care
HRHSSA	Hay River Health and Social Services Authority
HSSA	Health and Social Services Authority
HSW	Home Support Worker
IADL	Instrumental Activities of Daily Living
ICT	Information Communication Technology
ISDM	Integrated Service Delivery Model
LHIN	Local Health Integration Network
LPN	Licensed Practical Nurse
LTC	Long-Term Care
MNP	MNP LLP (Contract consultant)
NIC	Nurse in Charge
NP	Nurse Practitioner
NTHSSA	Northwest Territories Health and Social Services Authority
NWT	Northwest Territories
OT	Occupational Therapist
PCA	Personal Care Attendant
PT	Physiotherapist
RHA	Regional Health Authority
RN	Registered Nurse
SFMC	Self and Family Managed Care
SMC	Self-Managed Care
SL	Supported Living
TCSA	Tlicho Community Services Agency

EXECUTIVE SUMMARY

INTRODUCTION

In 2004, the Northwest Territories (NWT) Department of Health and Social Services (DHSS) and Health and Social Services Authorities (HSSAs) adopted the Integrated Service Delivery Model (ISDM). The ISDM is a team-based, client-focused approach to providing health and social services in the NWT.

As a core service of the DHSS ISDM, continuing care services are delivered through three program streams, including:

- **Home and Community Care (HCC);**
- Supported Living (SL); and
- Long-Term Care (LTC) and Extended Care.

The delivery of HCC services in the NWT is reliant on the other core services in the NWT ISDM to ensure that clients have access to a multidisciplinary team of health service providers. HCC services provide individuals with nursing care as well as support for personal care and daily living activities when they are no longer able to perform these activities on their own. These services aid with maintaining independence for individuals in the places where they are most comfortable: HCC services support individuals with staying in their own homes rather than a hospital or LTC facility.

Improving HCC services and caregiver supports to enable seniors and elders to live in their own homes for as long as possible is a key objective (Objective 2) in the Government of Northwest Territories' (GNWT) current Continuing Care Services Action Plan. One key activity for achieving this objective is conducting a comprehensive territorial review of HCC services by region and community.

PURPOSE AND SCOPE OF THE REVIEW

GNWT has identified a need to be better positioned to respond to the growing demand for HCC services in the future. It is within this context that the GNWT DHSS contracted MNP LLP (MNP), a chartered accounting and business advisory firm, to conduct a comprehensive program review of the HCC program in the NWT.

The intent of this review is to inform options and decisions based on the best and most current data regarding optimal allocation of resources and future investments to HCC programs and services.

The scope of this review included the following activities:

- Conducting a comprehensive review of HCC services by region and community across the NWT;
- Conducting a demand-side analysis by region and community across the NWT;

- Conducting a targeted jurisdictional review of models, standards and practices in provincial/territorial jurisdictions;
- Conducting a supply-side analysis of the current HCC programs and related services the NWT has in place today;
- Conducting a gap analysis that identifies significant gaps in HCC programs and services in the NWT; and
- Identifying communication tools and methods to ensure the NWT is maximizing the use of existing resources.

The services examined as part of this review included: nursing services (in-home nursing care), home support (personal support, homemaking, home maintenance), in-home respite, and in-home palliative care.

REVIEW APPROACH

Project work was structured into three distinct, but linked phases. Each phase had distinct steps and outcomes.

A review matrix was developed to guide the HCC review and included 8 areas of review organized into 4 categories.

Review Category	Area of Review
Supply-Side Analysis and Current State Assessment	1. Types of HCC services provided across the NWT. 2. Utilization of HCC services across the NWT. 3. Effectiveness of HCC service delivery across the NWT. 4. Efficiency of HCC service delivery across the NWT.
Demand-Side Analysis	5. Projected demand for HCC services in the NWT. 6. Financial and resource requirements to meet future demand.
Jurisdictional Analysis	7. Best practices, trends, and innovative solutions from other jurisdictions for providing HCC services that support elders with aging in place.
Communication Review	8. Effectiveness of communication methods and tools used to promote HCC services in the NWT.

Data informing analysis and ultimately development of the report was collected using three methods including a detailed review of background documentation and administrative data; key informant consultations including 19 interviews and 18 focus groups; and best practice research including online research and discussions with representatives from other jurisdictions.

Overall, MNP visited 7 communities across the NWT to complete interview and focus group sessions with stakeholders including Behchoko, Fort Good Hope, Fort Simpson, Hay River, Inuvik, Norman Wells, and Yellowknife.

The HCC review findings were limited by the reliability and quality of data reported in the Health Suite system. In particular, the data collection and reporting processes for Health Suite data are inconsistent and not standardized. In addition, the system is time-dated and no longer functional as a reporting tool to inform decision-making. Accordingly, the data available limited the accuracy of the current state analysis and created difficulty with the development of reliable and accurate future state projections, which were limited to in-home services and did not include clinic-based services.

CONCLUSIONS

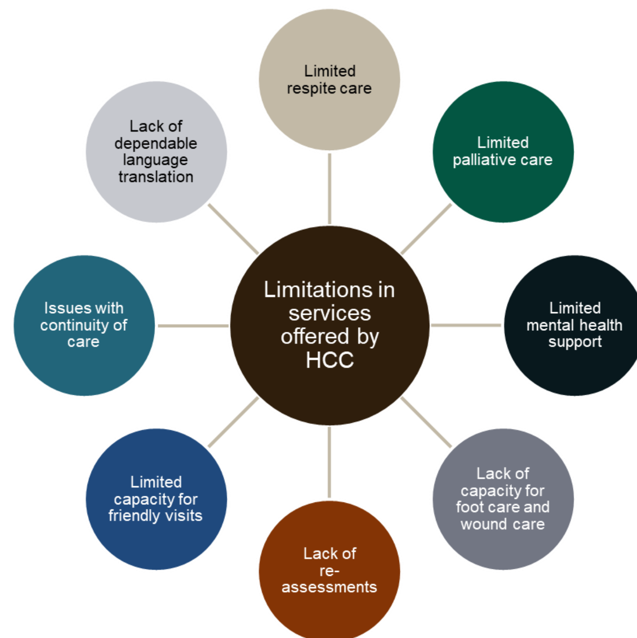
Conclusions were drawn based upon areas where either both quantitative and qualitative data existed to substantiate findings, or where strong perceptions by a majority of stakeholders existed in the absence of quantitative data.

1. **Overall, HCC program spending represented 3.2% of the total DHSS budget in 2017/18.** This is significantly lower than spending on HCC programs in other provinces such as Manitoba, Alberta and Newfoundland.
2. **The delivery of HCC services across the NWT is fragmented and inconsistent.** The services delivered by each HSSA/region vary and is dependent on the size of each community and the resources that exist to provide services.
3. **There are disparities and inequities in the delivery of HCC services between HSSAs/regions.** These were perceived to be due to the historical funding approach for HCC services rather than having a funding approach that is based on need.
4. **All communities report difficulties with hiring and retaining long-term HCC staff.** This has resulted in several limitations in services offered by the NWT HCC program.
    a. **Limited respite care:** Respite care was identified as a contributing factor to helping clients stay in their homes.
    b. **Limited palliative care:** A lack of palliative care services was attributed to a lack of staff, especially during evenings and weekends.
    c. **Limited mental health support:** Staff reported that there was a lack of support for clients' mental health and that there were challenges to hire mental health and social workers.
    d. **Lack of capacity for advanced foot care and advanced wound care:** HCC staff from all HSSAs reported a lack of capacity for providing advanced foot care and adequate territorial supports for providing advanced wound care to HCC clients.
    e. **Lack of clinical/needs re-assessments:** Staff reported difficulties with keeping clinical and needs assessments up to date, and a lack of regular clinical/needs re-assessments due to capacity.

f. **Limited capacity for friendly visits:** Clients expressed the desire for regular check-ins.

g. **Issues with continuity of care:** Turnover resulting from rotating staff was noted as negatively impacting continuity of care and ultimately quality of care offered.

h. **Lack of dependable language translation:** Language barriers between HCC workers (mostly nurses) and seniors and elders were reported to cause difficulties with providing proper care. The lack of a translation program placed the burden on HCC workers.



5. **Management and oversight for HCC services in the smaller remote communities in the NWT is inconsistent and sometimes insufficient.** In many of these communities, there is no dedicated HCC nurse, and oversight is provided by the CHN. This situation creates confusion for the HSWs working in these communities.
6. **Management and oversight for HCC services in the larger regional communities is more effective than what is experienced in the smaller remote communities in the NWT.** In the larger communities, oversight for HCC services is provided by dedicated HCC nurses, and this model should continue.
7. **Similar to other jurisdictions in Canada, the acuity and complexity of HCC clients is perceived to be increasing in the NWT and is expected to increase in the future.** Accordingly, the NWT HCC program will require a highly skilled team of HSWs and nursing staff who are properly trained to treat more complex issues in the home/community.
8. **The demand for HCC services in the NWT is projected to increase.** As shown in Section 4.3, the number of HCC clients is projected to increase from 1,558 clients in 2018 to 2,908 clients in 2035.
9. **The hours of operation for HCC services is not aligned with the needs of clients in some communities.** To mitigate this, some HSSAs/regions indicated that they already provide extended hours for evening as well as weekend services.
10. **There are training gaps for HSWs and nurses impacting quality of care.** For example, a portion of HSWs in the NWT have gone through a formal certification training program, while other HSWs have not, leading to inconsistent skill sets and a varying knowledge base.

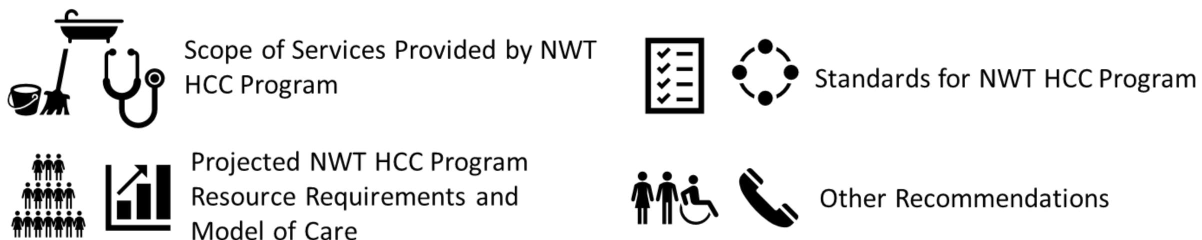
11. **There is a need to collaborate with more expert resources to support the NWT HCC program.** This includes specialists and professionals in geriatrics, psychology, advanced wound care and advanced foot care, palliative care, medical social work and allied health.
12. **Most regions lack a coordinated escort program to support HCC clients travelling outside of their community for medical care.** This leads to HCC clients sometimes travelling with escorts who are unreliable and do not attend medical appointments with them in Yellowknife or Edmonton, or to situations where HCC clients have to travel outside of the community for medical care without any escort for support. This was a major concern for HCC clients, especially those who are seniors and elders.
13. **The current Continuing Care Standards related to HCC service delivery are documented at too high of a level to effectively guide consistent HCC service delivery across the NWT.** In addition, there are no territorial policies or guidelines in place related to HCC service delivery to support the Continuing Care Standards. This was perceived to contribute to inconsistent service delivery for HCC across the territory.
14. **Charting and documentation processes are inconsistent.** HCC staff and managers reported that charting and documentation processes can be inefficient, are inconsistently applied, and lack smooth integration between different care providers (e.g. paper charts for HCC versus EMR for other health service providers).
15. **Data collection and reporting processes are inconsistent, and the Health Suite system is time-dated and no longer functional as a reporting tool to inform decision-making for the DHSS.** The data reported in Health Suite is inconsistent and unreliable, resulting in data sets that under-represent the actual level of services provided to clients, creating challenges for planning and decision-making regarding HCC program resource and funding allocations.
16. **There are limited reporting requirements for HCC funding.** This includes no requirements to report on HCC activity and outcomes for the core HCC funding, and limited reporting requirements for the First Nation and Inuit Home and Community Care Program (FNIHCC) funding.
17. **HCC resources are currently being used to fill gaps in community based services such as community transportation in some NWT communities.** As a result, there is less time available for staff to provide HCC services to clients in the home.
18. **Across the different HSSAs and regions, there is minimal communication on eligibility for HCC and the types of services offered.** This creates confusion in many communities regarding the scope of services offered by the NWT HCC program, and how to access the program.
19. **HSSAs and regions vary in the extent they use technology, and in opportunities existing to take greater advantage of technology.** For example, telehealth is underutilized in some remote communities and could be better utilized to improve the continuity of care for HCC clients.

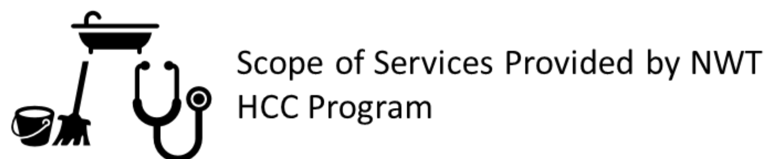
20. **There is a need to improve the communication between the HCC program and external organizations to help clients stay in their homes and communities longer.** Improved collaboration with social services staff/agencies (especially with regards to reporting elder abuse), indigenous organizations and the NWT Housing Corporation could help clients stay in their homes and communities longer.

RECOMMENDATIONS

MNP has provided 22 recommendations for improving the HCC program in the NWT. These recommendations are aligned with an "aging in the community approach" to care, a commitment of the Government of the Northwest Territories.

The recommendations have been organized into four categories as follows:





1. **The defined scope of services to be provided by the NWT HCC program should be based on a common set of principles.** MNP used the Harmonized Principles for Home Care, developed by Canadian Home Care Association, as a guide for recommending a defined scope of services for the NWT HCC program in recommendation 2. The principles, which have been adapted for the NWT context specifically, include the need for:
    - Client- and family-centred care
    - Consistency and equity
    - Evidence-informed care
    - Sustainable care
    - Integrated care
    - Accountable care
2. **Define the scope of services to be provided by the NWT HCC program.** Defining the scope of services provided by the NWT HCC program should improve the consistency of services provided by the HCC program in HSSAs/regions across the NWT, as well as

help set expectations for NWT residents and clients of the HCC program regarding the types of services to be provided through the HCC program.

The recommended scope of services to be provided by the NWT HCC program has been divided into four (4) categories as follows.

ADLs and IADLs – Personal Care and Homemaking Services

ADL - Personal Care Services (based on assessed need)	IADL - Homemaking Services (based on assessed need)
Feeding/Nutrition – Assistance with the ability to feed oneself (does not include meal preparation)	Light Housekeeping – Assistance with dishes, dusting, and sweeping, maintain a hygienic residence
Toileting – Assistance with getting on and off the toilet and cleaning oneself	Laundry – Assistance with washing clothes, bedding and towels as required
Mobility/Lifts/Transfers – Assistance with moving oneself from seated to standing, and getting out of bed	Meal Preparation – Assistance with meal planning, cooking, clean up and storage
Bathing/Dressing/Grooming – Assistance with bating/showering, nail care, oral care and the ability to dress oneself.	Shopping/Errand Support – Assistance with shopping and running errands if no other option exists for the HCC client.

Nursing Care Services

Nursing Care Services (delivered based on community capacity and availability of resources)	
Post Hospital Acute Care	Home Care Nursing Assessments/Reassessments
Care Planning	Medication Management Support
Infusion Therapy	Home Oxygen Support
Continence Care	Ostomy Care
Chronic Disease Care	In-Home End of Life Care

Referral and Case Management Support (clinical and community services)

Consultative Clinical Services (delivered based on community capacity and availability of resources)	
Physiotherapy Services	Adult Social Worker Services
Occupational Therapy Services	Dietician Services
Nurse Practitioner Services	Speech Language Services
Advanced Foot Care	Advanced Wound Care
Dental Services	Physician Services (Specialty and Family Medicine)
Coordination of Services to Support IADL	
Community transportation	Snow clearing/woodcutting
Home repairs/maintenance	

Other HCC Services

Other Programs and Services (delivered based on community capacity and availability of resources)	
In-Home Respite Care	Accessing Medical Supplies/ Equipment Loans
Day Programming	Meals on Wheels/Community Meals

3. **Define the services that are out of scope for the NWT HCC program.** Defining the services which are not provided by the NWT HCC program should also improve the consistency of services provided by the HCC program in HSSAs/regions across the NWT, set expectations for NWT residents and clients, and result in more effective use of HCC resources.

   It is recommended that the following services be out of the scope of the HCC program, as they could be provided by family members, the community (local government agencies), and/or other service delivery agencies.

4. **Improve communication of which services are within scope and out-of-scope of the HCC NWT Program.** It is recommended that the scope of the NWT HCC program be communicated to NWT residents.
5. **Further explore the feasibility of expanding the hours of the HCC program operations in each HSSA/region.** The DHSS should pilot an extended-hours model for HCC services in additional communities where there is need (larger communities first where staff oversight is not as big a challenge) to test the feasibility of the model.

Projected NWT HCC Program Resource Requirements and Model of Care

6. **The DHSS should plan for an 80% increase in demand for HCC services by the year 2035.** The demand for HCC services in the NWT is projected to increase by 80% from 1,558 in 2018 to 2,809 in 2035.
7. **Develop guidelines regarding the average hours of care per year provided by HSWs to HCC clients assessed as requiring a combination of personal care services (ADLs) and homemaking services (IADLs).** It is recommended that the DHSS plan future HSW resource requirements based on the following guidelines for average hours of care:

- HSWs provide an average of 140 hours of care per year to HCC clients aged 75+, and an average of 102 hours of care per year to HCC clients aged 0-74, assessed as requiring a combination of personal care services (ADLs) and homemaking services (IADLs).
- The actual level of care provided by HSWs to each HCC client will vary and should be based on assessed client need and documented in client care plans.

8. **The DHSS should plan for recruiting additional HSWs annually to meet the growing demand for HCC services in the NWT to the year 2035.** The requirements for HSWs is projected to grow significantly from 59.13 FTEs in 2019 to 128.41 FTEs in 2035 in order to meet the growing demand for HCC services in the NWT.

HSSA/Region	Current	Projected HCC HSW FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	15.53	15.53	16.27	18.63	19.53	21.07	23.26
NTHSSA Dehcho Region	10.00	12.78	14.65	16.25	18.40	19.15	21.54
NTHSSA Sahtu Region	8.70	9.26	9.46	10.39	11.03	11.71	12.47
NTHSSA Yellowknife Region	11.30	18.48	22.51	27.30	31.11	35.75	41.15
Tlicho CSA	6.10	8.20	8.53	9.07	9.96	10.34	11.29
Fort Smith Region	2.50	3.40	4.05	4.63	4.68	5.30	5.84
Hay River Region	5.00	7.02	8.02	9.26	10.64	11.55	12.86
NWT Total	**59.13**	**74.67**	**83.49**	**95.53**	**105.35**	**114.87**	**128.41**

9. **Develop guidelines regarding the average hours of care per year provided by nurses to HCC clients assessed as requiring nursing care supports**. It is recommended that the DHSS plan future HCC nursing resource requirements based on the following guidelines for average hours of care:

- Nurses provide an average of 12 hours of care per year to HCC clients aged 75+, and an average of 14 hours of care per year to HCC clients aged 0-74, assessed as requiring nursing care supports.
- The actual level of care provided by nurses to each HCC client will vary and should be based on assessed client need and documented in client care plans.

10. **The DHSS should plan for recruiting additional nurses annually to meet the growing demand for HCC services in the NWT to the year 2035.** The requirements for nurses who provide nursing care and assessment services to HCC clients is projected to grow significantly from 24.78 FTEs in 2019 to 44.18 FTEs in 2035 in order to meet the growing demand for HCC services in the NWT.

HSSA/Region	Current	Projected HCC Nursing FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	2.53	3.71	4.05	4.50	4.65	4.88	5.20
NTHSSA Dehcho Region	2.00	2.16	2.03	2.22	2.47	2.56	3.37
NTHSSA Sahtu Region	1.00	1.53	1.63	1.73	1.84	1.92	2.03
NTHSSA Yellowknife Region	13.00	14.07	16.06	18.29	20.01	22.15	24.59
Tlicho CSA	1.25	1.40	1.47	1.54	1.66	1.72	1.86
Fort Smith Region	2.00	2.00	2.03	2.23	2.28	2.50	2.67
Hay River Region	3.00	3.00	3.24	3.60	3.95	4.15	4.46
NWT Total	**24.78**	**27.87**	**30.51**	**34.11**	**36.86**	**39.88**	**44.18**

11. **The DHSS will need to secure additional funding for the HCC program either through the core homecare funding envelope and/or the FNIHCC funding**

envelope to fund additional HSW and nursing positions. The projected funding requirements for the additional HSW and nursing staff requirements, in 2019 dollars (does not account for inflationary increases to salaries), is projected to be approximately $1.79 million in 2020 and $8.73 million by 2035.

HSSA/Region	Projected Additional Funding for Additional HCC HSW and Nursing Staff					
	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	$174,468	$294,282	$582,604	$689,362	$868,095	$1,121,220
NTHSSA Dehcho Region	$270,770	$419,516	$589,113	$816,262	$895,893	$1,223,165
NTHSSA Sahtu Region	$135,635	$170,407	$276,215	$355,334	$433,752	$524,549
NTHSSA Yellowknife Region	$751,441	$1,358,539	$2,062,081	$2,614,514	$3,293,335	$4,076,604
Tlicho CSA	$203,963	$242,392	$299,156	$393,349	$434,770	$536,949
Fort Smith Region	$77,682	$137,859	$215,080	$226,185	$309,574	$379,268
Hay River Region	$173,544	$291,897	$447,089	$612,957	$718,171	$872,619
Total Projected Additional Funding Requirements	**$1,787,503**	**$2,914,892**	**$4,471,338**	**$5,707,963**	**$6,953,590**	**$8,734,374**

12. **The DHSS should further explore the requirements for other HCC program clinical service resource supports including allied health professionals, advanced wound care specialists, advanced foot care specialists, and medical social workers.** Based on feedback received from stakeholders, there is a need to enhance the level of services provided by advanced wound care specialists, advanced foot care specialists, allied health professionals and medical social workers.

13. **The DHSS should strengthen the service delivery model in remote communities, to be more consistent with the service delivery model in larger regional communities.** Nursing service delivery and oversight provided to HSWs in most remote communities in the NTHSSA Beaufort-Delta, Dehcho and Sahtu regions as well as the Tlicho CSA is provided by CHNs, and not a dedicated Home Care Nurse, which is the model used in the larger regional centres.

    The CHN service delivery and oversight model was reported to create challenges with limited and/or inconsistent direction. However, the dedicated HCC nurse service delivery and oversight model used in the larger regional centres was reported to be more effective. Accordingly, it is recommended that dedicated HCC nurse service delivery and oversight model continue to be used in the larger regional communities, and that a similar model be implemented in the smaller communities as well. Two recommended options have been provided to improve HCC oversight and nursing care in the smaller remote communities including:

    - **Option 1:** Creating dedicated HCC nursing positions (RNs or LPNs) with a primary focus to provide HSW oversight and HCC nursing care, and a secondary focus to assist with community health centre nursing needs when not busy with HCC nursing tasks. This should improve HCC nursing oversight and care in these communities, as well as create additional capacity to provide palliative care when needed. It would also provide some additional capacity to provide nursing care in the community health centre.
        - MNP found that LPNs are being used for case management, nursing care, and HSW oversight in other jurisdictions such as Alberta, Yukon, and the Northern Health Region in Manitoba. Accordingly, it is recommended that the DHSS consider using LPNs for these positions.

  - If considered, this model should be piloted in some smaller communities in the NTHSSA Sahtu or Beaufort-Delta regions to test the effectiveness and feasibility of the model.
- **Option 2:** Creating dedicated regional HCC nursing positions (RNs or LPNs) to provide HSW oversight at a distance (via telehealth) and in person through monthly visits to smaller communities (assign 2 communities per nurse). This would require frequent and consistent communication about client charts with the local CHN when these HCC nurses are not in the community. Each nurse would require 1-2 weeks of travel per month.
  - If considered, this model should be piloted to test the effectiveness and feasibility of the model. The model could be tested by having 2 dedicated HCC nurses (RNs or LPNs) based in Norman Wells (NTHSSA-Sahtu region), who provide oversight to HSWs in the Sahtu region.

Standards for NWT HCC Program

14. **Continue with implementation of interRAI.** It is recommended that DHSS continue with the implementation of interRAI. Over time, it will improve the consistency of clinical assessments, the management of clients, and continuity of care in the HCC program and the entire continuum of care in the NWT.

    Although the implementation of interRAI will eventually improve the standardization and consistency of HCC assessment criteria, care planning, client charting, and continuity of care across the NWT; adoption and use of interRAI will take time, and there is a need to improve standardization of the NWT HCC program before interRAI is fully rolled out. Accordingly, recommendations 15 to 18 have been provided to improve the consistency of HCC service delivery while interRAI is in the process of being implemented.

15. **The DHSS should consider reviewing and adopting Accreditation Canada Standards for HCC service delivery.** The DHSS and the HSSAs in the NWT should consider reviewing and adopting these standards as guidelines for HCC service delivery in the NWT. This would improve consistency to adjust for local needs while allowing for some flexibility in how services are delivered.
16. **The DHSS should consider standardizing HCC program forms across the NWT.** It is recommended that the DHSS work with the HSSAs and regions to adopt and implement the use of the same forms for HCC assessments, referrals, care plans, client contracts, charting, and policies/procedures/processes.
17. **Ensure that all HSWs are certified and receive consistent training.** It is recommended that:

- The DHSS implement a consistent training program for all HSWs in the NWT and ensure that all HSWs are certified to deliver HCC services in the NWT.
- Have annual or biennial training events for HCC nurses and HSWs in the NWT to ensure skills are up to date and best practices are being shared.

18. **Improve data collection to more accurately monitor HCC service delivery across the NWT.** It is recommended that the DHSS improve HCC program data collection now, while interRAI is being implemented. There is a need to improve data collection to better monitor HCC service delivery across the NWT for measures such as: the hours of care by age group and type of service (i.e. homemaking services, personal care, nursing care, wound care, foot care, and other/allied health services), the level of care of clients, active monthly client caseload numbers by age group, and monthly admissions and discharges.

Other Recommendations

19. **The DHSS should proceed with test-piloting a paid caregiver support model in the NWT.** It is recommended that the DHSS proceed with its plan to test pilot a paid caregiver support option in some rural/remote areas of the NWT. In this option, caregivers in the NWT could be paid to assist with providing some home support services to HCC clients such as:
    - Shopping/running errands
    - Snow clearing
    - Wood cutting
    - Heavy housecleaning assistance
    - Transportation to community events
    - Transportation to medical appointments

    Assessment and oversight would still be required by HCC nurses in each HSSA and region.
20. **Increase use of telehealth services for the HCC program.** It is recommended that the HCC program makes better use of telehealth services for services with physicians, nurse practitioners, advanced wound/foot care specialists, OT/PT, adult medical social workers, and dietitians.
21. **Continue to improve communication with hospitals.** It is recommended that the HCC program continue to improve communication with Stanton Hospital and other hospitals in Alberta to better coordinate discharges of patients into the HCC program. This will help ensure proper HCC staffing and resources are available in the community when a HCC client returns.

22. **Improve communication and coordination of services with GNWT departments and other organizations/agencies.** It is recommended that the HCC program improve communication and coordination with:
    - NWT Housing Corporation to ensure:
        - HCC clients are aware of NWT Housing Corporation programs; and
        - That housing repair/maintenance needs are communicated to NWT Housing Corporation appropriately.
    - Local community government administration and agencies – could provide services for transportation to and from medical appointments and community events, snow clearing, wood cutting assistance, etc.

1. INTRODUCTION

1.1 HOME AND COMMUNITY CARE IN THE NWT

In 2004, the Northwest Territories (NWT) Department of Health and Social Services (DHSS) and Health and Social Services Authorities (HSSAs) adopted the Integrated Service Delivery Model (ISDM). The ISDM is a team-based, client-focused approach to providing health and social services in the NWT.

The ISDM has three key elements:

- Service integration and professional collaboration;
- Organizational integration; and
- A definition of the six core service areas including:
  - Promotion and prevention services,
  - Diagnostic and curative services,
  - Rehabilitation services,
  - Mental health and addictions services,
  - Continuing care services, and
  - Protection services.

As a core service of the DHSS ISDM, continuing care services are delivered through three program streams, including:

- **Home and Community Care (HCC);**
- Supported Living (SL); and
- Long-Term Care (LTC) and Extended Care.

The delivery of HCC services in the NWT is reliant on the other core services in the NWT ISDM to ensure that clients have access to a multidisciplinary team of health service providers. HCC services provide individuals with nursing care as well as support for personal care and daily living activities when they are no longer able to perform these activities on their own.[1] These services aid with maintaining independence for individuals in the places where they are most comfortable: HCC services support individuals with staying in their own homes rather than a hospital or LTC facility. Table 1 outlines the key elements of the NWT HCC program.

[1] Home and Community Care. Northwest Territories Department of Health and Social Services. https://www.hss.gov.nt.ca/en/services/continuing-care-services/home-and-community-care

Table 1: Overview of NWT HCC Program

Aims	To enable people to stay in their own homes rather than go to a hospital or LTC facility when they need nursing care or help with daily living activities because of age, disability, injury, or illness.[2]
Services	HCC includes the following essential services[3]: • Client assessment • Case management • Nursing services • Home support services for Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) • Respite care • Palliative/end-of-life care • Preventative health services • Medication supervision and/or administration • Informal caregiver support • Access to medical/surgical supplies and equipment In addition to the essential services articulated in the Continuing Care Standards, some communities provide additional services such as transportation services and translation services to meet the needs of clients. An overview of service provision by HSSA/region is provided in Section 3.1 below.
Clients	HCC clients include seniors and elders, adults with disabilities/chronic conditions, and children with disabilities/chronic conditions. HCC services are provided across all age groups.

[2] Ibid.
[3] Based on Standard 2.1.1 in the NWT Continuing Care Standards.

<table>
<tr><td>Admissions Criteria</td><td>In order to be admitted to the HCC program in different regions across the NWT, a client must[4]:
• Be a permanent NWT resident;
• Have a NWT Health Care card; and
• Be assessed as having unmet needs that the program can meet safely, efficiently and effectively in the home or clinic setting.
In addition, some HSSAs/regions have additional admission criteria such as:
• Being assessed as having needs that cannot be met by their support network; and
• Having a physician, Nurse Practitioner, and/or another clinician (such as a nurse who can access practitioner support if required) that is responsible for any medical needs.</td></tr>
<tr><td>Funding Model</td><td>The HCC services provided in the NWT are funded through DHSS core funding as well as from the First Nation and Inuit Home and Community Care Program (FNIHCC), which is administered by the Department on behalf of the First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada. More information on funding amounts and allocations is provided in Section 3.4.</td></tr>
</table>

Improving HCC services and caregiver supports to enable seniors and elders to live in their own homes for as long as possible is a key objective (Objective 2) in the GNWT's current Continuing Care Services Action Plan.[5] One key activity for achieving this objective is conducting a comprehensive territorial review of HCC services by region and community. Other key activities include:

- Developing a more skilled HCC workforce in the NWT;
- Improving access to clinical supports for HCC professionals;
- Developing and piloting a Paid Family/Community Caregiver Program as an option for seniors, elders and persons with disabilities to self-manage their care;
- Enhancing supports for family and community caregivers; and
- Increasing access to culturally appropriate information for family and community caregivers in the NWT.

Presently, and for many years, the DHSS has relied upon the Continuing Care Assessment Package (CCAP) as the standard assessment tool. The CCAP supports decisions related to

[4] Based on review of admission criteria from different regions across the NWT.
[5] GNWT Continuing Care Services Action Plan – 2017/18 to 2021/22, September 2017.

client access to services across the continuum of care – including HCC, supported living and LTC. The CCAP is lengthy and is not a validated evidence based assessment tool.

In recent years, interRAI has been implemented in most Canadian jurisdictions and is the standard tool being used for home care service decisions and data collection nationally and internationally. The Department completed a business case for interRAI in 2009/10 that confirmed it is the recommended assessment tool for continuing care services in the NWT including HCC and LTC. The DHSS is currently in the process of procuring and implementing interRAI across the NWT.

All NWT residents can be referred for an assessment to be admitted into the HCC program. However, as in many Canadian jurisdictions, the majority of HCC services are used by seniors (who are defined as 60 years and over in the NWT). This population tends to experience loss in function due to the prevalence of chronic diseases, injury, and illness.

1.2 PURPOSE AND SCOPE OF THE REVIEW

The NWT is geographically large and sparsely populated, which makes HCC service delivery challenging. In addition, according to the 2015 NWT LTC Program Review Report, seniors represent the fastest growing age group in the territory.

In 2014, 78% of seniors (age 60 and over) reported they were satisfied with life in the NWT (compared to 87% for the NWT as a whole), and 41% of seniors reported very or excellent self-perceived health (compared to 51% for the NWT as a whole).

Currently, there are an estimated 5,991 seniors (aged 60 and over) in the NWT spread across 33 communities, of which approximately 1,081 are older seniors (aged 75 and up). By 2035, the total number of seniors 60 years and older is projected to increase to 9,704; while the older senior population (aged 75 and up) is expected to increase to 3,345 by 2035. These older seniors are more likely to require more HCC and continuing care services than younger seniors.

As the number of seniors in the NWT is projected to increase, so will the burden that is placed on the NWT Health and Social Services (NWTHSS) System and family caregivers. This will increase demand for continuing care services including LTC, HCC, chronic disease management related care and pharmaceuticals. Many seniors live with one or more chronic conditions, such as heart disease, dementia, diabetes, and mental health problems. These conditions compromise their quality of life. Accordingly, the GNWT needs to be poised to respond to the growing demand for home and community care services in the future.

The Government of Northwest Territories (GNWT) has identified a need to be positioned to better respond to the growing demand for HCC services in the future. It is within this context that the GNWT DHSS contracted MNP LLP (MNP), a chartered accounting and

business advisory firm, to conduct a comprehensive program review of the HCC program in the NWT.

The intent of this review is to inform options and decisions based on the best and most current data regarding optimal allocation of resources and future investments to HCC programs and services.

The scope of this review includes the following activities:

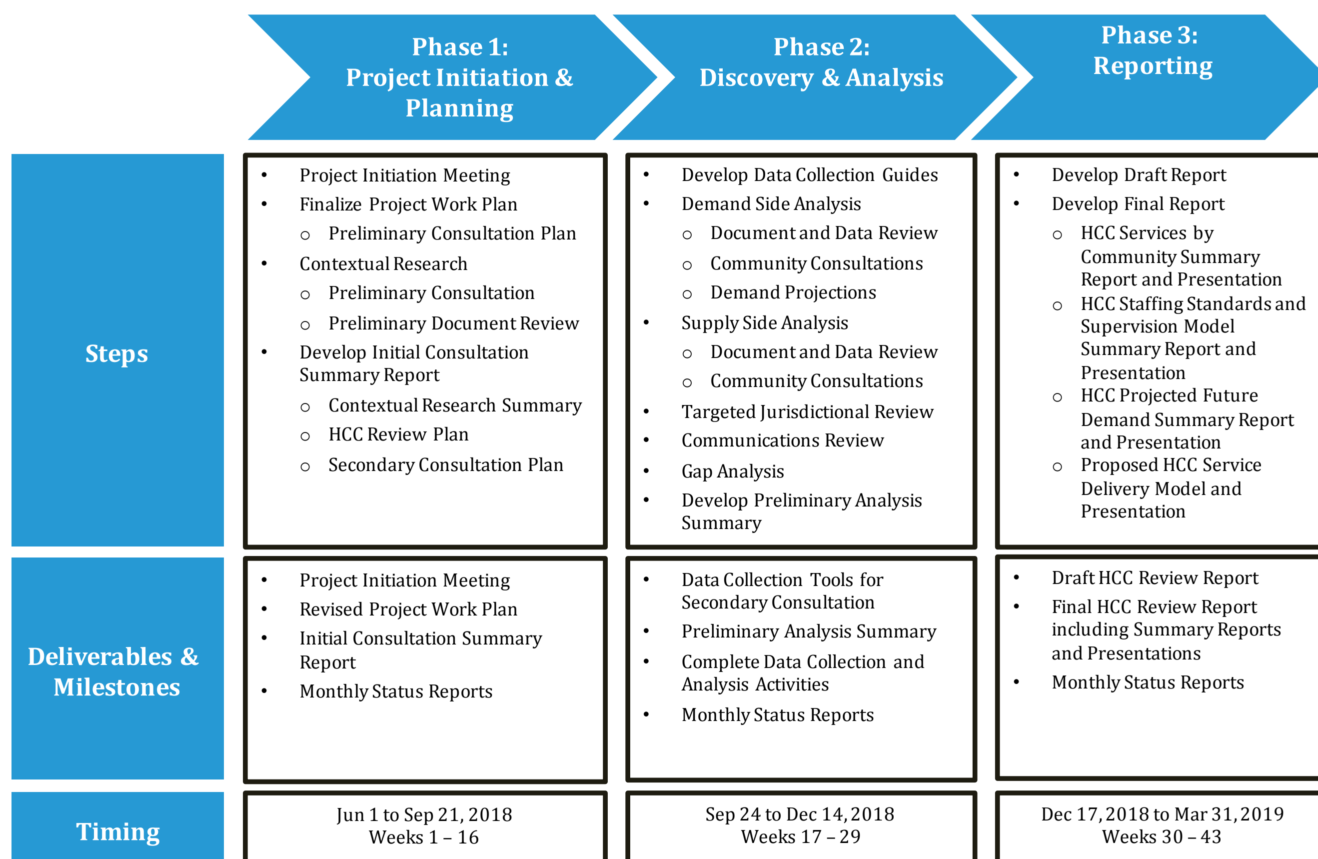
- Conducting a comprehensive review of HCC services by region and community across the NWT;
- Conducting a demand side analysis by region and community across the NWT;
- Conducting a targeted jurisdictional review of models, standards and practices in provincial/territorial jurisdictions;
- Conducting a supply-side analysis of the current HCC programs and related services the NWT has in place today;
- Conducting a gap analysis that identifies significant gaps in HCC programs and services in the NWT; and
- Identifying communication tools and methods to ensure the NWT is maximizing the use of existing resources.

The services examined as part of this review included: nursing services (in-home nursing care), home support (personal support, homemaking, home maintenance), in-home respite, and in-home palliative care. The review covered HCC programs and services provided across all age groups receiving services (i.e. seniors and elders, adults with disabilities/chronic conditions, and children with disabilities/chronic conditions), and it aimed to represent all regions (five regions in the Northwest Territories Health and Social Services Authority [NTHSSA], Hay River Health and Social Services Authority [HRHSSA], and Tlicho Community Services Agency [TCSA]), as well as select communities in the NWT at the direction of GNWT Contract Authority and members of the HCC Program Review Steering Committee.

2. APPROACH AND METHODOLOGY

Figure 1 summarizes the approach that was taken to complete the review. Project work was structured into three distinct, but linked phases. Each phase had distinct steps and outcomes.

Figure 1: Approach to Review



	Phase 1: Project Initiation & Planning	Phase 2: Discovery & Analysis	Phase 3: Reporting

Steps	• Project Initiation Meeting
	• Finalize Project Work Plan
	  o Preliminary Consultation Plan
	• Contextual Research
	  o Preliminary Consultation
	  o Preliminary Document Review
	• Develop Initial Consultation Summary Report
	  o Contextual Research Summary
	  o HCC Review Plan
	  o Secondary Consultation Plan
		• Develop Data Collection Guides
		• Demand Side Analysis
		  o Document and Data Review
		  o Community Consultations
		  o Demand Projections
		• Supply Side Analysis
		  o Document and Data Review
		  o Community Consultations
		• Targeted Jurisdictional Review
		• Communications Review
		• Gap Analysis
		• Develop Preliminary Analysis Summary
			• Develop Draft Report
			• Develop Final Report
			  o HCC Services by Community Summary Report and Presentation
			  o HCC Staffing Standards and Supervision Model Summary Report and Presentation
			  o HCC Projected Future Demand Summary Report and Presentation
			  o Proposed HCC Service Delivery Model and Presentation

Deliverables & Milestones	• Project Initiation Meeting • Revised Project Work Plan • Initial Consultation Summary Report • Monthly Status Reports	• Data Collection Tools for Secondary Consultation • Preliminary Analysis Summary • Complete Data Collection and Analysis Activities • Monthly Status Reports	• Draft HCC Review Report • Final HCC Review Report including Summary Reports and Presentations • Monthly Status Reports
Timing	Jun 1 to Sep 21, 2018 Weeks 1 – 16	Sep 24 to Dec 14, 2018 Weeks 17 – 29	Dec 17, 2018 to Mar 31, 2019 Weeks 30 – 43

A review matrix was developed to guide the HCC review and included 8 areas of review organized into 4 categories (Appendix A and Figure 2).

Figure 2: NWT HCC Program Areas of Review

Review Category	Area of Review
Supply-Side Analysis and Current State Assessment	1. Types of HCC services provided across the NWT. 2. Utilization of HCC services across the NWT. 3. Effectiveness of HCC service delivery across the NWT. 4. Efficiency of HCC service delivery across the NWT.
Demand-Side Analysis	5. Projected demand for HCC services in the NWT. 6. Financial and resource requirements to meet future demand.
Jurisdictional Analysis	7. Best practices, trends, and innovative solutions from other jurisdictions for providing HCC services that support elders with aging in place.
Communication Review	8. Effectiveness of communication methods and tools used to promote HCC services in the NWT.

Data informing the analysis and ultimately the development of the report was collected using the following methods:

- Detailed review of background documentation and administrative data provided by DHSS and the NWT Bureau of Statistics;
- Key informant consultations including interviews and focus groups (see Table 2); and
- Best practice research including online research and discussions with representatives from other jurisdictions.

The following administrative data sets and documents were included as part of the review:

- Continuing Care Action Plan
- NWT Health and Social Services System Strategic Plan – 2017-2020
- NWT Continuing Care Standards
- Senior's Information Handbook
- 2013 Continuing Care Review
- NWT Long-Term Care Program Review
- Our Elders; Our Communities
- NWT Disability Program Review and Renewal Project Technical Background Report
- NWT Bureau of Statistics population projections to 2035
- NWT Bureau of Statistics Population Estimates
- Health Suite Total Services Reports
- HCC staffing level data

- HCC budgets and expenses
- HCC contribution agreements
- HCC year end reports
- HSSA HCC forms, processes, policies, and communication materials
- interRAI Survey Monkey Results
- NWT Disability Projections

Table 2 outlines the key informant consultations that were conducted in support of the review. Please note that most in-person interviews were conducted on a group basis. The question guides used for the consultations are included in Appendix B.

Table 2: Summary of Key Informant Interviews

Stakeholder Group	In-person Interviews/ Group Interviews	Focus Groups (2 hours per session)	Telephone Interviews/ Group Interviews
Clients/Families*	-	5	5
HCC Management and Providers**	-	12	1
DHSS Representatives***	2	-	-
HSSA Representatives***	6	-	-
NWT Committees****	2	1	-
NWT Housing Corporation	-	-	1
NWT Seniors' Society	-	-	1
Regional Wellness Council (Sahtu Region)	-	-	1
Total	**10**	**18**	**9**

*Focus group sessions were completed in-person in the communities Behchoko, Fort Good Hope, Fort Simpson, Hay River, Inuvik, and Norman Wells, and 5 telephone interviews were completed with HCC clients in Yellowknife.
**Referred to as "HCC staff" throughout the report. Interviews/focus groups were completed in-person with HCC staff located in Behchoko, Fort Good Hope, Fort Simpson, Hay River, Inuvik, and Norman Wells, and by telephone with staff in Fort Smith and Yellowknife.
***Referred to as "government representatives" throughout the report.
****Includes the Rehab Advisory Committee (by telephone), Continuing Care Committee (in-person in Yellowknife), and Nursing Leadership Committee (by telephone).

Overall, MNP visited 7 communities across the NWT to complete interview and focus group sessions with stakeholders including Behchoko, Fort Good Hope, Fort Simpson, Hay River, Inuvik, Norman Wells, and Yellowknife.

MNP completed a jurisdictional scan of trends impacting HCC service delivery across Canada. In addition, MNP conducted a detailed targeted review of HCC service delivery in the following five (5) jurisdictions:

- Alberta (Fort McMurray)
- Newfoundland
- Nova Scotia
- Ontario (the North West Local Health Integration Network)
- Manitoba (Northern Health Region)

2.1 REPORT LIMITATIONS

MNP has relied upon the completeness, accuracy, and fair presentation of all information and data obtained through the various stakeholder consultations completed, along with documents and data sets that were made available for the review by June 28, 2019. The accuracy and reliability of the findings and opinions expressed in this report are conditional upon the quality of this same information. As a result, MNP cautions readers regarding their reliance on the findings and disclaims any associated liability.

Additionally, the findings and expressed opinions constitute judgments as of the date of the report and are subject to change without notice. MNP is under no obligation to advise of any such change brought to its attention which would alter those findings or opinions.

Further to this, MNP's evaluation findings were limited by the following factors:

- **Health Suite Data Limitations:** The data collection and reporting processes for Health Suite data are inconsistent and not standardized. In addition, the system is time-dated and no longer functional as a reporting tool to inform decision-making. Accordingly, the data available limited the accuracy of the current state analysis and created difficulty with the development of reliable and accurate future state projections, which were limited to in-home services and did not include clinic-based services. The following are limitations with the data:
    - **Data is not reported in a unit of service fashion** which would be the most useful for analysis and projection development.
    - **Hours or units of service are not reported by age group**, just by activity level or type of services. Seeing the total hours by age group would be informative, as it would provide a better indication of the level of care and complexity of care of clients in each age group. However, Health Suite does not report HCC data in this way.

- **Not all age group segments in the current population estimates are aligned with the age groupings of Health Suite.** For example, in the current NWT population estimates by age and community, the oldest age demographic is 60+. However, Health Suite can stratify by older age groups. For most regions, it appears that HCC usage increases in the older age demographics.
- **Poor data related to acuity levels by** age group**.**
- The total hours of HCC services reported for each HSSA and the NWT as a whole appears to be ***severely under-represented***, compared to other Canadian jurisdictions. Based on existing data, there is an average of 18.7 HCC hours of service provided per client per year (or 1.6 hours per month), which is significantly lower (by a magnitude of 10 times or more) than any other Canadian jurisdiction. Also, this does not provide an accurate starting point for developing the future projected HCC resource requirements in the NWT.
- Data for services provided by other health professional staff through the ISDM such as Community Health Nurses (CHNs), rehabilitation staff (i.e. Occupational Therapists (OT) and Physiotherapists (PT)) and social program staff is not captured in Health Suite.

To mitigate the impact of these Health Suite data limitations:

- The DHSS had MNP analyze data from other jurisdictions including recent projections developed for Manitoba and Newfoundland to inform assumptions for acuity/complexity levels and hours of care by age group, including assumptions for personal care/home supports and nursing care requirements. This option required additional research to fully understand the assumptions and data supporting the projections developed for each jurisdiction. ***Although this approach is not fully reflective of the NWT context, it does provide more reliable quantitative data to base future state projection assumptions than the current data available from Health Suite.***
- The DHSS reassessed and validated HCC client caseload data from NTHSSA Yellowknife and Sahtu regions, and the Hay River HSSA to determine the actual number of clients receiving homemaking services, personal care services, nursing services, and foot care services. ***This approach did improve estimates for the actual number of clients receiving HCC in the NWT in 2017/18. However, it did not provide improvements to hours of care data. Accordingly, the projection model utilized for projecting future Home Support Worker and HCC nursing staff requirements is based on assumptions informed by a combination of client caseload data from Manitoba and the NWT, and hours of care data from Manitoba.***

3. CURRENT STATE ASSESSMENT FINDINGS

The following section describes the current state of HCC service delivery in the NWT including:

- Supply-side analysis:
  - Inventory of HCC services provided by region across the NWT
  - Inventory of existing HCC staff/provider mix by region and community across the NWT
  - Comparison of HCC utilization by community and region across the NWT:
    - HCC Caseloads (by HSSA and community) and age demographic (by HSSA/Region)
    - Hours of service by community and activity/client type (by HSSA)
- Effectiveness of HCC service delivery across the NWT:
  - Perceived effectiveness of HCC service delivery by HCC clients
  - HCC data collection, performance measurement, and reporting
  - Service delivery agreements between DHSS and HSSAs
  - Consistency of HCC service delivery across the NWT
  - Processes and tools used to deliver HCC services in the NWT
  - Management and oversight of HCC service delivery
  - Effectiveness of communication methods and tools used to promote HCC programs and services in the NWT
- Efficiency of HCC service delivery across the NWT:
  - Variance analysis (budget versus actual costs)
  - Funding sources

3.1 SUPPLY-SIDE ANALYSIS

The supply-side analysis includes an inventory of HCC programs and services and staffing complements across the NWT, as well as a comparison of HCC service utilization across the NWT.

Inventory of HCC Services Provided Across the NWT

Figure 3 provides a comparison of the types of HCC services available in each of the five regions of the NTHSSA, HRHSSA, and TCSA, based on the Annual Year-End reports submitted to the DHSS by as well as feedback provided from focus groups with HCC service providers. There are differences in the availability of some types of non-core HCC services

in different regions such as transportation, meal services, transportation to appointments, adult medical social workers, day programming, translation services, dietician/nutrition services, and access to supports for woodcutting and snow clearing.

Figure 3: Comparison of HCC Services by NWT Region[6]

	Type of Service	NTHSSA					Hay River HSSA	Tlicho CSA
		Dehcho Region	Yellowknife Region	Beaufort-Delta Region	Fort Smith Region	Sahtu Region		
Core HCC Services (per Continuing Care Standards)								
1	Home support services for personal care and home management	X	X	X	X	X	X	X
2	Medical supplies and equipment loan	X	X	X	X	X	X	X
3	In-home respite	X	X	X	X	X	X	X
4	Palliative care	X	X	X	X	X	X	X
5	Client assessment and care coordination	X	X	X	X	X	X	X
6	Home care nursing services	X	X	X	X	X	X	X
7	Foot care	X	X	X	X	X	X	X
8	Wound care	X	X	X	X	X	X	X
9	Case management	X	X	X	X	X	X	X
10	Medication management	X	X	X	X	X	X	X
Additional HCC Services								
11	Transport to medical appointments	X		X	X	X	X	X
12	Shopping/Errand support	X	X	X	X	X	X	X
13	Medical social worker		X	X				X
14	Translation services	X						X
15	Post hospital care	X	X	X	X	X	X	X
16	Day programming	X	X	X	X	X		X
17	Meals on wheels or community meals	X	X	X	X		X	X
18	Dietician/Nutrition services		X		X			
19	Access to Allied Health services	X	X	X	X	X	X	X
20	Snow Clearing/Woodcutting	X					X (help coordinate service)	

HCC Service Provider Mix Across the NWT

The composition of HCC management and oversight, nursing support, and Home Support Workers (HSWs) varies between each HSSA, each region within the NTHSSA, and between different communities within a given region.

For example, some communities within the NTHHSA Beaufort Delta Region are quite small in terms of population. Accordingly, the corresponding smaller need for HCC services results in only one HSW being assigned to many of the communities (e.g. Tsiigehtchic, Ulukhaktok, Paulatuk). In contrast, the larger community of Inuvik has four HSWs and one relief HSW. Similarly, oversight also varies across these communities, with CHNs providing

[6] Based on information in year-end reports and feedback provided by community workers.

oversight in the smaller communities and dedicated Home Care Nurses providing oversight in larger communities such as Inuvik, Fort Smith, Hay River and Yellowknife. Communities for which nursing oversight is provided by CHNs through the ISDM and not a dedicated Home Care Nurse include:

- NTHSSA Beaufort-Delta Region: Tsiigehtchic, Ulukhaktok, Paulatuk, Tuktoyaktuk, Aklavik, Fort McPherson, and Sachs Harbour
- NTHSSA Sahtu Region: Colville Lake, Deline, Tulita, Fort Good Hope, and Norman Wells
- NTHSSA Dehcho Region: Fort Liard; Fort Providence; Jean Marie River; Nahanni Butte; Sambaa K'e; Kakisa; Wrigley
- Tlicho Community Service Agency – Behchoko, Whati, Wekweti, Gameti

A breakdown of funded HCC positions by HSSA/region and community is provided in Table 3 below. Overall, the number of funded HCC positions in the 2018/19 fiscal year increased for the NTHSSA Beaufort-Delta, Dehcho, Sahtu, and Yellowknife regions, as well as the Hay River HSSA compared to the 2017/18 fiscal year. The number of funded positions for the NTHSSA Fort Smith region remained the same in 2018/19, while the number of funded positions for the Tlicho CSA decreased slightly in 2018/19 compared to 2017/18.

MNP notes that the actual staffing complements reported by HSSA representatives as of January 2019 (i.e. number of filled positions as of January 2019) varied from the number of funded positions in Table 3 below. This included variations by position in some communities (but not all) in each HSSA/region, as well as variations in the total number of active full-time equivalent (FTE) HCC staff for each HSSA/region (except Hay River HSSA) compared to the funded 2017/18 fiscal year numbers and the projected 2018/19 fiscal year funded staffing levels. This discrepancy articulates the need for more accurate reporting and communication between the HSSAs and the DHSS to ensure the DHSS is aware of staffing recruitment and retention issues in each HSSA/region.

Table 3: Summary of HCC Staffing Complements by Funding Source (2014/15 to 2017/18) and 2018/19 Projection[7]

Position	Community	2014/15			2015/16			2016/17			2017/18			2018/19 Projected		
		Core	FNIHCC[8]	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total
NTHSSA Beaufort-Delta Region		**11**	**11**	**22**	**9**	**10.5**	**19.5**	**9**	**12.5**	**21.5**	**9**	**13.62**	**22.62**	**12**	**13.12**	**25.12**
Home Support Worker	Inuvik	1	1.5	**2.5**	0	1.5	**1.5**	0	2.5	**2.5**	0	3.53	**3.53**	2	3.53	**5.53**
Manager, Social Programs	Inuvik							1	0	**1**	1	0	**1**	1	0	**1**
Manager, Continuing Care	Inuvik							1	0	**1**	1	0	**1**	1	0	**1**
Coordinator Home Care Programs	Inuvik	1	1	**2**	1	1	**2**	0	1	**1**	0	1	**1**	0	1	**1**
Home Care Nurse	Inuvik	1	0	**1**	0	0	**0**	0	0.5	**0.5**	0	1.53	**1.53**	1	1.53	**2.53**
Clerical Support	Inuvik	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Medical Social Worker	Inuvik	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Elders Day Program – 2 HSW	Inuvik	0	2	**2**	0	2	**2**	0	2	**2**	0	2	**2**	0	2	**2**
Home Support Worker	Aklavik	1	2	**3**	1	2	**3**	1	2	**3**	1	1	**2**	1	1	**2**
Elders Day Program – 1 HSW	Aklavik	1	0	**1**	1	0	**1**									
Meal Preparation/Cook	Aklavik	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Home Support Worker	Tuktoyaktuk	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Elders Day Program	Tuktoyaktuk	0	0.5	**0.5**	0	0.5	**0.5**	0	0.5	**0.5**	0	0.53	**0.53**	0	0.53	**0.53**
Home Support Worker	Fort McPherson	1	1	**2**	1	0.5	**1.5**	1	0	**1**	1	0	**1**	1	0	**1**
Elders Day Program Coordinator	Fort McPherson							0	0.5	**0.5**	0	0.53	**0.53**	0	0.53	**0.53**
Home Support Worker	Ulukhaktok	1	0	**1**	1	0	**1**	1	0.5	**1.5**	1	0.5	**1.5**	1	0	**1**
Home Support Worker	Tsiigehtchic	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Paulatuk	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Sachs Harbour	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**

[7] Based on data provided by DHSS. Does not include projected HSSA staffing complements for 2018/19.
[8] Represents positions funded from FNIHCC funding from the First Nations and Inuit Health Branch (FNIHB).

Position	Community	2014/15			2015/16			2016/17			2017/18			2018/19 Projected		
		Core	FNIHCC[8]	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total
NTHSSA – Dehcho Region		**4.5**	**4.5**	**9**	**5**	**4.5**	**9.5**	**7**	**4.5**	**11.5**	**7**	**6**	**13**	**9.5**	**6**	**15.5**
Regional Coordinator	Fort Simpson	0	1	**1**	0	1	**1**				0	1	**1**	0	1	**1**
Home Care Nurse in Charge (NIC)/Team Lead	Fort Simpson							1	1	**2**	1	1	**2**	1	0	**1**
Manager, Continuing Care Services	Fort Simpson							1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Fort Simpson	2	1	**3**	2	1	**3**	2	1	**3**	2	1	**3**	2	1	**3**
Home Support Worker	Fort Providence	0	1	**1**	1	1	**2**	1	1	**2**	1	1	**2**	1	1	**2**
Home Care Nurse	Fort Providence													0	1	**1**
Activity Aid/Coordinator	Fort Providence	1	0.5	**1.5**	0.5	0.5	**1**	0.5	0.5	**1**	0.5	0.5	**1**	0.5	0.5	**1**
Home Support Worker	Fort Liard	1	1	**2**	1	1	**2**	1	1	**2**	1	1	**2**	1	1	**2**
Activity Aid	Fort Liard										0	0.5	**0.5**	0	0.5	**0.5**
Home Support Worker	Jean Marie River													0.5	0	**0.5**
Home Support Worker	Nahanni Butte													0.5	0	**0.5**
Home Support Worker	Sambaa K'e													0.5	0	**0.5**
Home Support Worker	Kakisa													0.5	0	**0.5**
Home Support Worker	Wrigley	0.5	0	**0.5**	0.5	0	**0.5**	0.5	0	**0.5**	0.5	0	**0.5**	1	0	**1**
NTHSSA – Fort Smith Region		**3.7**	**2.5**	**6.2**	**3**	**2.5**	**5.5**	**3**	**2.4**	**5.4**	**3**	**2.5**	**5.5**	**3**	**2.5**	**5.5**
Home Care Nurse (RN)	Fort Smith	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Care Nurse (LPN)	Fort Smith	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Fort Smith	1.7	1.5	**3.2**	1	1.5	**2.5**	1	2.4	**3.4**	1	1.5	**2.5**	1	1.5	**2.5**
Home Care Coord (RN)	Fort Smith	0	1	**1**	0	1	**1**				0	1	**1**	0	1	**1**
NTHSSA – Sahtu Region		**7.35**	**3.2**	**10.55**	**6.43**	**3.2**	**9.63**	**7.35**	**3.2**	**10.55**	**7.35**	**3.2**	**10.55**	**7.4**	**3.7**	**11.1**
Home Support Worker	Norman Wells	1	0.2	**1.2**	1	0.2	**1.2**	1	0.2	**1.2**	1	0.2	**1.2**	1	0.2	**1.2**
Community Health Nurse	Norman Wells	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**			
Manager, Continuing Care	Norman Wells	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Fort Good Hope	1	1	**2**	1	1	**2**	1	1	**2**	1	1	**2**	1	1	**2**
Community Health Nurse	Fort Good Hope	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**			
Elders Day Program HSW	Fort Good Hope													0	0.5	**0.5**

Position	Community	2014/15			2015/16			2016/17			2017/18			2018/19 Projected		
		Core	FNIHCC[8]	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total
Home Support Worker	Deline	1.5	1	**2.5**	1	1	**2**	1.5	1	**2.5**	1.5	1	**2.5**	1.5	1	**2.5**
Community Health Nurse	Deline	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**			
Custodian	Deline	0.35	0	**0.35**	0.43	0	**0.43**	0.35	0	**0.35**	0.35	0	**0.35**	0.4	0	**0.4**
Home Support Worker	Tulita	2.5	0	**2.5**	2	0	**2**	2.5	0	**2.5**	2.5	0	**2.5**	2.5	0	**2.5**
Community Health Nurse	Tulita	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**	0	0.25	**0.25**			
Community Health Nurse	Sahtu Region													0	1	**1**
NTHSSA – Yellowknife Region		**23**	**7.8**	**30.8**	**23**	**7.8**	**30.8**	**22**	**7.8**	**29.8**	**22**	**7.8**	**29.8**	**26**	**7.8**	**33.8**
Home Support Worker	Yellowknife[9]	5	2	**7**	5	2	**7**	5.5	2.8	**8.3**	5.5	2	**7.5**	6.5	2	**8.5**
Home Care (RN)	Yellowknife	4	2	**6**	4	2	**6**	6	2	**8**	6	2	**8**	6	2	**8**
Community Nurse	Yellowknife	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Medical Social Worker	Yellowknife	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Referral Care Coordinator	Yellowknife	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Dietician	Yellowknife	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
HSW Supervisor	Yellowknife	1	0	**1**	1	0	**1**	2	0	**2**	2	0	**2**	1	0	**1**
Manager	Yellowknife	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Unit Clerk	Yellowknife	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	1	1	**2**
Home Care LPN	Yellowknife	2	0	**2**	2	0	**2**	2	0	**2**	2	0	**2**	2	0	**2**
Enterostomal Therapy RN	Yellowknife	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Clinical Coordinator	Yellowknife	0	0	**0**	0	0	**0**									
Homemaker/Rehab Aid	Yellowknife	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Fort Resolution	1	0.8	**1.8**	1	0.8	**1.8**				0	0.8	**0.8**	0	0.8	**0.8**
Elders Lunch Cook	Fort Resolution	1	0	**1**	1	0	**1**	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**
Supervisor, HSWs	Fort Resolution	1	0	**1**	1	0	**1**							1	0	**1**
HCC Nurse	Fort Resolution	1	0	**1**	1	0	**1**							1	0	**1**
Home Support Worker	Lutsel K'e	1	0	**1**	1	0	**1**							1	0	**1**

[9] Yellowknife staffing includes services to Dettah and N'Dilo.

Position	Community	2014/15			2015/16			2016/17			2017/18			2018/19 Projected		
		Core	FNIHCC[8]	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total	Core	FNIHCC	Total
Elders Lunch Cook	Lutsel K'e	1	0	**1**	1	0	**1**	0.7	0	**0.7**	0.7	0	**0.7**	0.7	0	**0.7**
Tlicho CSA		**6.6**	**5**	**11.6**	**6.6**	**3.5**	**10.1**	**6.6**	**3.5**	**10.1**	**6.6**	**4**	**10.6**	**6.6**	**3.25**	**9.85**
Home Care RN/LPN	Behchoko/ Gameti	1	2	**3**	1	1	**2**	1	1	**2**	1	1	**2**	1	0.25	**1.25**
Medical Social Worker	Behchoko	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Home Support Worker	Behchoko	3.0	1.5	**4.5**	3.0	1	**4.0**	3.0	1	**4.0**	3.0	1	**4.0**	3	1	**4**
Clerk Interpreter	Behchoko	0	0.5	**0.5**	0	0.5	**0.5**	0	0.5	**0.5**	0	0.5	**0.5**	0	0.5	**0.5**
Manager of Continuing Care	Behchoko	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**
Home Support Worker	Whati	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**
Elders Day Program HSW	Whati										0	0.5	**0.5**	0	0.5	**0.5**
Home Support Worker	Gameti	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**	0.8	0	**0.8**
Hay River HSSA		**6.53**	**2.5**	**9.03**	**6.53**	**2.5**	**9.03**	**6.53**	**2.5**	**9.03**	**6.53**	**2.5**	**9.03**	**8.5**	**2.5**	**11**
Home Care Nurse (RN)	Hay River	2	0	**2**	2	0	**2**	2	0	**2**	2	0	**2**	2	0	**2**
Diabetes Nurse	Hay River	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Home Support Worker	Hay River	2.53	0.5	**3.03**	2.53	0.5	**3.03**	2.53	0.5	**3.03**	2.53	0	**2.53**	4.5	0.5	**5**
Home Care Nurse (LPN)	Hay River	0	0	**0**	0	0	**0**	1	0	**1**	1	0	**1**	1	0	**1**
Dietician	Hay River	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**	0	1	**1**
Foot Care LPN	Hay River	1	0	**1**	1	0	**1**									
Home Care Supervisor	Hay River	1	0	**1**	1	0	**1**	1	0	**1**	1	0	**1**	**1**	**0**	**1**

Table 4 below provides a breakdown of the ratio of HSW and nursing staff by region and community, based on the funded staffing complements provided by the DHSS. The ratio of HCC staff per 1,000 people varies significantly by community and HSSA/region across the NWT from 1.19 HSW/nursing staff per 1,000 people in the NTHSSA Yellowknife Region to 4.1.5 HSW/nursing staff per 1,000 people in the NTHSSA Dehcho Region. This variation in funded staffing complements is consistent with the variation in average service hours per client observed in Table 5 below.

Table 4: Ratio of HCC Staff to Population by Community and HSSA/Region

Region/Community	2018/19 Projected Population	HSW and Nursing HCC Staff (FTEs)	Nursing and HSW Staff/ 1,000 Population
NTHSSA - Beaufort Delta Region	**6,880**	**16.03**	**2.33**
Aklavik	623	2	3.21
Fort McPherson	684	1	1.46
Inuvik	3,536	8.03	2.27
Paulatuk	302	1	3.31
Sachs Harbour	111	1	9.01
Tsiigehtchic	198	1	5.05
Tuktoyaktuk	982	1	1.02
Ulukhaktok	444	1	2.25
NTHSSA - Dehcho Region	**3,374**	**14.00**	**4.15**
Fort Liard	537	2	3.72
Fort Providence	719	4	5.56
Fort Simpson	1,296	4	3.09
Other Communities	822	4	4.87
NTHSSA - Sahtu Region	**2,637**	**9.45**	**3.58**
Colville Lake	142	0.25	0.00
Délı̨ne	576	2.5	4.34
Fort Good Hope	570	2	3.51
Norman Wells	818	2.2	2.69
Tulita	531	2.5	4.71
NTHSSA - Yellowknife Region	**22,173**	**26.30**	**1.19**
Yellowknife/Dettah/N'Dilo	21,293	21.5	1.01
Lutsel'Ke	319	1	3.13
Fort Resolution	561	3.8	6.77
Tlicho CSA	**2,944**	**6.85**	**2.33**
Behchokǫ̀	2,010	5	2.49
Gamètì	301	1.05	3.49
Wekweètì	132	0	0.00
Whatì	501	0.8	1.60
NTHSSA - Fort Smith Region	**2,709**	**5.50**	**2.03**
Hay River HSSA	**3,824**	**9.00**	**2.35**
NWT Total	**44,541**	**87.13**	**1.96**

Utilization of HCC Services Across the NWT

Table 5 provides a summary of the total number of HCC clients, HCC hours of service, and average hours of service per client for each community and HSSA for the 2014/15, 2015/16, 2016/17, and 2017/2018 fiscal years. The average hours of service per client varies by community, HSSA and region within the NTHSSA, as well as by fiscal year.

MNP notes that the data used for analysis in this section was collected and reported through Health Suite, which was perceived by DHSS and HCC staff representatives to be under-represented of the true hours of HCC service provided in each HSSA/region, especially with regards to nursing services. In addition, hours of service data were not available for the NTHSSA Beaufort-Delta Region.

Table 5: Utilization of NWT HCC Services by HSSA, Region and Community[10]

	2014/15			2015/16			2016/17			2017/18		
Region/Community	Clients	Hours of Service	Avg Hours Per Client	Clients	Hours of Service	Avg Hours Per Client	Clients	Hours of Service	Avg Hours Per Client	Clients	Hours of Service	Avg Hours Per Client
NTHSSA - Beaufort Delta Region	**145**	n/a	n/a	**140**	n/a	n/a	**153**	n/a	n/a	**144**	n/a	n/a
Aklavik	34	n/a	n/a	35	n/a	n/a	39	n/a	n/a	35	n/a	n/a
Fort McPherson	18	n/a	n/a	16	n/a	n/a	22	n/a	n/a	30	n/a	n/a
Sachs Harbour	2	n/a	n/a	2	n/a	n/a	2	n/a	n/a	2	n/a	n/a
Tsiigehtchic	5	n/a	n/a	4	n/a	n/a	6	n/a	n/a	4	n/a	n/a
Tuktoyaktuk	16	n/a	n/a	21	n/a	n/a	22	n/a	n/a	21	n/a	n/a
Ulukhaktok	11	n/a	n/a	12	n/a	n/a	13	n/a	n/a	8	n/a	n/a
Paulatuk	11	n/a	n/a	11	n/a	n/a	11	n/a	n/a	9	n/a	n/a
Inuvik	48	n/a	n/a	39	n/a	n/a	38	n/a	n/a	35	n/a	n/a
NTHSSA - Dehcho Region	**199**	**4,372.27**	**21.97**	**276**	**6,478.98**	**23.47**	**311**	**4,673.54**	**15.03**	**285**	**5,624.32**	**19.73**
Fort Liard	16	22.75	1.42	17	406.50	23.91	26	67.51	2.60	32	868.17	27.13
Fort Providence	115	1,991.29	17.32	139	2,778.14	19.99	181	1,916.40	10.59	150	1,958.50	13.06
Fort Simpson	68	2,358.23	34.68	120	3,294.34	27.45	104	2,689.63	25.86	103	2,797.65	27.16
Other Communities	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
NTHSSA - Sahtu Region	**196**	**7,966.24**	**40.64**	**182**	**7,173.56**	**39.42**	**139**	**6,225.97**	**44.79**	**154**	**6,488.90**	**42.14**
Colville Lake	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Délı̨ne	57	3,320.66	58.26	50	2,605.40	52.11	35	2,066.25	59.04	52	2,223.88	42.77
Fort Good Hope	42	1,893.75	45.09	58	2,169.33	37.40	42	1,915.44	45.61	48	2,205.14	45.94
Norman Wells	30	1,150.09	38.34	18	977.75	54.32	13	908.10	69.85	12	647.99	54.00
Tulita	67	1,601.74	23.91	56	1,421.08	25.38	49	1,336.18	27.27	42	1,411.89	33.62
NTHSSA - Yellowknife Region	**811**	**13,116.13**	**16.17**	**824**	**14,483.71**	**17.58**	**956**	**14,049.23**	**14.70**	**1,025**	**14,472.23**	**14.12**
Yellowknife	777	12,222.98	15.73	795	13,543.70	17.04	916	13,416.30	14.65	978	13,494.53	13.80
Dettah	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Lutsel'Ke	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00	24	473.18	19.72
Fort Resolution	34	893.15	26.27	29	940.01	32.41	40	632.93	15.82	23	504.52	21.94
Tlicho CSA	**96**	**1,640.08**	**17.08**	**74**	**1,477.68**	**19.97**	**80**	**2,016.52**	**25.21**	**124**	**2,486.13**	**20.05**
Behchokǫ̀	78	839.67	10.77	58	815.67	14.06	62	938.09	15.13	111	1327.93	11.96
Gamètì	9	640.33	71.15	8	583.59	72.95	8	599.83	74.98	6	443.33	73.89
Wekweètì	0	0.00	0.00	0	0.00	0.00	0	0	0.00	0	0	0.00
Whatì	9	160.08	17.79	8	78.42	9.80	10	478.6	47.86	7	714.87	102.12
NTHSSA - Fort Smith Region	**111**	**2,578.50**	**23.23**	**111**	**3,131.48**	**28.21**	**114**	**3,120.50**	**27.37**	**116**	**1,846.78**	**15.92**
Hay River HSSA	**236**	**4,003.22**	**16.96**	**177**	**3,795.97**	**21.45**	**171**	**3,659.97**	**21.40**	**141**	**3,680.84**	**26.11**
NWT Total	**1,794**	**33,676.44**	**20.42**	**1,784**	**36,541.38**	**22.23**	**1,924**	**33,745.73**	**19.05**	**1,989**	**34,599.20**	**18.75**

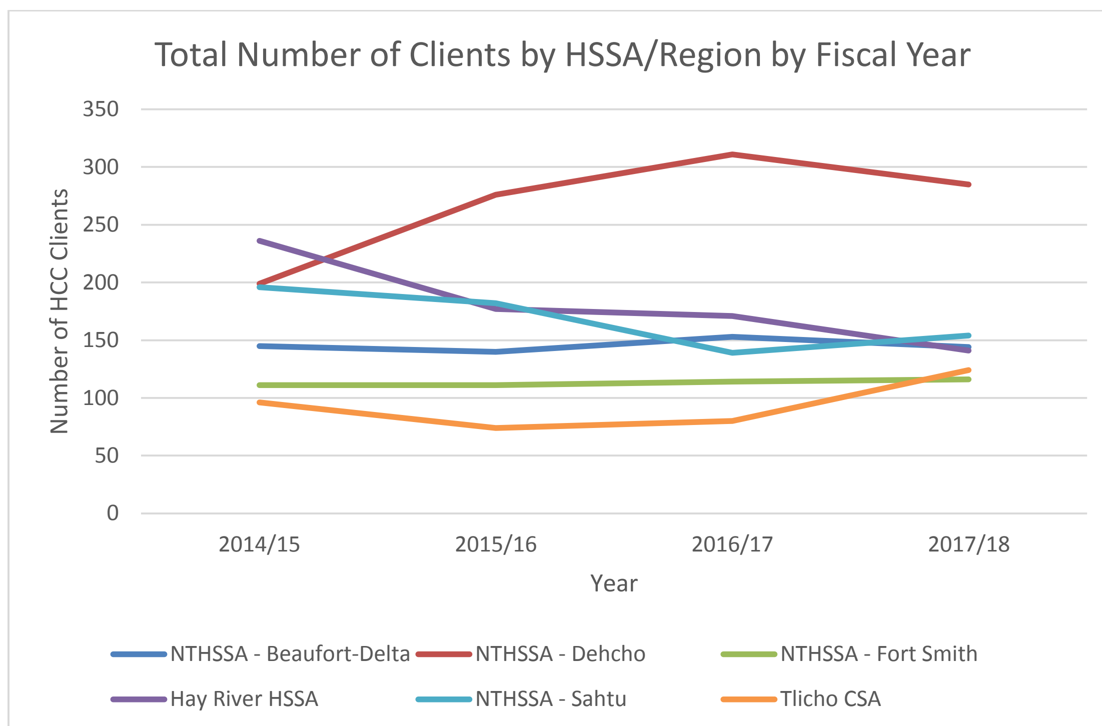
[10] Based on Health Suite data provided by the DHSS. Note, hours of service data were not available for the Beaufort-Delta Region.

Client Caseload – Health Suite Data Analysis from 2015/16 to 2017/18

According to Health Suite data, the total number of clients receiving HCC services in the NWT increased by 11% from 1,794 in 2015/16 to 1,989 in 2017/18 (Table 6).

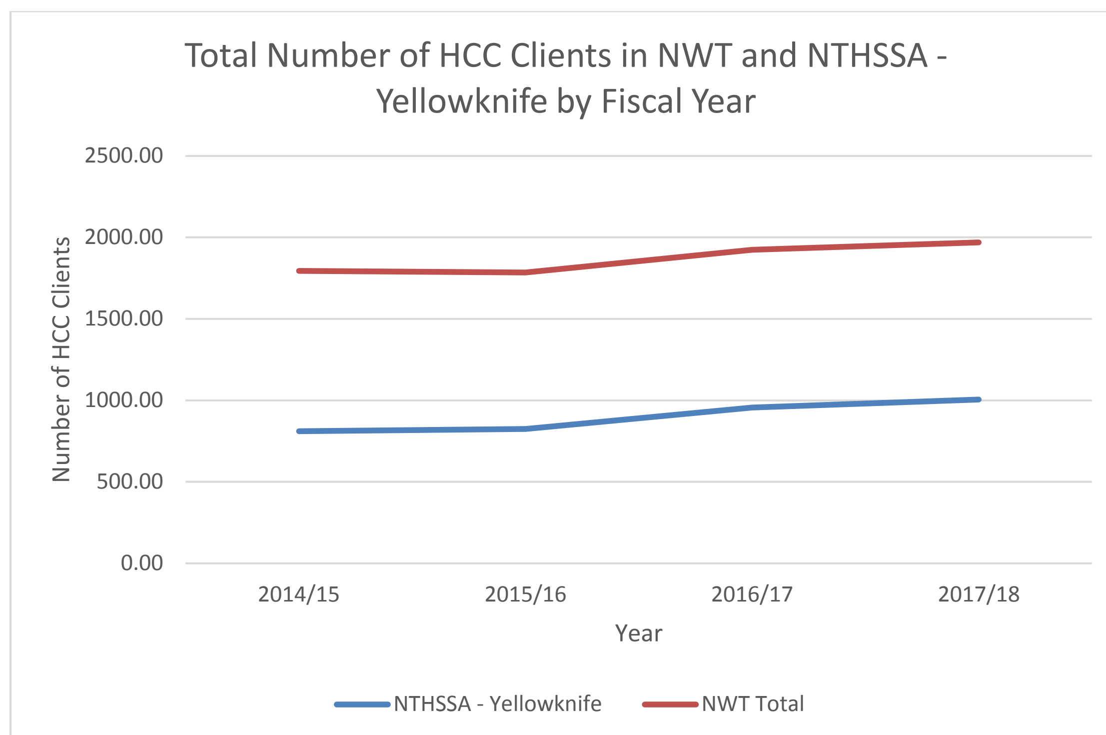
Figures 4 and 5 show that from 2014/15 to 2017/18, the number of HCC clients receiving services increased in some HSSAs/regions (i.e. NTHSSA Dehcho Region, Yellowknife Region, and Tlicho CSA), remained the relatively the same in some HSSAs/regions (i.e. NTHSSA Fort Smith Region and Beaufort-Delta Region), and decreased in some HSSAs/regions (i.e. NTHSSA Sahtu Region and Hay River HSSA).

Figure 4: Trends in HCC Client Numbers by HSSA and Region[11]



[11] Based on Health Suite data provided by DHSS. Does not include data for NTHSSA – Yellowknife Region or NWT overall.

Figure 5: Trends in HCC Client Numbers for NTHSSA – Yellowknife Region and NWT Overall[12]



Client Caseload – Reassessment of 2017/18 Caseloads in Select HSSA/Regions

Due to the unreliability of Health Suite data, the DHSS reassessed and recollected 2017/18 client caseload data for the following HSSAs/regions:

- NTHSSA Yellowknife and Sahtu regions
- Hay River HSSA

Based on the actual revised client caseload data provided, MNP estimated the client caseloads for NTHSSA Dehcho, Beaufort-Delta, and Fort Smith regions, as well as the Tlicho CSA. Overall, the total client caseload in the NWT was estimated to be 1,558 clients, which is 431 clients (22%) less than what was reported in the Health Suite data for the 2017/18 fiscal year (Table 6). In addition, approximately 37% of HCC clients receive personal care and/or home making services, and approximately 27% of HCC clients receive nursing care services.

[12] Based on Health Suite data provided by DHSS.

Table 6: Estimated Client Caseload in 2017/18 Based on Revised Data

Region/Community	Clients Receiving Only Personal Care Services	Clients Receiving Home Making Services	Clients Receiving Nursing Care	Clients Receiving Foot Care	Total Number of Clients (Based on Updated Data)	Total Number of Clients (Health Suite Data)
NTHSSA - Beaufort Delta Region**	**20**	**53**	**36**	**52**	**144**	**144**
0-59	3	4	8	7	19	19
60-74	3	16	14	19	46	46
75+	14	33	14	26	79	79
NTHSSA - Dehcho Region*	**41**	**103**	**6**	**7**	**193**	**285**
0-59	13	8	0	3	33	43
60-74	11	47	6	3	75	124
75+	17	48	0	1	85	118
NTHSSA - Sahtu Region	**22**	**57**	**2**	**3**	**106**	**154**
0-59	5	3	0	1	13	17
60-74	4	17	2	1	27	45
75+	13	37	0	1	66	92
NTHSSA - Yellowknife Region	**74**	**77**	**296**	**138**	**826**	**1,025**
0-59	6	18	158	41	324	479
60-74	47	26	75	47	266	393
75+	21	33	63	50	236	153
Tlicho CSA*	**20**	**42**	**2**	**4**	**86**	**124**
0-59	9	6	0	2	24	32
60-74	3	13	2	1	21	34
75+	8	23	0	1	41	58
NTHSSA - Fort Smith Region***	**11**	**32**	**22**	**33**	**88**	**116**
0-59	1	1	2	2	5	7
60-74	2	14	12	17	41	54
75+	8	17	8	14	42	55
Hay River HSSA	**8**	**22**	**55**	**76**	**115**	**141**
0-59	0	4	16	12	24	24
60-74	0	7	18	27	41	63
75+	8	11	21	37	50	54
NWT Total	**196**	**386**	**419**	**313**	**1,558**	**1,989**
0-59	37	44	184	68	442	621
60-74	70	140	129	115	517	759
75+	89	202	106	130	599	609

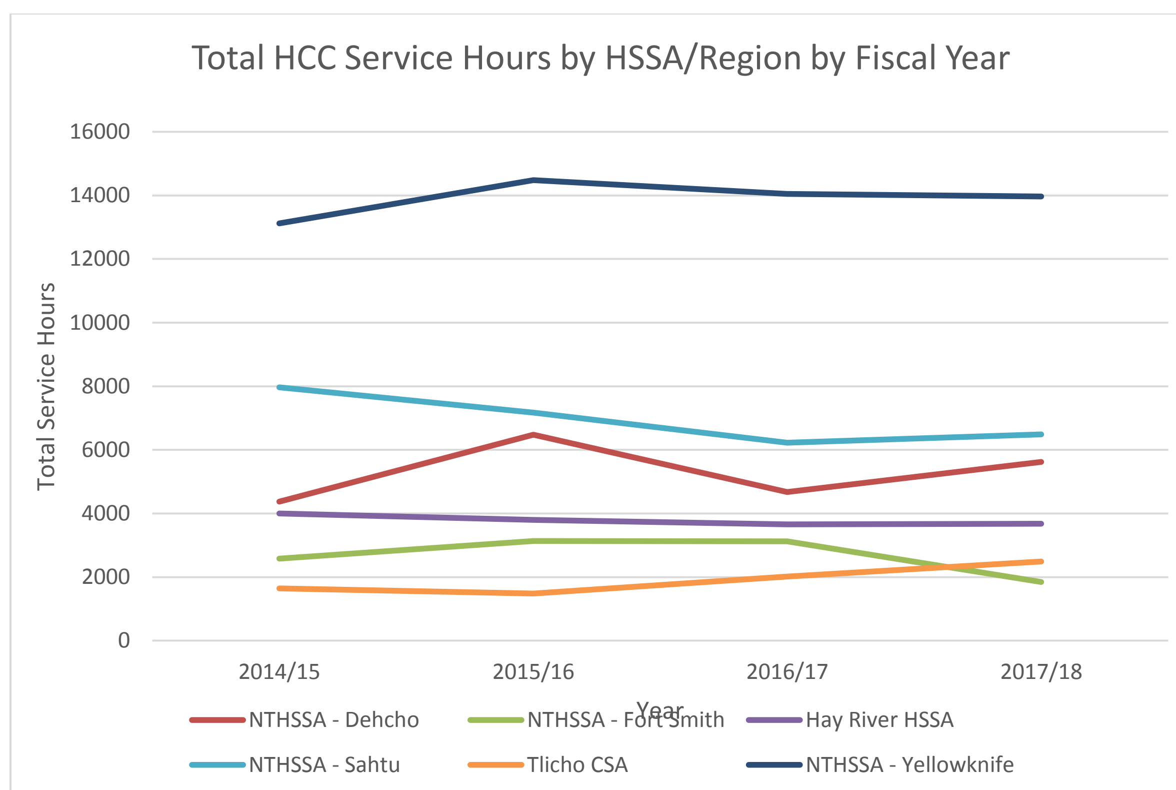
* Total number of clients estimated based on revised data for NTHSSA Sahtu region. Distribution of client services based on NTHSSA Sahtu region data.
** Total number of clients for NTHSSA Beaufort-Delta region based on existing data. Distribution of client services based on average of Hay River HSSA and NTHSSA Sahtu Region.
*** Total number of clients estimated based on revised data for Hay HSSA region. Distribution of client services based on average of Hay River HSSA and NTHSSA Sahtu Region.

Hours of Service Analysis – Health Suite Data

As shown in Table 5 above, the total reported hours of HCC service[13] in the NWT decreased from 36,541 hours in 2015/16 to 34,599 hours in 2017/18. Given that the total number of clients receiving HCC services in the NWT increased over this time (see Figures 4 and 5 and Table 5 above, based on Health Suite data), there has been a decrease in the average annual HCC service hours per client from 22.23 in 2015/16 to 18.75 in 2017/18 (note, the estimated average annual HCC service hours per client was 22.38 in 2017/18 based on the revised client caseload data provided by DHSS). In addition, the average annual HCC service hours per client varies significantly each fiscal year between different communities and regions in the NWT (Table 5 above).

Figure 6 shows that the total hours of HCC service increased in some HSSAs/regions (i.e. NTHSSA Dehcho and Yellowknife Regions, and Tlicho CSA), and decreased in all other HSSAs/regions (i.e. NTHSSA Fort Smith and Sahtu Regions, and Hay River HSSA). It is unclear if the observed decreases are associated with challenges in reporting, or actual decreases in service levels.

Figure 6: Trends in Hours of HCC Service by HSSA and Region[14]



[13] Does not include hours of service data for the NTHSSA – Beaufort Delta Region, as this data was not available.
[14] Based on Health Suite data provided by DHSS. Note, does not include data for NTHSSA – Beaufort Delta Region.

Table 7 provides a breakdown of total HCC hours by type of client service. The majority of HCC service hours (73-78% of total HCC hours) in the NWT are spent providing care to chronic clients, which includes chronic continuous, chronic mental health, and chronic time limited clients. The next most prominent type of service provided was acute post-hospital care (10-13% of total HCC hours), with the majority of hours being provided to clients in the NTHSSA Yellowknife Region and Hay River HSSA. Overall, the distribution of HCC hours by service type varies by HSSA/region.

Table 7: Breakdown of HCC Service Hours by Type of Service by HSSA/Region[15]

HSSA/Region	Acute Clients*	Acute Post-Hospital	Chronic Clients**	Disabled	Long Term	Palliative	Short Term/ Non Client***	Total
NWT Total								
2014/15	1,084.02	3,850.69	26,303.28	475.18	686.03	1,073.53	203.67	**33,676**
2015/16	1,059.97	4,871.15	26,740.34	522.51	535.92	2,463.34	348.33	**36,542**
2016/17	1,557.71	4,337.42	24,632.75	411.23	288.72	2,420.65	97.25	**33,746**
2017/18	1,824.34	3,465.00	25,796.43	625.54	215.34	2,403.55	268.15	**34,599**
NTHSSA - Dehcho Region								
2014/15	66.94	23.18	4061.56	146.67	0.00	2.83	71.09	**4,372**
2015/16	194.75	76.75	4654.30	251.74	0.00	1057.29	244.33	**6,479**
2016/17	306.86	60.42	2375.87	237.50	0.00	1675.22	17.67	**4,674**
2017/18	320.72	62.73	3000.79	272.15	0.00	1854.36	113.57	**5,624**
NTHSSA - Fort Smith Region								
2014/15	0.00	31.17	2438.33	0.00	0.00	109.00	0.00	**2,579**
2015/16	0.00	104.46	2758.96	0.00	0.00	268.06	0.00	**3,131**
2016/17	84.77	196.40	2779.84	0.00	43.07	16.42	0.00	**3,121**
2017/18	17.17	52.01	1751.34	26.26	0.00	0.00	0.00	**1,847**
Hay River HSSA								
2014/15	953.48	417.58	1644.55	205.50	686.03	54.00	42.08	**4,003**
2015/16	834.66	432.33	1688.64	176.75	535.92	43.42	84.25	**3,796**
2016/17	1135.08	661.00	1477.41	47.50	245.65	35.75	57.58	**3,660**
2017/18	1411.08	203.91	1616.26	72.00	215.34	55.50	106.75	**3,681**
NTHSSA - Sahtu Region								
2014/15	48.02	91.26	7730.46	81.00	0.00	3.00	12.50	**7,966**
2015/16	28.14	11.26	7033.14	94.02	0.00	7.00	0.00	**7,174**
2016/17	23.50	1.42	6130.56	64.66	0.00	2.33	3.50	**6,226**
2017/18	47.61	0.00	6264.94	70.75	0.00	91.27	14.33	**6,489**
Tlicho CSA								
2014/15	7.25	1.50	1612.07	0.00	0.00	18.76	0.50	**1,640**
2015/16	0.00	0.00	1477.68	0.00	0.00	0.00	0.00	**1,478**
2016/17	0.00	0.00	2016.52	0.00	0.00	0.00	0.00	**2,017**
2017/18	11.25	0.75	2426.62	18.92	0.00	9.09	19.50	**2,486**
NTHSSA - Yellowknife Region								
2014/15	8.33	3286.00	8816.31	42.01	0.00	885.94	77.50	**13,116**
2015/16	2.42	4246.35	9127.62	0.00	0.00	1087.57	19.75	**14,484**
2016/17	7.50	3418.18	9852.55	61.57	0.00	690.93	18.50	**14,049**
2017/18	16.51	3145.60	10736.48	165.46	0.00	393.33	14.00	**14,472**

* Includes acute chronic and acute mental health clients.
** Includes chronic continuous, chronic mental health and chronic time limited clients.
*** Represents short-term for Hay River HSSA and non-client for NTHSSA - Yellowknife.

[15] Based on Health Suite data provided by DHSS. Note, does not include data for NTHSSA – Beaufort Delta Region.

Table 8 provides a breakdown of total HCC hours by activity. The majority of HCC service hours (50-53% of total HCC hours) in the NWT are spent providing total home making and personal care activities (i.e. services provided by HSWs). The next most prominent activity was nursing hours (22-30% of total hours), with the majority of nursing hours being provided in the NTHSSA Yellowknife and Fort Smith Regions, and Hay River HSSA. MNP notes that although CHNs provide HCC services in the NTHSSA Dehcho, Sahtu, and Beaufort-Delta regions as well as the Tlicho CSA, most of these nursing hours are not captured in Health Suite. Similar to service type hours, the distribution of HCC hours by activity also varies by HSSA/region.

Table 8: Breakdown of HCC Service Hours by Activity by HSSA/Region[16]

HSSA/Region	Total Home Making	Personal Care	In-Home Respite	Case Assess Coordination	Nursing	Supportive Services	Total
NWT Total							
2014/15	11,077.20	5,735.28	3,368.99	2,290.27	10,069.95	1,134.75	**33,676**
2015/16	12,066.50	6,801.00	3,777.58	2,870.78	9,799.43	1,226.09	**36,542**
2016/17	10,394.23	7,007.67	4,097.26	2,532.10	8,638.31	1,076.21	**33,746**
2017/18	10,584.87	8,086.91	4,391.45	2,868.32	7,524.47	1,142.99	**34,599**
NTHSSA - Dehcho Region							
2014/15	1870.07	1026.57	974.03	291.25	210.35	0.00	**4,372**
2015/16	2602.35	1617.65	1633.60	545.21	80.17	0.00	**6,479**
2016/17	1717.58	1346.60	1219.14	371.22	19.00	0.00	**4,674**
2017/18	2208.11	1676.28	1231.34	383.89	123.95	0.75	**5,624**
NTHSSA - Fort Smith Region							
2014/15	1234.65	0.00	0.00	31.53	1312.32	0.00	**2,579**
2015/16	1610.23	40.75	0.00	53.30	1427.20	0.00	**3,131**
2016/17	1854.72	21.33	0.00	43.00	1201.45	0.00	**3,121**
2017/18	1050.02	21.09	0.00	6.25	769.42	0.00	**1,847**
Hay River HSSA							
2014/15	685.25	908.67	524.24	165.33	1719.73	0.00	**4,003**
2015/16	585.25	918.33	534.50	196.00	1561.89	0.00	**3,796**
2016/17	597.50	1040.98	443.50	188.41	1389.58	0.00	**3,660**
2017/18	578.58	1377.58	365.00	194.10	1165.58	0.00	**3,681**
NTHSSA - Sahtu Region							
2014/15	4103.51	1204.12	1286.13	835.80	536.68	0.00	**7,966**
2015/16	3772.12	1295.03	1051.61	822.32	232.48	0.00	**7,174**
2016/17	3223.46	949.50	1178.20	717.78	157.03	0.00	**6,226**
2017/18	2966.18	1041.90	1285.54	944.26	251.02	0.00	**6,489**
Tlicho CSA							
2014/15	494.50	504.92	506.42	89.08	45.16	0.00	**1,640**
2015/16	527.27	364.42	321.07	264.92	0.00	0.00	**1,478**
2016/17	808.70	432.61	615.25	159.34	0.67	0.00	**2,017**
2017/18	1017.00	408.15	779.90	277.92	3.01	0.00	**2,486**
NTHSSA - Yellowknife Region							
2014/15	2689.22	2091.00	78.17	877.28	6245.71	1134.75	**13,116**
2015/16	2969.28	2564.82	236.80	989.03	6497.69	1226.09	**14,484**
2016/17	2192.27	3216.65	641.17	1052.35	5870.58	1076.21	**14,049**
2017/18	2764.98	3561.91	729.67	1061.90	5211.49	1142.24	**14,472**

[16] Based on Health Suite data provided by DHSS. Note, does not include data for NTHSSA – Beaufort Delta Region.

Average Hours of Service – Based on Revised 2017/18 Caseload Data

MNP re-calculated the estimated average hours of care provided by HSWs (i.e. hours for total home making, personal care and respite care) as well as the average hours of care provided by nursing staff (i.e. nursing hours and case assessment coordination) in 2017/18, based on the estimated HCC client caseload distribution calculated from the revised data provided by the DHSS. The analysis found that:

- The average hours of care per client per year provided by HSWs is estimated to be 40.04 hours per year (23,063 hours/576 clients)
- The average hours of care per client per year provided by nursing staff is estimated to be 24.80 hours of per year (10,393 hours/419 clients)
- Total average hours of care per client per year provided by nursing and HSWs in 2017/18 is estimated to be 64.84, compared to the 18.75 hours of care per client per year calculated from the Health Suite Data (see Table 5 above).

HCC Referral, Admission, and Discharge Activity

Based on Health Suite data[17], the number of HCC referrals in the NWT ranged from 699 in 2016/17 to 718 in 2017/18, and the number of HCC admissions ranged from 678 in 2016/17 to 705 in 2017/18 (Table 9). This resulted in admission rates that ranged from 97% of referrals in 2016/17 to 98.5% of referrals in 2015/16. It should be noted that the majority of referrals and admissions were reported from the NTHSSA Fort Smith and Yellowknife Regions, and the Hay River HSSA. This suggests that referral and admission data is currently being under-reported in the other HSSAs and regions.

[17] Does not include data for the NTHSSA – Beaufort-Delta Region.

Table 9: Summary of Annual HCC Referral, Admission, and Discharge Data by Community and HSSA/Region

Region/Community	2014/15			2015/16			2016/17			2017/18		
	Referrals	Admissions	Discharges	Referrals	Admissions	Discharges	Referrals	Admissions	Discharges	Referrals	Admissions	Discharges
NTHSSA - Dehcho Region	**5**	**5**	**2**	**7**	**8**	**3**	**2**	**2**	**1**	**17**	**20**	**2**
Fort Liard	2	2	1	1	1	0	0	0	1	4	1	0
Fort Providence	0	0	0	3	3	1	2	2	0	1	1	0
Fort Simpson	3	3	1	3	4	2	0	0	0	12	18	2
Other Communities	0	0	0	0	0	0	0	0	0	0	0	0
NTHSSA - Sahtu Region	**12**	**12**	**6**	**4**	**5**	**14**	**3**	**3**	**10**	**9**	**7**	**5**
Colville Lake	0	0	0	0	0	0	0	0	0	0	0	0
Délı̨ne	3	3	0	1	1	0	1	1	0	2	2	0
Fort Good Hope	3	3	5	2	3	13	1	1	9	1	1	4
Norman Wells	0	0	1	1	1	1	1	1	1	0	0	1
Tulita	6	6	0	0	0	0	0	0	0	6	4	0
NTHSSA - Yellowknife Region	**624**	**604**	**405**	**615**	**600**	**367**	**628**	**608**	**500**	**645**	**628**	**613**
Yellowknife	624	604	405	615	600	367	626	606	497	645	628	610
Dettah	0	0	0	0	0	0	0	0	0	0	0	0
Lutsel'Ke	0	0	0	0	0	0	0	0	0	0	0	0
Fort Resolution	0	0	0	0	0	0	2	2	3	0	0	3
Tlicho CSA	**4**	**5**	**4**	**1**	**1**	**1**	**0**	**0**	**1**	**1**	**1**	**1**
Behchokǫ̀	4	5	4	0	0	0	0	0	0	1	1	1
Gamètì	0	0	0	1	1	1	0	0	0	0	0	0
Wekweètì	0	0	0	0	0	0	0	0	0	0	0	0
Whatì	0	0	0	0	0	0	0	0	1	0	0	0
NTHSSA - Fort Smith Region	**19**	**19**	**6**	**48**	**48**	**11**	**22**	**22**	**9**	**9**	**13**	**4**
Hay River HSSA	**38**	**41**	**17**	**39**	**41**	**28**	**44**	**43**	**23**	**37**	**36**	**11**
NWT Total	**702**	**686**	**440**	**714**	**703**	**424**	**699**	**678**	**544**	**718**	**705**	**636**

The number of discharges from the HCC program in the NWT ranged from 424 in 2015/16 to 636 in 2016/17 and was lower than the number of admissions into the program each fiscal year. This is consistent with the growth in HCC client numbers observed in Table 5 above. As with referral and admission data, the majority of discharges were reported from the NTHSSA Fort Smith and Yellowknife Regions, and the Hay River HSSA, suggesting that discharges are being under-reported in the other HSSAs and regions.

3.2 EFFECTIVENESS OF HCC SERVICE DELIVERY ACROSS THE NWT

Based on a review of information and MNP's consultations with various stakeholder groups[18] that receive HCC services or are responsible for the delivery and oversight of NWT HCC services, a summary of the effectiveness of HCC service delivery is provided below. The effectiveness of HCC service delivery was assessed from the perspective of:

- Perceived overall effectiveness of HCC services by clients;
- Staffing complements;
- Consistency of service delivery;
- Usage of forms, policies, and procedures;
- Usage and effectiveness of processes and tools;
- Usage of agreements;
- Management and oversight;
- Data collection and performance measurement; and
- Communication methods and tools used to promote services.

Perceived Effectiveness of HCC Services in the NWT by Clients

Overall, there was resounding appreciation by clients and their caregivers for the availability of funded HCC services across the NWT. Clients were particularly grateful for the in-home supports they receive and opportunities to partake in programs (e.g. the elders in Motion program) and events (e.g. bingo nights, seniors' lunches) that help seniors and elders continue to participate in the community and maintain social belonging. Assistance with grocery shopping, attending medical appointments, and running errands is also greatly appreciated.

The following are some stories and comments regarding positive client experiences with HCC services in different communities and HSSAs/regions across the NWT.

"Sometimes I'm lucky to have the HCC people drive me to medical appointments. Sometimes I get footcare done. Sometimes they will bring the kit to my home and do bloodwork on me at home."

***

"It's important that they come around. 'What can we do?' they [HSWs] all say. They check my mail, take me to the store, drive me around for one hour, and get me medication. Every time I [almost] run out [of meds] I phone so I don't run out of medication. My steps are too slippery and too high. I can fall."

***

"I get excellent home care. Grocery shopping, a little bit of house cleaning. I am not allowed to cook as it's a safety issue. My son, who is 38, is my primary care giver and lives with me. I have to let HCC [know]

[18] Outlined in Section 2.

in advance if I need a ride. I ensure that I call ahead of time if there's a community event I want to participate in."

***

"The services are very good for our needs. People are very well trained, polite, and good with elders. I have absolute trust in them which is more than I would say for the nurses at the hospital, having been a nurse for many years. The quality of care [of HCC] is outstanding."

***

"I certainly didn't know about it [HCC] till I needed it. That it is available is great. I enjoy the fact that there are 6 to 8 workers that come to the house on a rotating basis. I get to see them all and they all do a great job. I have to say I'm quite satisfied with the services I'm getting."

***

"I have a walker and a wheelchair. They take good care of me. I tell them that they spoil me. I enjoy every minute of it…They come and do a bit of a cleaning every two weeks. That really helps because I have a walker and I have no balance – I couldn't handle vacuuming…I would probably fall."

***

"I myself find the nurses very helpful, very friendly and I feel comfortable with them because they laugh with you, talk to you and listen to you when you want to talk…They are very friendly and supportive. I live by myself and it gives me company. It's a pleasure to have them here. They come about once a week unless I need them more often. If I need help, I can always call them."

***

"I was in the hospital for a month because I broke my ankle in two places. When I got home, I couldn't move, and they were there all the time. They'd come over twice a week and would ask if I need any groceries or anything. They're always there when I want something or if I need a ride, especially if you don't have a vehicle."

***

"They keep the floors clean, they do your laundry, make your bed for you, and they will sit and talk to you…sometimes I find that's more important than a clean house."

***

Before HCC, I used to go to emergency to get my bandages changed. I used to sit there for hours."

***

"My personal bias of having someone else take care of my personal needs was the biggest hurdle. But they are really nice ladies."

***

"I am Inuit and I'm from Ulukhaktok. My father was very strict with me and I grew up being very independent. When I broke my ankle and started staying home, I had to get over it and say 'I cannot do this on my own, I need help'…so I finally accepted it. And I'm glad I did. It's made a lot of difference."

***

"I like them, but I wish they could do a major cleanup maybe twice a year for us elders…I wouldn't mind if they dust the place once in a while for me because I can't move stuff around. Some of it is too heavy to move around…Sometimes they are only here for only 20 mins instead of an hour. I wish they would clean my dishes, the stove, and dust. Other than that, I'm ok with their service. They are nice ladies. I like them."

The following are some stories and comments regarding client concerns with HCC services and continuing care services provided in different communities and HSSAs/regions across the NWT.

"All they do is just come and rush out. I've been in their care for about a week since being discharged from the hospital...They didn't even show me how to use my cane and its functionalities...I didn't get an eye patch that I needed. If they come to your home, they just rush in and out – they don't ask you how you're doing."

*****

"Home care services. When I broke my leg last November, everybody in the assistance came over to my house and wanted to help...The home care workers were asked to bring me out to a taxi – there was 4 of them...They couldn't do it – they would not bring me downstairs. I don't know if it's because they aren't insured if someone gets injured, or if they weren't trained for it. All they had to do is bring me down with the wheelchair down 6 stairs. These HCC workers must be trained to take people up and down stairs. I think that all the people working in HCC need this kind of training."

*****

"A home care worker should not just phone, but at least come and be friendly and ask me how I'm doing...The first time a HCC worker came to my house, it felt like a home invasion."

*****

"We have all these seniors and elders in surrounding communities waiting for beds in LTC. So LTC is part of a band aid solution to what's really going on. If you don't address the issue, then you get elder abuse and neglect."

Staffing Complements

Government representatives and regional HCC staff identified several issues relating to HCC staffing complements including difficulties with hiring, high turnover rates, disparities in the levels of HCC work experience, and limited staff training.

HCC staff reported that staffing was based on the needs of the community but also often noted that positions went unfilled due to difficulties with hiring. For example, consultations with staff in Fort Smith revealed that the Direct Supervisor in charge of their HCC and LTC facility was a position that remained unfilled for nearly five months.

HCC staff across the different regions consistently noted difficulties with hiring an adequate number of staff at all levels to meet the needs of communities as well as for coverage of sick days and holidays. For example, in Norman Wells (NTHSSA Sahtu Region), it was reported that a lack of CHNs meant that they cannot make as many visits to HCC clients, because they are focussed on meeting more pressing needs within acute care. In Fort Good Hope (NTHSSA Sahtu Region), HCC staff noted that even with a group of casual nurses, covering any holidays or sick time is challenging. As a result of hiring issues, many communities have turned to locums and job shares which have reportedly negatively impacted continuity of care.

Government representatives and HCC staff throughout the different communities also reported high turnover, further impacting continuity of care. For example, HCC staff in Norman Wells (NTHSSA Sahtu Region) noted that limited training of locum nursing contributes to care plans that are not being used correctly, and that frequently changing nurses can create frustration for clients having to re-explain their health concerns.

Government representatives noted that the varying levels of HCC staff expertise and exposure to HCC also impacts HCC service delivery. For example, due to the broad scope of a CHN, a lack of previous exposure to HCC can make it challenging for nurses that are new to HCC to help meet the various client needs. This issue was raised by government representatives as being common since many nurses who are attracted to community care positions are often those who worked in acute care settings without experience in providing home care nursing services.

Service delivery was also impacted by limitations in training for staffing complements. The gaps in training reported by HCC staff ranged from specific training needs, like advanced wound and foot care in Inuvik (NTHSSA Beaufort-Delta Region), to general training for HSWs in Norman Wells (NTHSSA Sahtu Region).

According to government representatives, ensuring that staff are provided with adequate training can be difficult, especially with high staff turnover. For example, it is difficult for people to leave their homes to attend an eight-month training program through Aurora College. Providing training is made additionally complicated due to the high costs of bringing in external expertise to train local staff compared to having staff that is already trained and travels on work time to train others. HCC staff also pointed out that training can sometimes take up a substantial amount of the total time when locum staff are based in the community. Ultimately, limited training impacts the service clients receive and is particularly problematic in satellite sites, where HSWs are on their own and oversight is provided from afar.

"There are also no conferences for HSWs to get together, to know what services are being provided in each community. These would be of value to HSWs, to know what is happening in other communities, and what training they should be getting. Would help with improving service delivery."

***

"[Locum staff] can't go to Yellowknife for two-week training when they are here for [only] six weeks."

***

"HSWs are the nurses' eyes so [they] need better training to be able to do this."

- HCC Staff

Consistency of Service Delivery

Based on MNP's review of documentation across the health regions, the supply-side analysis completed in Section 3.1 above, and consultations with government representatives and staff, there is currently a lack of consistency in HCC service provision as well as equitable access to effective and appropriate HCC services across the NWT.

Prior to the establishment of the NTHSSA on August 1, 2016, eight independent HSSAs existed in the NWT.[19] According to government representatives interviewed, there were inconsistencies across these HSSAs in terms of each region's policies, practices, service provision, and interpretation of legislation.

To improve patient care and systemic efficiency, among other things, the NTHSSA was formed by amalgamating six HSSAs including the Beaufort-Delta HSSA, Sahtu HSSA, Dehcho HSSA, Fort Smith HSSA, Yellowknife HSSA, and Stanton Territorial Hospital.[20] In the interim, the Hay River HSSA and Tlicho CSA continue to operate as independent entities.

While the establishment of the NTHSSA provides the foundation to make systemic improvements to the NWT's health and social services system, there are still challenges related to implementing consistency in such a complex and multifaceted environment. Despite having territorial Community Care Standards, which include high-level standards for the delivery of HCC services, the following challenges exist:

- Different service delivery models are employed, with communities adapting services based on needs, available resources and capabilities (i.e. depending on the skill set of the workers, some of which have no formal training as HSWs).
- Some smaller communities only have HSWs delivering any form of HCC while extensive HCC services are provided in the regional centres.
- There is ambiguity across the regions regarding what is entailed in HCC. For instance, there is confusion regarding whether some services such as transportation and housekeeping should fall within or outside the basket of HCC.

> ***"In our community health program standards, we say that community nurses provide HCC services depending on available resources and their circumstances (the availability of the basket of home care services)."***
>
> \- Nursing Leadership Committee

HCC staff from all communities expressed some interest in standardization while also acknowledging the importance of flexibility because of the variation of community needs within HCC work. Some anecdotes from HCC staff are outlined below.

[19] Northwest Territories Health and Social Services Authority. https://www.nthssa.ca/en/about-us.
[20] Ibid.

"But to put similar services to every community…what you'll find in every community – there are things in [our community] that may not work in other communities because of the clientele…There are lots of elders that would like to be driven to the Northern store for groceries. This takes away from other things that HSWs could be doing. But it's part of our service. Are we truly mandated to do so? Sometimes we bend the rules a bit. We're here for the client."

***

"I like the idea of HCC standards being the same across the board. I try to keep our practice very close to the policy because we have a lot of people going to the MLA. That's why everything falls back to the Code of Conduct and our policies."

***

"It would be nice to have a set of standards, but what works for us wouldn't always work for someone else because the culture is different across communities."

- HCC Staff

While program standards (stating the minimum expected standards for community health programs) are applicable to community health centres and public health units, the ability for community health services to be able to deliver HCC depends on their capacity and the resources available to them. Thus, while a standardized approach would be beneficial, the standard may not always be feasible depending on the community's capacity. This may warrant a need for common elements/guidelines rather than stringent standards.

The NTHSSA is currently working on standardizing services; a centralized team has been tasked with going to different locations to assess what needs to be done in terms of standardization, and this work is still in progress.

3.3 USAGE OF FORMS, POLICIES, AND PROCEDURES

MNP reviewed over 200 documents across 5 regions including NTHSSA Sahtu, Beaufort-Delta, and Yellowknife Regions, Hay River HSSA, and Tlicho CSA. These documents included internal documents used by HCC staff for HCC operations, client specific documents, and external communications materials. Overall, there is considerable variation between the regions when it comes to the usage of region-specific or NTHSSA forms (Appendix C).

The documents received were sorted into twelve different categories.[21] Due to the variation between the regions, only documents within seven of the twelve categories were used by most communities. Figure 7 below outlines the forms within these seven categories that are used by two or more regions.

[21] Please refer to Appendix C for definitions of each document category as well as the full inventory of documents received within each category.

Figure 7: Types of Documents Used by Different HSSAs/Regions in the NWT[22]

Document Type	HSSA/Region				
	Hay River HSSA	NTHSSA Sahtu	NTHSSA Beaufort-Delta	NTHSSA Yellowknife	Tlicho CSA
Communication Material					
Footcare	✓		✓	✓*	
General HCC	✓		✓	✓* (EN&FR)	
Policies, Procedures, & Guidelines					
Home Support Services			✓	✓✓*	
Admission Criteria			✓	✓	
Home Safety Risk Assessment			✓	✓*	
Client Identifiers			✓	✓*	
Fall Prevention Strategy			✓	✓*	
Hand Hygiene Program			✓*	✓*	
Hand Hygiene Compliance Auditing			✓*	✓*	
Wound Care Strategy			✓*	✓*	
Intake/Admission Forms					
HCC Referral	✓✓✓*		✓	✓✓✓*	
HCC Admission		✓			✓
Care Plans					
HCC Plan and Service Record	✓✓*	✓	✓✓✓*	✓*	✓
Assessments					
CCAP Assessment Form	✓✓✓*	✓	✓✓✓*	✓✓✓*	
Other Assessment Forms		✓			✓
Priority Screening Tool	✓			✓	
Footcare	✓			✓*	
Braden Pressure Ulcer Risk Assessment	✓		✓		
Falls Risk Assessment			✓	✓	
Environmental/Home Safety Assessment			✓	✓	✓
Client Consent and Agreement Forms					
HCC Client Contract	✓✓*	✓	✓		✓
Footcare Program	✓			✓*	

[22] Based on forms and documents provided by each HSSA/region. No documents were provided by NTHSSA Dehcho or Fort Smith Regions and have not been included in the analysis.

Document Type	HSSA/Region				
	Hay River HSSA	NTHSSA Sahtu	NTHSSA Beaufort-Delta	NTHSSA Yellowknife	Tlicho CSA
Flow Sheets					
HCC	✓*	✓	✓		
Footcare	✓			✓*	
Wound Care			✓*	✓*	
Ostomy			✓*	✓*	

Legend	
✓	Region uses this document
✓*	NTHSSA Document
✓✓*	Region specific and DHSS Documents
✓✓✓*	GNWT DHSS Document

The similarities and differences in form use is exemplified when comparing the HCC care plan forms from each region. While the type of HCC care plan forms used by the different regions is not consistent, the general content of all the forms used is similar. More specifically, they each contain a listing of the actions that are to be taken to meet the needs of the client. Two of the five regions (i.e. Hay River HSSA and NTHSSA Beaufort-Delta) use the same GNWT DHSS form for HCC care plans. Yellowknife uses the NTHSSA HCC care plan form, which is not the same as the GNWT version that is used by Hay River HSSA and NTHSSA Beaufort-Delta Region. Three out of the five regions use a region-specific form (including Hay River HSSA, which uses both a GNWT DHSS and region-specific form).

In general, across all documents reviewed, there is variation between the regions in whether region-specific, NTHSSA, or GNWT DHSS forms are used. However, for the main documents and forms used in operations within the seven categories above, the content of the documents does not differ substantially.

Usage and Effectiveness of Processes and Tools

Through consultations, HCC staff were asked to describe and comment on the effectiveness of processes for providing HCC services for the following:

- Making referrals to the HCC program;
- Assessing referrals to the HCC program;
- Developing and reassessing care plans for HCC clients;
- Managing HCC client cases and charting client activities;
- Scheduling home visits; and

- Ensuring client access to other relevant service providers (e.g. Occupational Therapists (OTs), Physiotherapists (PTs), and Dieticians).

The following sections summarize the current state of each area. Where possible, the client perspective was also incorporated.

Making Referrals to the HCC Program

Referrals to the HCC program can be made via self-referral as well as referral by friends and family members, physicians discharging patients from the hospital, and other health care providers such as nurses, HSWs, and pharmacists. In Yellowknife, for example, most referrals to HCC reportedly come from physicians or hospital discharges. It should be noted that Yellowknife also takes referrals from Edmonton and remote communities for clients needing care when recovering from surgery. Referrals made by a friend include a consent process to ensure that the referred client is aware of the referral.

While there are various ways by which clients can be referred to the HCC program, there is limited communication across the communities regarding the eligibility for and availability of HCC services. Within the consultations completed, clients expressed being unaware of their eligibility for different services.

Assessing Referrals to the HCC Program

After a referral is made to the HCC program, either the CCAP assessment forms or a HSSA/region specific assessment form are completed (see Figure 7 above). While HSSAs/regions strive to implement a team-based approach to assessments, the individual(s) conducting assessments vary by region. For example, in the NTHSSA Yellowknife Region, the referral care coordinator (who is an RN) does the intake and assesses the referral using a prioritization tool either in the home or at the hospital. If there is a need for HCC services, the nurse then conducts an assessment that considers types of home care services required that may include wound care, chronic health management, blood work, palliative care. The HSW supervisor In Yellowknife will complete an assessment if home support services for ADl or IADl support such as personal care, meal prep, grocery assist are required, and an RN or LPN reviews the care plan with the supervisor in adherence to Continuing Care standards.

In the Tlicho CSA Region, assessments are completed by LPNs. In the Hay River HSSA, the Home Care Supervisor (who is also a RN) conducts the assessments and is sometimes accompanied (for the initial assessment) by a HSW and a nurse. In the NTHSSA Beaufort-Delta Region, a HCC nurse assesses clients in Inuvik, while CHN's conduct the assessments in other

> ***"It would be awesome if I could travel more and get people's charts and assessments up to date but right now it's just not possible."***
>
> - HCC Staff

communities in the region. CHNs or the NIC assess clients in the NTHSSA Sahtu and Dehcho Regions, while in the NTHSSA Fort Smith Region, a RN or LPN from the HCC program conducts the assessment.

It should be noted that, in some communities, the ability to complete an assessment is dependent on the CHN's or NIC's availability. More specifically, the assessment could be completed by both the HSW and the nurse in the community. For example, in Tuktoyaktuk and Ulukhaktok, the HSW or the CHN assess clients. In the event that the HSW completes the CCAP, he/she subsequently validates it with the nurse, who does the final sign off.

Developing and Reassessing Care Plans

As shown in Figure 7 above, the forms used for care plans varies by HSSA/region. The individualized care plans developed for each HCC client are usually completed by nursing staff across the regions.

In the NTHSSA Beaufort-Delta Region, a nurse collaborates with HSWs to develop care plans and sometimes reviews them with the client's family to validate HCC service requirements. Similarly, in the NTHSSA Dehcho Region, the NIC collaborates with HSWs on the development of care plans.

In the NTHSSA Yellowknife Region, the HSW supervisor develops the care plans for home support services, which are reviewed and approved by the Home Care RNs. The HCC RN develops the care plans for most HCC clients; which is done with the client and family input.

> ***"Having time set aside to work in a team is important as it relates to care planning."***
>
> - HCC Staff

During consultations with HCC staff across the NWT, it was acknowledged that HSW staff are mostly up-to-date on clients' needs and situations; therefore, it is important to include them in the care planning process.

The frequency at which care plans are reassessed and updated varies across HSSAs/regions. For example, in the NTHSSA Yellowknife Region, care plans are updated daily (i.e. when something changes or is added) and the supervisor does reassessments every few months (except for long-term clients, who get reassessed annually). In some other areas, like the NTHSSA Sahtu and Fort Smith Regions, reassessments typically do not take place unless there is a change in the client's condition or circumstances, or a HSW raises an issue.

Managing HCC Client Cases and Charting

Across the NWT, case management and charting are typically completed by HCC nurses, CHNs, or a NIC, with support from HSWs. Charting client activities is done on paper.

Currently, charting and documentation processes are inconsistently applied and lack integration between different care providers (e.g. HCC nurses (paper charts), HSWs,

physicians and OT/PT (EMR)). The main issues with the documentation process include the lack of access for HSWs to patient charts through EMR, staff finding the CCAP process challenging, and the data collected not accurately representing the reality of client services carried out. Some factors contributing to these issues include a lack of training for staff and the complexity of the system. Some anecdotes and quotes from HCC staff are outlined below.

"Let's say we're there for an hour and we're helping them clean up their house. But the behind story is that it was a mental health visit because they needed our support. You can't record both in Health Suite, so it looks like we are just there to clean the house. The data isn't fully representative of the activities that are going on."

***

"The nurses are able to pull the chart and see what the HSWs are doing in the house. Every Wednesday, the HCC team has a joint meeting where clients are discussed. Each nurse does his/her own care plan updating."

***

"It is challenging because HSWs don't have access to a patient's chart. When the HSW documents their activities, they can't open the client chart and see the plan. Their notes become side notes to what is in the client's chart. They put it into a spreadsheet or put it into the patient's notes which gets attached to the patient's chart."

***

"Sometimes it's a challenge when a nurse has a paper chart, and a HSW cannot access the paper chart for providing care. If we do go to EMR, need data on some type of device to provide care in the home. Sometimes we take pictures on the phone and have to print them off and put in the chart. They don't have data on work phones and cannot email pics. HCC keeps client information in other places than EMR as well. Docs don't realize that HCC information is not kept in EMR. This is a gap, and HCC is getting isolated from rest of medical care."

***

"If a nurse sees a client, she charts on the EMR and prints it off (the notes) and puts it in a paper chart so that HSWs can see the flow."

- HCC Staff

Scheduling Home Visits

In most HSSAs/regions, the scheduling of home visits is done by someone in a supervisory role (e.g. RNs (HCC or CHN), LPNs, NIC, or HSW supervisor) in collaboration with HSWs, as they are most familiar with clients' patterns (e.g. sleep cycles) and habits in order to identify the best time for visitation. In Hay River HSSA, HSWs make their own appointments. In the event that teams are short-staffed, home visits are prioritized based on client needs.

It was noted, through consultations with HCC staff and clients, that friendly check-ins can sometimes be difficult to incorporate into schedules due to limited staffing capacity, especially when unexpected situations arise. Several clients throughout the different communities that were visited by MNP expressed the desire for regular check-ins.

"Most of the time our clients will have certain days that we visit them…We are always aware of who is where, so we aren't double visiting."

***

"In some situations, people don't have families and we are the only people who visit and see them, so we become family to them."

- HCC Staff

***

"Should have a coordinator to visit all the seniors and elders on a day-to-day basis just to ask if we're doing ok…if we are fine."

***

"A home care worker should not just phone, but at least come and be friendly and ask me how I'm doing."

Integration with Other Relevant Service Providers

Consultations with HCC staff indicated that, while HCC clients generally receive OT/PT supports, other relevant services can sometimes be hard to obtain. Across the HSSAs/regions, OTs/PTs are available for in-person home visits and assessments as well as remotely, through telehealth consults. However, the frequency of visits by OTs/PTs varies across the HSSAs/regions and communities.

For example, smaller communities like Ulukhaktok in the NTHSSA Beaufort-Delta Region get visitation from an OT once a year, while the NTHSSA Dehcho Region gets visitation every three months.

Prior to HCC in the Tlicho CSA being able to send referrals for OT/PT support, clients need to visit Yellowknife to receive support. Now, Behchoko gets monthly visitation from OTs/PTs. The NTHSSA Yellowknife Region HCC indicated having PT support 1.5 days per week and OT support about 3 days per week, but that this is not enough given the demand for assessments and reassessments.

> ***"In health centres that have higher staff like Aklavik (4-5 staff), we receive a lot of home assessments – we can rely on them for lots of OT/PT needs, etc. But in health centres where there are only 1-2 nurses, they have no time and we (OTs) get no information from those areas."***
>
> *********
>
> ***"We try to visit each community 2-3 times a year depending on need. We go in for a week at a time. Each therapist has 4 communities. They report back on the communities, do follow ups and equipment need assessments. We don't have a dedicated home care OT in Inuvik itself. We are all general...We use telehealth services. We have a unit in rehab itself and it's booked up 75% of the time."***
>
> - OTs supporting HCC

In addition, HCC representatives from different HSSAs/regions indicated the need for greater access to other relevant supports, including adult medical social workers, nurses that can administer IV medications at home, advanced foot care service coverage, advanced wound care specialists, as well as respite, geriatric and palliative care supports. More information related to the demand for further HCC services is provided in Section 4.3.

> ***"From a continuing care perspective, there is more need to treat those [mental health] issues. As people try to stay in their homes longer, it'll likely increase. If someone has a mental breakdown, they go to Yellowknife and get medications. When they come back...who do they fall under? There's nobody to communicate with them and help them. There are no dedicated counsellors or psych nurses. We access community counselling nurses. Psychiatrists only come every few months and it's not consistent – it's a different person every time."***
>
> - HCC Staff

Management and Oversight

As noted earlier in Section 3.1 above, CHNs/NIC provide oversight in the smaller communities and dedicated Home Care Nurses provide oversight in larger communities such as Inuvik, Fort Smith, Hay River and Yellowknife. In some instances, the oversight provided by the local CHN/NIC is not consistent with the direction provided by HCC management within a particular region, creating confusion for HSWs.

Communities for which nursing oversight is provided by CHNs/NIC through the ISDM and not a dedicated Home Care Nurse include:

- NTHSSA Beaufort-Delta Region: Tsiigehtchic, Ulukhaktok, Paulatuk, Tuktoyaktuk, Aklavik, Fort McPherson, and Sachs Harbour
- NTHSSA Sahtu Region: Colville Lake, Deline, Tulita, Fort Good Hope, and Norman Wells
- NTHSSA Dehcho Region: Fort Liard; Fort Providence; Jean Marie River; Nahanni Butte; Sambaa K'e; Kakisa; Wrigley
- Tlicho Community Service Agency – Behchoko, Whati, Wekweti, Gameti

GNWT representatives as well as HCC staff reported that the staff oversight model is inadequate in some HSSAs/regions. GNWT representatives also indicated that oversight of HCC staff is inconsistent and unregimented.

A lack of management and oversight for HCC services was also identified in some HSSAs/regions by HCC staff. For example, in NTHSSA Dehcho Region, it was noted that smaller communities (e.g. Fort Liard, Providence) may not have adequate oversight. To address this issue, it was suggested that there is a need for more HCC nurses to provide clinical oversight around the different communities, especially smaller communities. In Norman Wells (NTHSSA Sahtu Region), it was also noted that there is a need for dedicated supervision of HSWs and HCC services. Overall, the lack of management and oversight was considered to be a substantial issue that requires attention moving forward.

Data Collection and Performance Measurement

Consultations with GNWT representatives indicated that HCC program performance measurement in HSSAs varies and is region-specific. Government representatives perceived that the reliability of Health Suite data was a challenge, and unrepresentative of the actual level of HCC services being provided in each community. While funding related information is currently being collected and reported to First Nations and Inuit Health (FNIH), the process is not standardized across HSSAs/regions. In addition, no work has been done on a territorial level to create performance measures for the purpose of planning and managing HCC programs.

From the HCC staff perspective, it was perceived that HSW reported activity levels in Health Suite were more accurate than the reported level for nursing services, but that activity levels overall were most likely under-represented. Workers in the HCC program also perceived that regions have adopted EMR differently, leading to inconsistencies in how HSWs chart and an inability to obtain data in a useable way. interRAI[23], which is currently in the process of being implemented in the NWT, could help by:

- Avoiding double charting (as done with the current system);
- Encouraging standardization and consistency in the way that clients are assessed;
- Having evidence-based reporting (there is currently no way to export data from EMR);

> ***"interRAI is a very complex system, and if it's going to be used as a tool that will accurately decide the needs of the client, the level of needed care, the complete picture of the client...I think (given our situation of locum CHNs and those that work 6 weeks in, 6 weeks out) that it is unrealistic to believe that this same level will be maintained. You'd have to keep retraining."***
>
> \- HCC Staff

[23] interRAI. http://www.interRAI.org/

- Making data driven decisions; and
- Benchmarking against other jurisdictions.

However, there are still some outstanding questions and considerations around interRAI's usage and its interaction with EMR. For instance:

- It is unclear who is going to be responsible and trained as the coder.
- There are still issues around computer illiteracy with HCC staff that will need to be addressed to successfully implement interRAI.
- There are issues regarding remote communities' web connectivity (the Lutselk'e community, for example, has no connectivity).

Communication of HCC Services

Across the NWT, communication around HCC eligibility and the range of services offered is generally limited to pamphlets or handouts, and word of mouth (i.e. nurses and HSWs sharing what services are offered). The communication in some communities is even more limited. For example, HCC staff in the NTHSSA Fort Simpson Region noted that a pamphlet outlining services offered and client rights was needed, but not something they currently offered. Staff in the NTHSSA Fort Smith Region also noted that communication is largely limited to word of mouth. While Fort Good Hope's HCC staff (NTHSSA Sahtu Region) shared that their communication strategy includes a radio awareness program, clients still expressed that there is a need for clearer communication for how the services provided by HSWs can help seniors and elders the community.

> ***"There is a need to communicate to seniors and elders what HSWs are and what they are supposed to do."***
>
> ***
>
> ***"Our status card and our treaty cards only help so much. We don't know what it covers."***
>
> - HCC Clients

Within consultations, clients from many of the communities expressed that they are not fully aware of their eligibility for different services. Interviews with the NWT Seniors Society representatives and Sahtu Region Wellness Council representatives both raised the need for better communication around eligibility for HCC services. GNWT representatives also noted that there are misconceptions around the scope of HCC services that can lead to unrealistic expectations, especially in smaller communities.

> ***"We need to be clear of who can refer somebody to home care and who cannot. We are not sure if family or community members can refer somebody to home care in some communities. But there are vulnerable seniors who need care, who are falling through the cracks in some communities."***
>
> - Seniors Society Staff
>
> ***
>
> ***"Are they just elders? They have to do a better job of doing an inventory on who is eligible in the community. I don't think they know who they are."***

3.4 EFFICIENCY OF HCC SERVICE DELIVERY ACROSS THE NWT

The HCC services delivered in the NWT are funded through 2 key sources:

- Core Homecare Funding through the GNWT DHSS
- First Nation and Inuit Home and Community Care Program (FNIHCC) – administered by DHSS on behalf of FNIHB

The GNWT DHSS just recently entered into a new agreement with FNIHB (through Indigenous Services Canada) and allocates the FNIHCC funding through separate contribution agreements with each HSSA and region within the NTHSSA. The core GNWT homecare funding is administered by the DHSS as part of the Core Funding Contribution Agreements with each HSSA in the NWT.

The core GNWT homecare funding provided by the DHSS is allocated based on historical funding levels with a provision for inflation. The funding provided to each HSSA is not allocated based on any type of formula that accounts for demographics or service requirements. The FNIHCC funding is allocated based on proposal submissions received from each HSSA and region with the NTHSSA.

There are no requirements to report on HCC activities and outcomes for the GNWT core homecare funding provided through the Core Funding Contribution Agreements. However, the FNIHCC Contribution Agreements do require that HSSAs report on HCC program activities (based on Health Suite reporting capabilities), as well as staffing complements and vacancies and the skill sets of nurses and HSWs providing HCC services.

Table 10 summarizes the level of HCC funding and spending by HSSA and region in the NWT for 2015/16, 2016/17 and 2017/18. The budget for HCC services in the NWT increased by 18.5% from $11.14 million in 2015/16 to $13.21 million in 2017/18. Overall in 2017/18, approximately 59% ($7.84 million) of funding was from GNWT core homecare funding, and 41% ($5.37 million) was from FNIHCC funding.

The level of funding per HCC client in each HSSA and region varied significantly from $3,526 per client in the NTHSSA Yellowknife region to $24,258 per client in the NTHSSA Beaufort-Delta region (Figure 8). In addition, the budget for HCC services in 2017/18 was only $121,000 lower for the NTHSSA Beaufort-Delta region compared to the NTHSSA Yellowknife region, despite a significantly lower number of HCC clients in 2017/18 (1,025 compared to 144 clients).

In 2017/18 there was an annual surplus of approximately $1.23 million including a surplus of approximately $1 million from GNWT core homecare funding and approximately $223,000 from FNIHCC funding. Based on discussions with DHSS representatives, the surplus was a result of unused funding. The accumulated surplus from FNIHCC funding between April 1, 2014 to March 31, 2018 was approximately $621,100.

MNP also notes that at total of $900,300 in funding was used to support the Continuing Care Action Plan and $487,472 was used to support DHSS program administration and support in 2017/18.

In addition to the direct funding provided for HCC services in the NWT through GNWT core homecare funding and FNIHCC funding, HCC clients are also receiving services from health professionals such as CHNs and Allied Health professionals funded by different program areas of the DHSS through the ISDM. These costs are currently not tracked and are not included in Table 10 below.

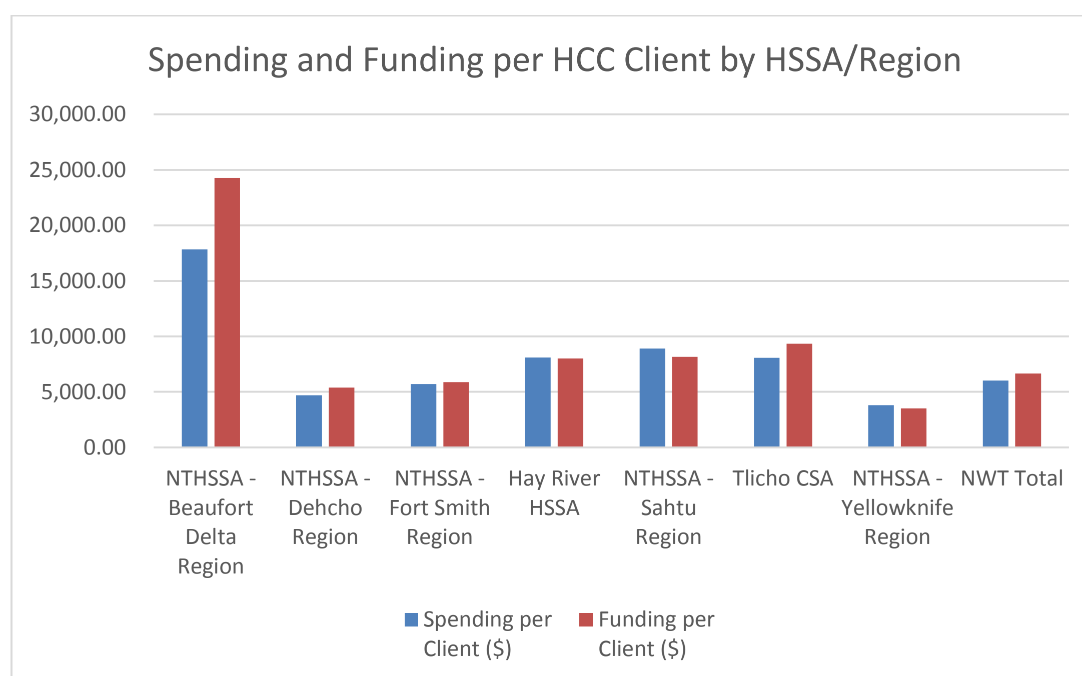
Table 10: NWT HCC Program Variance Analysis[24]

HSSA/Region	2017/18			2016/17			2015/16		
	Budget ($)	Actual ($)	Variance ($)	Budget ($)	Actual ($)	Variance ($)	Budget ($)	Actual ($)	Variance ($)
NTHSSA Beaufort-Delta	**3,493,147**	**2,569,150**	**923,997**	**2,630,952**	**2,194,238**	**436,714**	**2,648,373**	**2,128,104**	**520,269**
Core Homecare	1,881,826	957,829	923,997	1,315,000	923,286	391,714	1,315,000	815,317	499,683
FNIHCC	1,611,321	1,611,321	0	1,315,952	1,270,952	45,000	1,333,373	1,312,787	20,586
NTHSSA Dehcho	**1,536,358**	**1,341,325**	**195,033**	**1,189,406**	**1,300,738**	**(111,332)**	**1,198,406**	**1,270,267**	**(71,861)**
Core Homecare	911,549	756,207	155,342	697,000	808,332	(111,332)	697,000	768,861	(71,861)
FNIHCC	624,809	585,118	39,691	492,406	492,406	0	501,406	501,406	0
NTHSSA Fort Smith	**683,234**	**662,081**	**21,153**	**669,030**	**673,660**	**(4,630)**	**673,431**	**625,899**	**47,532**
Core Homecare	390,000	380,704	9,296	390,000	394,630	(4,630)	390,000	361,677	28,323
FNIHCC	293,234	281,377	11,857	279,030	279,030	0	283,431	264,222	19,209
Hay River HSSA	**1,128,554**	**1,140,043**	**(11,489)**	**965,731**	**1,082,993**	**(119,262)**	**999,065**	**1,059,766**	**(60,701)**
Core Homecare	807,431	852,480	(45,049)	625,000	787,289	(162,289)	625,000	720,417	(95,417)
FNIHCC	321,123	287,563	33,560	340,731	295,704	43,027	374,065	339,349	34,716
NTHSSA Sahtu	**1,254,683**	**1,369,333**	**(114,650)**	**1,165,552**	**1,304,928**	**(139,376)**	**1,173,788**	**1,317,180**	**(143,392)**
Core Homecare	647,000	727,943	(80,943)	647,000	813,489	(166,489)	647,000	854,747	(207,747)
FNIHCC	607,683	641,390	(33,707)	518,552	491,439	27,113	526,788	462,433	64,355
Tlicho CSA	**1,157,335**	**998,914**	**158,421**	**1,144,453**	**992,339**	**152,114**	**1,118,003**	**941,337**	**176,666**
Core Homecare	697,000	538,579	158,421	697,000	554,378	142,622	697,000	520,334	176,666
FNIHCC	460,335	460,335	0	447,453	437,961	9,492	421,003	421,003	0
NTHSSA Yellowknife	**3,614,076**	**3,885,376**	**(271,300)**	**2,154,000**	**2,578,862**	**(424,862)**	**2,154,000**	**2,488,276**	**(334,276)**
Core Homecare	2,401,567	2,615,885	(214,318)	2,154,000	2,578,862	(424,862)	2,154,000	2,488,276	(334,276)
FNIHCC	1,212,509	1,269,491	(56,982)	0	0	0	0	0	0

[24] Based on data provided by DHSS.

HSSA/Region	2017/18			2016/17			2015/16		
	Budget ($)	Actual ($)	Variance ($)	Budget ($)	Actual ($)	Variance ($)	Budget ($)	Actual ($)	Variance ($)
NTHSSA	**346,405**	**18,166**	**328,239**						
Core Homecare	100,000	0	100,000						
FNIHCC	246,504	18,166	228,239						
NWT Total	**13,213,891**	**11,399,270**	**1,229,503**	**11,156,458**	**11,365,092**	**(208,634)**	**11,140,975**	**10,654,072**	**486,903**
Core Homecare	7,836,373	6,829,627	1,006,746	6,525,000	6,860,266	(335,266)	6,525,000	6,167,952	357,048
FNIHCC	5,377,518	5,154,761	222,757	4,631,458	4,504,826	126,632	4,615,975	4,486,120	129,855

Figure 8: Level of Spending and Budget per HCC Client by HSSA and Region in 2017/18[25]



Overall, HCC spending represented 3.2% of the total DHSS budget in 2017/18. This is lower than the level of spending on HCC services in other provinces in Canada such as Manitoba (5.5% to 6.0%)[26], Alberta (9%)[27], and Newfoundland (6%)[28].

[25] Based on Health Suite Data and Funding Data Provided by DHSS.
[26] Future of Home Care Services in Manitoba, Reg Toews, December 2016.
[27] Alberta Health 2017/18 Annual Report.
[28] Based on https://www.budget.gov.nl.ca/budget2014/estimates/budget_estimates_2014.pdf and Provincial Home Support Program Review.

4. FUTURE REQUIREMENTS AND PROJECTED DEMAND FOR NWT HCC SERVICES

The following section describes the future requirements for HCC service delivery in the NWT including:

- Perceived improvements to HCC service delivery in the NWT;
- Perceived gaps in HCC service delivery in the NWT; and
- Projected demand for HCC service delivery in the NWT;
    - Projected HCC caseloads; and
    - HCC service delivery models and staffing requirements.

4.1 SERVICE DELIVERY IMPROVEMENTS

The focus of HCC service delivery improvements in the NWT was on better service integration with other NWT health and social services providers, as well as groups/organizations that provide supports to HCC clients.

Integration of patient/client services from acute care through to HCC service delivery can positively impact the continuity of care for HCC clients. GNWT representatives and HCC staff identified several areas where integration could improve the delivery of HCC services. Within transitions between different levels of care (e.g. hospital patient discharges back to the community), GNWT representatives and HCC staff identified opportunities for improving communication between hospital staff and HCC staff.

Opportunities for integration were also identified within charting and documentation processes, as well as through collaboration in service delivery with other groups (e.g. NWT Housing Corporation, communities, Indigenous organizations).

Need for Improved Transitions in Care

A lack of continuity with hospital discharges was identified as an issue by both GNWT representatives and HCC staff throughout the NWT. Staff perceived that there is a need to improve communication between HCC staff and acute care staff throughout the territory as well as with southern hospitals in order to improve the continuity of care of clients transitioned into the HCC program following hospital discharges.

HCC staff noted that discharges on Fridays were particularly difficult as they require HCC staff to carry out home visits after hours and on weekends. In addition to this, HCC staff noted that they usually get late notice, sometimes accompanied by referrals that do not contain the necessary information about the client, many of which have complex cases. Currently, most communities and regions in the NWT (with the exception of Yellowknife) only provide HCC Monday through Friday, usually between the hours of 8 am to 5 pm.

Some HCC staff also noted that there was a lack of discharge planning for patients referred to them. They shared that discharges taking place on Sunday, for example, do not consider that their ability to provide HCC services during weekends is very limited.

In general, HCC staff noted that it can be difficult to accommodate last minute discharges and expressed the need for improved discharge planning.

"For an elder coming out of the hospital on Friday, they come to our doorstep not knowing what they have to do."

***

"For example, the staff in hospital on a Sunday will say 'refer to HCC' even though our hours are limited...so communication within the system could be improved to improve coordination. I would like to see it far more seamless when we have our clients leave the hospital...In terms of discharge planning – there is none of that."

***

"[We are] not equipped to act quickly when someone is discharged without the proper planning [including, for example] palliative care patients released from hospital."

- HCC Staff

Need for Integration Within the Documentation Process

Government representatives shared that EMR implementation varied across the HSSAs/regions, and even by community within a HSSA/region. This has led to a lack of consistency in how it is used and makes the data entered challenging to search through and difficult to use.

HCC staff reported that the main barrier to service integration within documentation processes is that HSWs lack access to EMR, which can negatively impact the continuity of care for HCC clients. In particular, HSWs cannot see client specific charts and plans developed by clinicians and are unable to add notes directly to tracking documents (these must be added by a nurse or another clinician). As a result, HSWs are limited in their ability to cater the care they deliver to HCC clients, or to address notes that have been made by different care providers (e.g. nurses, physicians, OTs/PTs). HCC staff shared that, as a result of this lack of access, charting takes place both on paper by HSWs and electronically (e.g. EMR, Health Suite) by nurses.

GNWT representatives perceived that moving forward with the implementation of interRAI will help with tracking indicators and minimizing some double entry resulting from the use of two systems (i.e. EMR and Health Suite). HSSA and HCC staff from the different communities had varying opinions about the implementation of interRAI, with some stakeholders feeling it would improve documentation and reporting, and others wondering if it would actually improve the current situation.

Need for Collaboration with Communities, the NWT Housing Corporation and Across Regions

Government representatives, as well as HCC staff and clients, identified opportunities for greater collaboration with other organizations that provide supports to HCC clients including the NWT Housing Corporation and Indigenous community organizations.

Collaboration with Indigenous Community Organizations

A caregiver in Fort Good Hope (NTHSSA Sahtu Region) noted that Chief and Council used to receive and manage funding for HCC services in the community prior to devolution. They felt that HCC service delivery better met the needs of community members, and that HCC service delivery has declined since devolution. They felt that it would be beneficial if the community received its HCC funding directly from the federal government.

HCC staff in Fort Simpson (NTHSSA Dehcho Region) shared that Chief and Council used to provide snow shovelling services. However, funding to provide snow shovelling services stopped, leaving a gap for seniors and elders in the community. There is a need for the First Nation to be more involved in supporting seniors and elders in the community.

Collaboration with the NWT Housing Corporation

HCC clients and staff throughout the territory noted the poor housing situations in which many HCC clients reside. In Fort Good Hope (NTHSSA Sahtu Region), HCC staff noted that many clients' homes were overcrowded or needed repairs (e.g. broken doors and windows). In Fort Simpson (NTHSSA Dehcho Region), HCC staff shared that HSWs sometimes help clients make their homes more accessible by installing equipment and that there is a great need for this in the community.

> ***"I sat on a housing meeting last fall and became aware of the grants they offer. A lot of our clients live in assisted housing. For those that don't, we know programs that they can access funds and supports through for things like ramps. We can refer clients to those programs."***
>
> \- HCC Staff

HCC staff in Hay River HSSA noted that there are many grants available to help improve clients' housing infrastructure and that there is an opportunity to improve referrals to these grants.

HCC staff also noted that some policies of the NWT Housing Corporation are not conducive to supporting seniors and elders. For example, HCC staff in one community noted that since rent is based on household income, it can mean seniors and elders are paying too much since family members are living with them to avoid costs. Staff in another community noted that rent being tied to household income seems to create a disincentive for children to live with seniors and elders and support them.

The NWT Seniors' Society identified a need for better coordination and communication between the NWT Housing Corporation and HCC services in the NWT to help seniors and elders with home maintenance. A representative from the NWT Senior's Society shared

that seniors and elders have a difficult time looking after their homes or finding people to help with repairs and maintenance.

Representatives from the NWT Housing Corporation reported that, despite efforts to advertise their programs in all communities, there is still limited awareness of the different programs and services they provide. To address this issue, representatives shared that it would be helpful if HCC workers were more proactive in letting the NWT Housing Corporation know about client needs for handrails or ramps. They offer grant programs that could be helpful for HCC clients including: Seniors Aging-in-Place Retrofits and Contributing Assistance for Repairs and Enhancements.

Better Collaboration and Communication between HSSAs and Regions in the NTHSSA

GNWT representatives reported that there are opportunities for the different regions in the NTHSSA and the HSSAs to work together to provide complementary resources that fall outside of the bucket of services funded by the HCC program, such as dietician services, rehabilitation services, adult services social workers (for complex family situations, family violence or elder abuse), enhanced respite care, and oral health programs for seniors and elders. This would enable better access to these services.

4.2 PERCEIVED SERVICE DELIVERY GAPS FOR HCC CLIENTS

HCC Clients and staff, and GNWT representatives described the need for improved services in several areas. The main gaps identified were in relation to:

- Transportation services
- Respite care
- After-hours and palliative care
- Mental health support
- Dependable language translation
- Medical travel escorts
- Financial supports for caregivers

The following sub-sections examine each of these areas in further detail. Other gaps identified earlier in the report are also outlined.

"Seniors and elders don't have transportation to get them shopping…some of them barely get around. It's slippery outside."

***

"We want to be involved in community events – weddings, celebrations, funerals. Everyone wants to be involved but it's hard for people to partake in those activities."

***

"Before they used to travel with buses – elders would be taken around by bus and now there's nothing like that happening around here."

***

"If I wanted to do something at the library … to access recreational activities, which I think is important and part of a balanced lifestyle…there's no service for that."

***

"You can't phone in for an appointment at the hospital. You have to go in person to get a ticket for an appointment. If you live far away, that could mean a $20 cab ride there, $20 back and another $40 to go back to the appointment."

- HCC Clients

Transportation Services

Government representatives noted that there was a lack of programming and supports from other government departments and/or community organizations related to providing transportation services to HCC clients in many communities across the NWT. There were concerns regarding if it is the responsibility of the HCC program to provide transportation services in remote communities.

HCC staff in many communities noted being unable to meet clients' transportation needs. Some reasons for the lack of transportation services in remote communities included a lack of funding to purchase appropriate vehicles as well as difficulties with hiring drivers. For example, HCC staff in Behchoko (Tlicho CSA) reported both a lack of vehicles and drivers and noted that some vehicles are also not equipped to drive HCC clients that use wheelchairs. In Fort Good Hope (NTHSSA Sahtu Region), HCC staff noted that there is a need for a replacement vehicle and a van that could help HCC staff drive clients for grocery shopping.

Across all the territory, clients expressed a deep appreciation for transportation services provided through the HCC program. These services allowed HCC clients to continue to take part in community events, safely shop for groceries, and attend necessary medical appointments within the community. While many HCC clients shared their appreciation, there is also a need for further expansion of transportation programs to enable clients' continued participation in the community. For example, a client shared being unable to access services like the library due to lack of transportation services. HCC Staff in NTHSSA Yellowknife Region also noted that limited affordable transportation service options for seniors and elders and HCC clients meant that they were unable to participate in community events. Similarly, staff in Fort Simpson (NTHSSA Dehcho Region) shared that clients are unable to participate in events like drum dances due to a lack of transportation services outside of the HCC program.

> ***"Fortunately, we have a vehicle but there just aren't enough vehicles to get everyone around. Social workers use these same vehicles. Somehow, we try to make it all work around here, but we can't meet everyone's needs."***
>
> ***
>
> ***"In May there are drum dances but there's no one to bring them there or pick them up. And that's kind of sad. Some of them miss out."***
>
> - HCC Staff

Respite Care

HCC staff from several HSSAs/regions reported difficulties with providing adequate respite care to meet current demand, many due to a lack of staff and some due to a lack of respite beds in the community. Although respite care was identified as something that could help keep clients in their homes longer, communities reported that the lack of respite care caused a burden on HCC clients who are left with the option to travel or leave the

community in order to obtain respite care, causing further burden on caregivers. In Fort Good Hope (NTHSSA Sahtu Region), HCC staff shared that clients need to travel to Yellowknife, Inuvik or Norman Wells in order to access respite care. Staff in Fort Simpson (NTHSSA Dehcho Region) reported that there are not enough beds and that limited staffing also contributed to difficulties in providing respite care.

> ***"There are not enough beds. The community was supposed to have 2 respite beds, but one was blocked for a long time. While there is a new facility opening in Behchoko and Hay River has beds, people do not want to travel to get these services."***
>
> - HCC Staff

After-Hours and Palliative Care

Consultations with GNWT representatives and HCC staff identified a lack of 24-hour care and limited services during evenings and weekends in most communities (with the exception of Yellowknife). HCC staff noted that clients can get very sick at any time, and that additional hours are needed to support them at these irregular times. The need for services on weekends, in order to accommodate HCC client and caregiver schedules, was also stressed by HCC staff.

HCC staff also reported that further after-hour services are needed to meet the demand for palliative care. In particular, it was reported that the lack of night companions and 24-hour care means that many HCC clients who wish to die in their homes are unable to. HCC staff in some communities noted using flex-time in order to meet palliative care needs on weekends, but that they have difficulties obtaining family support on weekends when services are limited.

> ***"A lot of people get very sick and we have to call nursing staff and others to help them out. This doesn't always happen during daytime weekdays. We need extra time on evenings and weekends."***
>
> ***
>
> ***"The region does not have night companions or 24-hour care. Many clients want to die in the home and many times that is not possible, so clients have to leave their home to die and ultimately their needs have not been met."***
>
> - HCC Staff

Mental Health Supports and Adult Social Workers

GNWT representatives and HCC staff noted gaps in services for those with disabilities and mental health issues. Government representatives noted that these issues are particularly challenging in small communities, where seniors and elders can face significant social isolation. The only

> ***"For mental illness, there is nothing. There is a need for a psychiatrist or a psychiatric nurse. More resources are needed to support mental health support in the community."***
>
> - HCC Staff

community that government representatives considered as having a handle on case management for mental health clients was Inuvik (NTHSSA Beaufort-Delta Region), which has two centres. In several communities, HCC staff noted that the HSWs are left filling the gaps left from not having staff to provide mental health services.

In addition to mental health supports, HCC staff also identified the need for adult social workers (i.e. those that have an orientation and responsibility for an adult population) to help address some persisting social issues such as elder abuse. GNWT representatives also identified the need for further support services related to elder abuse acknowledging that they are some of the most marginalized and vulnerable populations. Both HCC staff and GNWT representatives expressed that, in many regions, there is overcrowding of houses, and, in some cases, families are dependent on the income of the seniors and elders.

> ***"It can be safer for seniors and elders to go grocery shopping with HSW than with their families. Sometimes they get taken advantage of by their families; they add groceries in the cart."***
>
> ***
>
> ***"Elders have to pay people to help them – pay even their own grandkids to translate for them, to cut wood from them. Lots of elder abuse from their grandchildren and their own family."***
>
> ***
>
> ***"Social workers see that family only goes in during pension time… Some of the elders don't want to speak up because that family member is the only person they have that can, for example, give them a ride."***
>
> - HCC Staff

Dependable Language Translation

HCC staff reported that the lack of a dependable language translation program was creating difficulties with providing effective HCC services to clients in their native language. For example, in one community, HCC staff reported that they were dependent on the ability of client family members for translation services and were otherwise unable to communicate with seniors and elders without translation support. In another community, HCC staff explained that HSWs have additional strain placed on them to provide translation services, taking away from their provision of other work.

> ***"Home support workers can be pulled away to accompany people to appointments in Yellowknife to translate. That really throws off their schedule."***
>
> ***
>
> ***"Workers understand the traditional language but don't speak it, so it can be hard to communicate with elders. Need more help from family members for translation."***
>
> - HCC Staff

Medical Travel Escorts

Another gap in HCC service delivery identified by HCC staff was the lack of a coordinated escort service for clients requiring travel for medical purposes. For example, in Fort Good

Hope (NTHSSA Sahtu Region), HCC staff are unable to offer transportation to the airport, which is located a 5-minute drive outside of the community. HCC staff also explained that clients are escorted by volunteers, and that travelling for cancer treatment to Edmonton for example could mean being away for two to three months. Within this time, only travel costs are covered for volunteers, not their time away from missing work. HCC staff in Norman Wells (Sahtu Region) also noted that they do provide transportation to the airport.

In Behchoko (Tlicho CSA), HCC staff shared that they have hired a contract worker that drives clients to medical appointments in Yellowknife in a van. Staff in Fort Simpson (NTHSSA Dehcho Region) noted that funds to support medical escorts could help incentivise families to take on the role of escorts. However, none of the regions have a coordinated program that aids with clients travelling for care.

> ***"Some people have never left the Territory before and they're going all the way to Edmonton. To get on the airplane, people have been denied chemotherapy because they don't have identification."***
>
> ****
>
> ***"It would be nice to have family more involved. But sometimes they're doing their own thing and it's hard to get family members to get involved. They would probably escort their parents if they got paid."***
>
> - HCC Staff

Financial Support for Caregivers

As identified above in the preceding sections, there are a number of gaps in relation to providing supports to seniors and elders in communities across the NWT, such as transportation (for medical and non-medical purposes), running errands (i.e. shopping and other), providing medical escort services, providing a sufficient level of housekeeping and food preparation services, and providing assistance with daily living chores such as snow shovelling and wood cutting services. One potential solution that has been suggested to overcome these gaps by GNWT representatives and some HCC staff, especially in more remote communities, is to provide financial supports for caregivers (family or other) to provide these supports to seniors and elders. This could help incentivise family members to be caregivers and support seniors and elders in their communities and overcome misconceptions that it is the governments responsibility to provide care for them. Further discussion regarding different self-funded care models in some other Canadian jurisdictions is provided in Section 5 below.

Other Gaps

Other gaps within HCC service delivery in the NWT identified by HCC staff and GNWT representatives outlined earlier in the report include:

- A lack of capacity to keep up with assessments and regular re-assessments in many regions across the NWT. This impacts the quality of care provided, as well as identifying HCC clients who might be ready to be discharged from the HCC program.

- A lack of capacity to provide advanced foot care and supports for advanced wound care across many communities in the NWT. Advanced foot care and advanced wound care continue to be a much-needed service for many HCC clients.
- A lack of capacity to schedule friendly visits with HCC clients. HCC staff and clients from across the territory reported the social and mental wellbeing benefits of having staff visit clients on a regular basis. However, given time resource restraints, staff are unable to provide this service on a regular basis.

4.3 PROJECTED DEMAND FOR HCC SERVICES IN THE NWT

The following section articulates the projected demand for HCC services in the NWT including:

- Projected HCC case loads
- HCC service delivery models and resource requirements

As part of this analysis, MNP also analyzed historical population growth rates by age demographic in the NWT to understand the current trends that are impacting HCC service delivery.

Historical Demographic Analysis

As seen in Table 11 below, the population in the NWT grew by a total of 2.7% over 10 years from 43,360 people in 2008 to 44,541 people in 2018. Despite the small growth in total population, there was significant growth in the 60 plus age demographic, which grew by 65.6% from 2008 to 2018. This includes a 76.5% increase in the 60-74 age group, and a 26.9% increase in the 75 plus age group (Table 11). Further, the 45-59 age group grew by 9.9% between 2008 to 2018. Per capita, the 55-74 and 75 plus age groups have the highest usage of HCC services in the NWT (see Table 13 below).

Table 11: Population Growth by Age Group in the NWT from 2008 to 2018[29]

	NWT Population Counts			Population Growth Rates	
Age Group	2018	2013	2008	5 year growth rate (2012 - 2017)	10 year growth rate (2017 - 2017)
0 to 4	3,180	3,194	3,285	-0.4%	-3.2%
5 to 9	3,036	3,043	2,978	-0.2%	1.9%
10 to 14	2,889	2,803	3,310	3.1%	-12.7%
15 to 24	5,952	6,803	7,262	-12.5%	-18.0%
25 to 44	13,753	13,965	14,045	-1.5%	-2.1%
45 to 59	9,750	9,424	8,869	3.5%	9.9%
60-74	4,976	3,647	2,819	36.4%	76.5%
75+	1,005	926	792	8.5%	26.9%
Total	**44,541**	**43,805**	**43,360**	**1.7%**	**2.7%**

The growth of the 60 plus age demographic from 2008 to 2018 varies by community as well as HSSA/region, and ranges from 35.9% in the NTHSSA Beaufort Delta Region to 102.4% in the NTHSSA Yellowknife Region (Table 12).

Table 13 shows that 31% of HCC clients in the NWT are 75 years and older, 38% are in the 55-74 age group, and 31% of clients are 54 and under. The breakdown of HCC clients by age group varied by community and HSSA/region in the NWT. For example, 15% of clients in the NTHSSA Yellowknife Region are 75 years and older, compared to 47% of HCC clients in all regions excluding the NTHSSA Yellowknife Region.

[29] Based on NWT Bureau of Statistics Population estimates as of July 1, 2018.

Table 12: Population Growth of 60 Plus Age Demographic by Community from 2007 to 2017[30]

	60+ Population Counts			Population Growth Rate		
Region/Community	2018	2013	2008	5 Year Growth Rate (2012 - 2017)	10 Year Growth Rate (2017 - 2017)	2018 Population 0 - 59
NTHSSA Beaufort-Delta Region	**909**	**762**	**669**	**19.3%**	**35.9%**	**5,971**
Aklavik	94	94	73	0.0%	28.8%	529
Fort McPherson	121	110	121	10.0%	0.0%	563
Inuvik	453	361	283	25.5%	60.1%	3,083
Paulatuk	32	30	31	6.7%	3.2%	270
Sachs Harbour	17	17	11	0.0%	54.5%	94
Tsiigehtchic	27	26	29	3.8%	-6.9%	171
Tuktoyaktuk	110	86	83	27.9%	32.5%	872
Ulukhaktok	55	38	38	44.7%	44.7%	389
NTHSSA Dehcho Region	**572**	**449**	**384**	**27.4%**	**49.0%**	**2,802**
Fort Liard	85	55	58	54.5%	46.6%	452
Fort Providence	151	95	88	58.9%	71.6%	568
Fort Simpson	199	165	126	20.6%	57.9%	1097
Hay River Dene 1	44	39	33	12.8%	33.3%	287
Wrigley	23	28	30	-17.9%	-23.3%	91
Other Communities	70	67	49	4.5%	42.9%	307
NTHSSA Sahtu Region	**358**	**301**	**236**	**18.9%**	**51.7%**	**2,279**
Colville Lake	10	15	16	-33.3%	-37.5%	132
Délı̨ne	85	51	49	66.7%	73.5%	491
Fort Good Hope	77	89	77	-13.5%	0.0%	493
Norman Wells	100	84	46	19.0%	117.4%	718
Tulita	86	62	48	38.7%	79.2%	445
NTHSSA Yellowknife Region	**2,752**	**1,896**	**1,360**	**45.1%**	**102.4%**	**19,421**
Yellowknife	2,412	1,665	1,147	44.9%	110.3%	18,195
Dettah/N'Dilo/Other	169	116	101	45.7%	67.3%	517
Lutsel'Ke	59	41	41	43.9%	43.9%	260
Fort Resolution	112	74	71	51.4%	57.7%	449
Tlicho CSA	**312**	**256**	**227**	**21.9%**	**37.4%**	**2,632**
Behchokǫ̀	196	165	151	18.8%	29.8%	1,814
Gamètì	43	31	30	38.7%	43.3%	258
Wekweètì	15	17	8	-11.8%	87.5%	117
Whatì	58	43	38	34.9%	52.6%	443
NTHSSA Fort Smith Region	**448**	**393**	**314**	**14.0%**	**42.7%**	**2,261**
Hay River HSSA	**630**	**516**	**421**	**22.1%**	**49.6%**	**3,194**
NWT Total	**5,981**	**4,573**	**3,611**	**30.8%**	**65.6%**	**38,560**

[30] Based on NWT Bureau of Statistics Population estimates as of July 1, 2018.

Table 13: HCC Client Age Distribution by Community[31]

Region/Community	Number of Clients (54 and under)	Number of Clients (55 - 74)	Number of Clients (75+)	Total Clients	% of Clients 54 and under	% of Clients 55 - 74	% of Clients 75+	% of 75+ Population	% of 55 - 74 Population	% of 0 - 54 Population
NTHSSA Beaufort-Delta Region	**19**	**46**	**79**	**144**	**13.2%**	**31.9%**	**54.9%**	**40.1%**	**4.0%**	**0.3%**
Aklavik	3	13	19	35	8.6%	37.1%	54.3%	57.6%	12.1%	0.6%
Fort McPherson	3	7	20	30	10.0%	23.3%	66.7%	45.5%	4.7%	0.6%
Sachs Harbour	0	0	2	2	0.0%	0.0%	100.0%	40.0%	0.0%	0.0%
Tsiigehtchic	1	0	3	4	25.0%	0.0%	75.0%	23.1%	0.0%	0.6%
Tuktoyaktuk	7	8	6	21	33.3%	38.1%	28.6%	50.0%	5.3%	0.9%
Ulukhaktok	0	2	6	8	0.0%	25.0%	75.0%	46.2%	3.3%	0.0%
Paulatuk	0	5	4	9	0.0%	55.6%	44.4%	50.0%	11.9%	0.0%
Inuvik	5	11	19	35	14.3%	31.4%	54.3%	27.5%	1.8%	0.2%
NTHSSA Dehcho Region	**43**	**124**	**118**	**285**	**15.1%**	**43.5%**	**41.4%**	**95.2%**	**19.2%**	**1.7%**
Fort Liard	0	11	21	32	0.0%	34.4%	65.6%	87.5%	11.7%	0.0%
Fort Providence	27	58	65	150	18.0%	38.7%	43.3%	166.7%	35.8%	5.2%
Fort Simpson	16	55	32	103	15.5%	53.4%	31.1%	133.3%	19.0%	1.6%
Other Communities	0	0	0	0	n/a	n/a	n/a	0%	0%	0.0%
NTHSSA Sahtu Region	**17**	**45**	**92**	**154**	**11.0%**	**29.2%**	**59.7%**	**105.7%**	**10.5%**	**0.8%**
Colville Lake	0	0	0	0	n/a	n/a	n/a	0	0%	0.0%
Délı̨ne	8	21	23	52	15.4%	40.4%	44.2%	164.3%	20.6%	1.7%
Fort Good Hope	3	9	36	48	6.3%	18.8%	75.0%	102.9%	13.0%	0.6%
Norman Wells	0	6	6	12	0.0%	50.0%	50.0%	42.9%	4.4%	0.0%
Tulita	6	9	27	42	14.3%	21.4%	64.3%	128.6%	8.3%	1.5%
NTHSSA Yellowknife Region	**479**	**393**	**153**	**1,025**	**46.7%**	**38.3%**	**14.9%**	**46.8%**	**9.8%**	**2.7%**
Yellowknife	479	363	136	978	49.0%	37.1%	13.9%	48.4%	10.0%	2.9%
Dettah	0	0	0	0	n/a	n/a	n/a	0.0%	0.0%	0.0%
Fort Resolution/Lutsel'Ke	0	30	17	47	0.0%	63.8%	36.2%	54.8%	42.3%	0.0%
Tlicho CSA	**32**	**34**	**58**	**124**	**25.8%**	**27.4%**	**46.8%**	**73.4%**	**9.2%**	**1.3%**
Behchokǫ̀	32	30	49	111	28.8%	27.0%	44.1%	100.0%	12.6%	1.9%
Gamètì	0	3	3	6	0.0%	50.0%	50.0%	27.3%	7.5%	0.0%
Wekweètì	0	0	0	0	n/a	n/a	n/a	0	0.0%	0.0%
Whatì	0	1	6	7	0.0%	14.3%	85.7%	40.0%	1.4%	0.0%
NTHSSA Fort Smith Region	**7**	**54**	**55**	**116**	**6.0%**	**46.6%**	**47.4%**	**64.0%**	**10.0%**	**0.3%**
Hay River HSSA	**24**	**63**	**54**	**141**	**17.0%**	**44.7%**	**38.3%**	**45.8%**	**7.4%**	**0.8%**
NWT Total	**621**	**759**	**609**	**1,989**	**31.2%**	**38.2%**	**30.6%**	**59.8%**	**9.5%**	**1.7%**
All Regions Outside of NTHSSA Yellowknife Region	**142**	**366**	**456**	**964**	**14.7%**	**38.0%**	**47.3%**	**66.0%**	**9.2%**	**0.8%**

[31] Based on 2017/18 Health Suite Data and 2018 NWT Bureau of Statistics Data.

Projected HCC Caseload and Resource Requirements

The following section articulates the projected caseload and resource requirements for HCC in-home HSW and nursing services in the NWT by HSSA/region to the year 2035.

Population projections for the 0-59 years, 60-74 years and 75 years plus age demographics to the year 2035 are summarized in Table 14. MNP notes that the population projections were developed by the NWT Bureau of Statistics for the 2017 NWT Disability Program Review and Renewal Project Technical Background Report and are accepted by the GNWT as being valid.

Table 14: Population Age Projections by Age Group and HSSA/Region to the Year 2035[32]

HSSA/Region/Age Group	Current	Projected Population					
	2018	2020	2023	2026	2029	2032	2035
NWT Total	**44,541**	**44,669**	**44,923**	**45,076**	**45,215**	**45,425**	**45,768**
0 - 59 years	38,560	38,025	37,133	36,513	36,280	36,065	36,064
60 - 74 years	4,976	5,283	6,149	6,534	6,536	6,561	6,359
75+ years	1,005	1,361	1,641	2,029	2,399	2,799	3,345
NTHSSA Beaufort-Delta Region	**6,880**	**6,616**	**6,543**	**6,457**	**6,360**	**6,271**	**6,201**
0 - 59 years	5,971	5,633	5,397	5,206	5,096	5,000	4,917
60 - 74 years	712	749	895	954	946	916	875
75+ years	197	234	251	297	318	355	409
NTHSSA Dehcho Region	**3,374**	**3,374**	**3,350**	**3,325**	**3,293**	**3,253**	**3,215**
0-59 years	2,802	2,767	2,686	2,603	2,526	2,456	2,415
60 - 74 years	456	470	499	532	542	559	516
75+ years	116	137	165	190	225	238	284
NTHSSA Sahtu Region	**2,637**	**2,514**	**2,482**	**2,449**	**2,416**	**2,386**	**2,363**
0-59 years	2,279	2,142	2,059	2,005	1,957	1,918	1,883
60 - 74 years	271	263	312	318	322	317	317
75+ years	87	109	111	126	137	151	163
NTHSSA Yellowknife Region	**22,173**	**22,767**	**23,151**	**23,480**	**23,807**	**24,179**	**24,641**
0-59 years	19,421	19,678	19,394	19,235	19,353	19,376	19,559
60 - 74 years	2,425	2,616	3,135	3,373	3,343	3,424	3,360
75+ years	327	473	622	872	1,111	1,379	1,722
Tlicho CSA	**2,944**	**2,976**	**2,956**	**2,926**	**2,896**	**2,863**	**2,834**
0-59 years	2,632	2,641	2,582	2,545	2,484	2,426	2,379
60 - 74 years	233	244	283	281	297	319	321
75+ years	79	91	91	100	115	118	134
Fort Smith Region	**2,709**	**2,511**	**2,527**	**2,534**	**2,547**	**2,570**	**2,598**
0-59 years	2,261	2,030	2,003	1,985	1,975	1,979	2,005
60 - 74 years	362	360	374	370	393	382	356
75+ years	86	121	150	179	179	209	237
Hay River Region	**3,824**	**3,911**	**3,914**	**3,905**	**3,896**	**3,903**	**3,916**
0-59 years	3,194	3,134	3,012	2,934	2,889	2,910	2,906
60 - 74 years	512	581	678	706	693	645	614
75+ years	118	196	224	265	314	348	396

[32] Based on the Population Projections prepared by the NWT Bureau of Statistics for the NWT Disability Program Review and Renewal Project Technical Background Report, July 2017.

Overall, the 60 years plus age demographic is projected to grow by 60% in the NWT from 5,981 in 2018 to 9,704 in 2035. This growth is projected to vary by region from 32% in the NTHSSA Fort Smith Region to 85% in the NTHSSA Yellowknife Region. The projected growth of the 60 plus age group will result in more demand for HCC services in the future.

NWT HCC client projection and resource requirement models were developed based on an analysis of:

- Revised NWT client caseload data for 2017/18 as well as hours of service data captured in Health Suite. Due to concerns regarding the reliability of hours of service data captured in Health Suite, MNP also analyzed client caseload and hours of service projection data from Manitoba and Newfoundland.
- The current distribution of HCC clients by age group in the NWT for 2017/18 (based on the revised data collected by the DHSS), as well as in Manitoba and Newfoundland (as reference points).
- Population projections in the NWT for the 0-59 years, 60-74 years and 75 years plus age demographics to the year 2035.
- An analysis of HCC projection models developed for Manitoba[33] and Newfoundland[34] to assess the proportion of the population from different age demographics that will require HCC services moving forward.
- An analysis of the hours of care provided by HCC client age groups in Manitoba and Newfoundland.

An analysis of the HCC projections developed for Manitoba provided the following key insights:

- Approximately 61% of HCC clients are in the 75 plus age group, and 27% of the people in this age group will require the use of HCC services due to a higher prevalence of strokes, coronary artery disease, ADL impairments, cognitive impairments and/or dementia, and disease co-morbidities.
- Approximately 15% of HCC clients are in the 65-74 age group, and 5% of the people in the age group will require the use of HCC services.
- The demand for HCC services is projected to grow approximately 70% from 38,246 clients in 2015 to approximately 65,000 clients in 2035.
    - The projected increase in demand for HCC services will be largely driven by the projected increase in the 75 plus age demographic. As this age demographic continues to grow, they will continually utilize a larger portion of HSW and nursing care hours in proportion to other age groups over time.

[33] Based on Future of Home Care Services in Manitoba, Reg Toews, December 2016.
[34] Based on review conducted by Deloitte in 2016: Provincial Home Support Program Review.

An analysis of the HCC projections for Newfoundland provided the following key insights:

- Approximately 60% of HCC clients will be in the 65 plus age group, and approximately 4.3% of this age group will require the use of HCC services.
- Approximately 38% of HCC clients will be adults with disabilities, and approximately 1% of the 20-64 age group will require the use of HCC services.
- The demand for HCC services is projected to grow approximately 19% from 7,197 clients in 2015 to 8,565 clients in 2021.
    - The 65 plus age group will utilize a larger proportion of HSW hours in 2021 compared to 2015.

MNP developed two models to project the needs for in-home HSW and nursing staff to the year 2035 including:

- **Model 1:** Assumptions reflect the estimated client caseload distributions and average hours of care per client for HSWs and nursing care based on revised 2017/18 client caseload data as well as hours of care data from Health Suite.
- **Model 2:** Assumptions reflect a combination of the estimated client caseloads for NWT (based on 2017/18 revised data) and Manitoba projection caseload estimates, and Manitoba estimates for hours of care.

A summary of the projected caseloads, hours of care, and HSW/nursing staffing requirements to the year 2035 , including key assumptions, is provided in the sections that follow.

Projection Model 1 – Reflective of Current Environment in NWT

The assumptions underlying projection model 1 are reflective of the estimated client caseload distributions and average hours of care per client for HSWs and nursing care for 2017/18 based on revised client caseload data provided by the DHSS, as well as hours of care data from Health Suite. The key assumptions underlying this projection model are provided in Appendix D.

The demand for HCC services in the NWT is projected to increase from 1,558 clients in 2018 to 1,803 clients in 2020, 2,054 clients in 2023, 2,352 clients in 2026, 2,596 clients in 2029, 2,861 clients in 2032, and 3,199 clients in 2035. This growth is projected to be largely driven by the demand for HCC services by the 75 plus age group, which is projected to grow by 251% by 2035. A breakdown of the demand for HCC services by age group and HSSA/region under projection model 1 is provided in Figure 9.

MNP notes that the demand for HCC services in the NTHSSA Dehcho region is projected to decrease significantly in 2020 compared to 2018. This is most likely reflective of the limited reliability and quality of data reported in Health Suite, such that the number of clients in the HCC program is over-represented, rather than a true decrease in the actual demand for HCC services.

Figure 9: Projected Demand for HCC Services by Age Group and HSSA/Region in the NWT under Projection Model 1

HSSA/Region/Age Group	Current	Projected HCC Caseload					
	2018	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	**144**	**233**	**254**	**284**	**294**	**310**	**333**
0 - 59 years	19	35	33	32	32	31	30
60 - 74 years	46	74	88	94	93	90	86
75+ years	79	124	133	158	169	189	217
NTHSSA Dehcho Region	**193**	**136**	**154**	**169**	**189**	**196**	**217**
0-59 years	33	17	17	16	16	15	15
60 - 74 years	75	46	49	52	53	55	51
75+ years	85	73	88	101	120	126	151
NTHSSA Sahtu Region	**106**	**97**	**103**	**110**	**117**	**123**	**130**
0-59 years	13	13	13	12	12	12	12
60 - 74 years	27	26	31	31	32	31	31
75+ years	66	58	59	67	73	80	87
NTHSSA Yellowknife Region	**826**	**957**	**1,117**	**1,320**	**1,492**	**1,695**	**1,939**
0-59 years	324	329	324	321	323	324	327
60 - 74 years	266	287	344	370	367	376	369
75+ years	236	341	449	629	802	995	1243
Tlicho CSA	**86**	**88**	**92**	**97**	**105**	**109**	**118**
0-59 years	24	16	16	16	15	15	15
60 - 74 years	21	24	28	28	29	31	32
75+ years	41	48	48	53	61	63	71
Fort Smith Region	**88**	**112**	**129**	**143**	**146**	**161**	**173**
0-59 years	5	13	12	12	12	12	12
60 - 74 years	41	35	37	36	39	38	35
75+ years	42	64	80	95	95	111	126
Hay River Region	**115**	**180**	**205**	**229**	**253**	**267**	**289**
0-59 years	24	19	19	18	18	18	18
60 - 74 years	41	57	67	70	68	64	61
75+ years	50	104	119	141	167	185	210
NWT Total	**1,558**	**1,803**	**2,054**	**2,352**	**2,596**	**2,861**	**3,199**
0 - 59 years	442	442	434	427	428	427	429
60 - 74 years	517	549	644	681	681	685	665
75+ years	599	812	976	1,244	1,487	1,749	2,105

Under projection model 1, the demand for HSW hours of care is projected to increase from 32,834 in 2018 to 43,162 in 2035, based on the assumptions articulated in Appendix D. However, based on the HSW staffing assumptions articulated in Appendix D, the requirement for HSW staffing is projected to decrease in each HSSA/region in the NWT, resulting in a decrease from 59.13 FTEs in 2019 to 25.44 FTEs in 2020 (Figure 10). By 2035, the requirement for HSWs in the NWT is projected to be 44.27 FTEs.

Figure 10: Projected HSW Staffing Requirements by HSSA/Region under Projection Model 1

HSSA/Region	Current	Projected HCC HSW FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	15.53	4.74	5.17	5.87	6.12	6.54	7.15
NTHSSA Dehcho Region	10.00	4.17	4.73	5.20	5.82	6.05	6.70
NTHSSA Sahtu Region	8.70	2.96	3.03	3.30	3.48	3.66	3.88
NTHSSA Yellowknife Region	11.30	7.43	9.07	11.05	12.64	14.56	16.82
Tlicho CSA	6.10	2.66	2.79	2.94	3.20	3.33	3.61
Fort Smith Region	2.50	1.33	1.59	1.82	1.84	2.08	2.29
Hay River Region	5.00	2.15	2.46	2.81	3.20	3.46	3.82
NWT Total	**59.13**	**25.44**	**28.84**	**32.99**	**36.30**	**39.68**	**44.27**

The projected demand for nursing hours is also projected to increase from 10,937 in 2018 to 24,593 in 2035, based on the assumptions articulated in Appendix D. However, similar to the situation for HSWs, the projected staffing requirements are projected to decrease in each HSSA/region in the NWT, resulting in a decrease from 24.78 FTEs in 2019 to 18.61 FTEs in 2020 (Figure 11). By 2035, the requirement for HSWs in the NWT is projected to be 30.28 FTEs.

Figure 11: Projected Nursing Staff Requirements by HSSA/Region under Projection Model 1

HSSA/Region	Current	Projected HCC Nursing FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	2.53	1.83	1.98	2.16	2.21	2.28	2.39
NTHSSA Dehcho Region	2.00	1.05	0.97	1.04	1.13	1.17	1.50
NTHSSA Sahtu Region	1.00	0.73	0.78	0.81	0.86	0.89	0.93
NTHSSA Yellowknife Region	13.00	10.23	11.53	13.19	14.62	16.30	18.32
Tlicho CSA	1.25	0.70	0.73	0.76	0.80	0.83	0.88
Fort Smith Region	2.00	1.57	1.78	1.96	2.00	2.19	2.35
Hay River Region	3.00	2.50	2.83	3.14	3.45	3.62	3.91
NWT Total	**24.78**	**18.61**	**20.60**	**23.06**	**25.07**	**27.28**	**30.28**

MNP is confident that the projected decreases in nursing and HSW staffing complements is a reflection of the under-representation of hours of service data reported in Health Suite and not due to over-staffing of nurses and HSWs in the NWT HCC program, based on the feedback received from all stakeholder groups and the limitations noted in Section 2.1 above. **Accordingly, MNP will not use projection model 1 as basis for making future state recommendations in Section 6.2 below.**

Projection Model 2 – NWT/Manitoba Hybrid Model

The assumptions underlying projection model 2 include a combination of the estimated client caseloads for NWT (based on 2017/18 revised data) and Manitoba projection caseload estimates, and Manitoba estimates for hours of care. The key assumptions underlying this projection model are provided in Appendix E.

The demand for HCC services in the NWT is projected to increase from 1,558 clients in 2018 to 1,696 clients in 2020, 1,913 clients in 2023, 2,155 clients in 2026, 2,344 clients in 2029, 2,549 clients in 2032, and 2,809 clients in 2035. This growth is projected to be largely driven by the demand for HCC services by the 75 plus age group, which is projected

to grow by 186% by 2035. A breakdown of the demand for HCC services by age group and HSSA/region under projection model 2 is provided in Figure 12.

MNP notes that the demand for HCC services in the NTHSSA Dehcho region is projected to decrease significantly in 2019/20 compared to 2017/18. This is most likely reflective of the limited reliability and quality of data reported in Health Suite, such that the number of clients in the HCC program is over-represented, rather than a true decrease in the actual demand for HCC services.

Figure 12: Projected Demand for HCC Services by Age Group and HSSA/Region in the NWT under Projection Model 2

	Current	Projected HCC Caseload					
HSSA/Region/Age Group	2018	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	**144**	**233**	**254**	**284**	**294**	**310**	**333**
0 - 59 years	19	35	33	32	32	31	30
60 - 74 years	46	74	88	94	93	90	86
75+ years	79	124	133	158	169	189	217
NTHSSA Dehcho Region	**193**	**136**	**154**	**169**	**189**	**196**	**217**
0-59 years	33	17	17	16	16	15	15
60 - 74 years	75	46	49	52	53	55	51
75+ years	85	73	88	101	120	126	151
NTHSSA Sahtu Region	**106**	**97**	**103**	**110**	**117**	**123**	**130**
0-59 years	13	13	13	12	12	12	12
60 - 74 years	27	26	31	31	32	31	31
75+ years	66	58	59	67	73	80	87
NTHSSA Yellowknife Region	**826**	**850**	**976**	**1,123**	**1,240**	**1,383**	**1,549**
0-59 years	324	329	324	321	323	324	327
60 - 74 years	266	287	344	370	367	376	369
75+ years	236	234	308	432	550	683	853
Tlicho CSA	**86**	**88**	**92**	**97**	**105**	**109**	**118**
0-59 years	24	16	16	16	15	15	15
60 - 74 years	21	24	28	28	29	31	32
75+ years	41	48	48	53	61	63	71
Fort Smith Region	**88**	**112**	**129**	**143**	**146**	**161**	**173**
0-59 years	5	13	12	12	12	12	12
60 - 74 years	41	35	37	36	39	38	35
75+ years	42	64	80	95	95	111	126
Hay River Region	**115**	**180**	**205**	**229**	**253**	**267**	**289**
0-59 years	24	19	19	18	18	18	18
60 - 74 years	41	57	67	70	68	64	61
75+ years	50	104	119	141	167	185	210
NWT Total	**1,558**	**1,696**	**1,913**	**2,155**	**2,344**	**2,549**	**2,809**
0 - 59 years	442	442	434	427	428	427	429
60 - 74 years	517	549	644	681	681	685	665
75+ years	599	705	835	1,047	1,235	1,437	1,715

Under projection model 2, the requirement for HSW hours of care is projected to increase from 32,834 in 2018 to 125,209 hours in 2035, based on the HSW hours assumptions articulated in Appendix E. According to the HSW staffing assumptions articulated in Appendix E, the requirement for HSW staffing is projected to increase in each HSSA/region in the NWT (except for the NTHSSA Beaufort-Delta region in 2020), resulting in an increase

from 59.13 FTEs in 2019 to 74.11 FTEs in 2020, 83.49 FTEs in 2023, 95.53 FTEs in 2026, 105.35 FTEs in 2029, 114.87 FTEs in 2032 and 128.41 FTEs in 2035 (Figure 13).

Figure 13: Projected HSW Staffing Requirements by HSSA/Region under Projection Model 2

HSSA/Region	Current	Projected HCC HSW FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	15.53	14.97	16.27	18.63	19.53	21.07	23.26
NTHSSA Dehcho Region	10.00	12.78	14.65	16.25	18.40	19.15	21.54
NTHSSA Sahtu Region	8.70	9.26	9.46	10.39	11.03	11.71	12.47
NTHSSA Yellowknife Region	11.30	18.48	22.51	27.30	31.11	35.75	41.15
Tlicho CSA	6.10	8.20	8.53	9.07	9.96	10.34	11.29
Fort Smith Region	2.50	3.40	4.05	4.63	4.68	5.30	5.84
Hay River Region	5.00	7.02	8.02	9.26	10.64	11.55	12.86
NWT Total	59.13	74.11	83.49	95.53	105.35	114.87	128.41

The demand for nursing care/assessment service hours is also projected to increase under projection model 2 from 10,973 in 2018 to 35,896 in 2035, based on the nursing hours assumptions articulated in Appendix E. According to the nursing staffing assumptions articulated in Appendix E, the requirement for nursing staffing is projected to increase in each HSSA/region in the NWT (except for the NTHSSA Fort Smith region and Hay River HSSA in 2020), resulting in an increase from 24.78 FTEs in 2019 to 27.49 FTEs in 2020, 30.51 FTEs in 2023, 34.11 FTEs in 2026, 36.86 FTEs in 2029, 39.88 FTEs in 2032 and 44.18 FTEs in 2035 (Figure 14).

Figure 14: Projected Nursing Staffing Requirements by HSSA/Region under Projection Model 2

HSSA/Region	Current	Projected HCC Nursing FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	2.53	3.71	4.05	4.50	4.65	4.88	5.20
NTHSSA Dehcho Region	2.00	2.16	2.03	2.22	2.47	2.56	3.37
NTHSSA Sahtu Region	1.00	1.53	1.63	1.73	1.84	1.92	2.03
NTHSSA Yellowknife Region	13.00	14.07	16.06	18.29	20.01	22.15	24.59
Tlicho CSA	1.25	1.40	1.47	1.54	1.66	1.72	1.86
Fort Smith Region	2.00	1.77	2.03	2.23	2.28	2.50	2.67
Hay River Region	3.00	2.85	3.24	3.60	3.95	4.15	4.46
NWT Total	24.78	27.49	30.51	34.11	36.86	39.88	44.18

MNP used projection model 2 as the basis for making recommendations detailed in Section 6.2 .

5. JURISDICTIONAL ANALYSIS

5.1 HOME AND COMMUNITY CARE SERVICES ACROSS CANADA

Hours of Service Comparison to Other Canadian Jurisdictions

In November 2018, the Canadian Health Coalition published a policy brief which included a comparison of home support hours per client by Canadian jurisdictions (Table 15). Although the comparisons made in the brief are not direct "apples to apples" comparisons for each province/territory, they do highlight the large discrepancy in home support service levels provided across Canada.

Table 15: Comparison of Maximum Home Support Hours of Service in Canadian Jurisdictions

Canadian Jurisdiction	Maximum Hours of Service
Ontario	120 hours in the first 30 days of service and 90 hours a month for personal support services
Manitoba	55 hours per week of home care attendant services
Quebec	15 hours per week
New Brunswick	215 hours per month for home support
Nova Scotia	100 hours of home support every 28 days
Prince Edward Island	28 hours a week, or 3 visits
Newfoundland	$3,490 per month for home support to pay for: • 4 hours a day of personal care and/or behavioural support; • Up to 1 hour a day for meal preparation and 2 hours a week for homemaking when a caregiver doesn't live with the client; • 2 hours a week of homemaking when a caregiver lives with the client and there are additional homemaking requirements; • Respite services for caregivers living with someone who needs 24-hour care or supervision.
Nunavut	5 hours per week for homemaking services and 2 hours per day for personal
Yukon	35 hours per week for homemaking, personal care and respite care
NWT	4 hours per month for housekeeping services* (currently average 40 hours of services per year for homemaking and personal care and in-home respite services, based on revised data provided by DHSS for the 2017/18 fiscal year)

Currently, the NWT has the lowest maximum hours of service for home support services of the 10 jurisdictions included in the study. In addition, based on revised client caseload activity data, the average hours per client in 2017/18 for homemaking, personal care and in-home respite services is estimated to be 40 hours per year (or 3.3 hours per month). This is **significantly lower** than any other jurisdiction and suggests that the hours of services being provided to HCC clients in the NWT are being severely underreported, consistent with perceptions of DHSS and HCC staff.

HCC Program and Service Availability by Canadian Jurisdiction[35]

The information in this section was informed by the following sources:

- Future of Home Care Services in Manitoba (Reg Toews, December 2016)
- Portraits of Home Care in Canada (Canadian Home Care Association, 2013)
- Provincial/Regional Variation in Availability, Cost of Delivery and Wait Times for Accessing Home Care Services to Address Avoidable Admissions to Long Term Care, Alternate Level of Care Bed Days and Hospitalization (Keefe et al, 2014).
- Homecare in Canada, an Environmental Scan (Johnson et al, October 2017).

Programs and Services Available by Jurisdiction

Figure 15 below provides a comparison of the types of HCC services available in each jurisdiction. MNP cautions that the comparison of services in Figure 15 is based on information from reports developed in 2013 and 2014 and was updated based on the 2017 report by Johnson et al and interviews conducted by MNP with representatives from other jurisdictions.

Figure 15: Comparison of HCC Services Available by Canadian Jurisdiction

Homemaking Services within Home Care Jurisdictions													
	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NT	NU
Light housekeeping	X	X	X	X	X	X	X	X	X	X	X	X	X
Laundry	X	X	X	X	X	X	X	X	X	X	X	X	
Meal preparation	X	X	X	X	X	X	X	X	X	X	X	X	X
Menu planning			X		X		X	X					
Home maintenance/repairs			X		X								
Running errands/ appointments			X		X	X	X				X	X	X
Banking					X	X				X			

Personal Care Services within Home Care Jurisdictions													
	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NT	NU
Mobility	X	X	X	X	X		X	X	X	X			
Nutrition/feeding	X	X	X	X	X	X	X	X	X	X		X	
Lifts/transfers	X	X	X	X	X	X	X	X	X	X			
Bathing/dressing/ grooming	X	X	X	X	X	X	X	X	X	X	X	X	X
Toileting	X	X	X	X	X	X	X	X	X	X			

[35] Adapted based on work completed by Reg Toews for the Future of Home Care Services in Manitoba, and information/data provided in Portraits of Home Care in Canada (Canadian Home Care Association, 2013) and Provincial/Regional Variation in Availability, Cost of Delivery and Wait Times for Accessing Home Care Services to Address Avoidable Admissions to Long Term Care, Alternate Level of Care Bed Days and Hospitalization (Keefe et al, 2014).

Nursing Services within Home Care Jurisdictions													
	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NT	NU
Admin of chemo	X+				X	X				X*		X++	
Admin of narcotics	X		X	X	X	X		X		X*	X	X	X
Blood and blood products								X					
Infusion pumps/ Central lines	X	X*	X	X	X			X		X	X*	X*	X
Ventilator care	X	X**	X	X*	X			X		X			
Tracheostomy tube	X	X**	X	X*	X			X		X			
Enterostomal Therapy	X	X*	X	X	X			X		X	X*	X	X
Hemodialysis					X								
Peritoneal Dialysis			X	X	X			X		X	X		X
Infusion therapy	X	X*	X	X	X	X		X		X		X*	X
Home 02	X		X	X	X	X	X	X		X		X	X
Wound Care	X		X	X	X	X		X	X	X	X	X	X

X* Geographic differences in availability
X** provision of service is strongly regulated
X+ Chemotherapy - oral
X++ Chemotherapy; subcutaneous or intramuscular methotrexate

Allied Health Services within Home Care Jurisdictions													
	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NT	NU
Physiotherapy	X	X	X	X	X	X	X	X	X	X	X	X+	X
Occupational therapy	X	X	X	X	X	X	X	X	X	X	X	X+	X
Dietetics	X*	X		X**	X	X	X		X	X		X+	X
Speech Language Pathology		X			X	X	X			X++	X	X+	X
Audiology					X	X							X
Respiratory Therapy		X		X**	X	X	X			X++			
Pharmacology					X	X	X		X***				
Social Work	X	X			X	X	X		X	X	X	X+	X

X* homebound clients only
X** limited availability in Winnipeg only
X*** pallitative clients only
X+ offered through Regional Support Services
X++ limited availability

Of particular interest in the analysis is that there are currently 7 other jurisdictions in Canada that provide some form of service for running errands/transportation to appointments as part of their HCC programs. All provinces provide homemaking services (i.e. light housekeeping, meal prep, laundry) and personal care services (bathing/dressing, and grooming). Nursing and allied health services vary significantly between provinces and territories.

Summary of HCC Funding Models[36]

Figure 16 provides a summary of HCC service funding structures in provinces and territories across Canada, based on work completed for the Future of Home Care Services report, data obtained from the 2014 Keefe et al report, and information provided by representatives interviewed in Nova Scotia and Newfoundland and Labrador. MNP cautions that data in this table for many provinces is based on information from 2014.

Figure 16: Summary of Client Fees for HCC Services in Different Jurisdictions

Client Fees for Service				
	Homemakeing	Personal Care	Nursing	Allied Health Professional
BC - Client	Income scaled to max of $300/month		No Charge	
BC - System	Data Not Available			
AB - Client	$5.00/hr	No Charge		
AB - System	$29.50/hr ($5.00/hr client fee recovery on homemaking)		$65.00 - 70.00/hr	
SK - Client	First ten hrs per month at $7.68; remaining hours income scaled to a maximum of $465.00/month based on income levels		No Charge	
SK - System	Data Not Available			
MB - Client	No Charge for Services			
MB - System	Data Not Available			
ON - Client	No Charge for Services			
ON - System	$28.00-32.00/unit of care		$74.00-107.00/visit	$89.00-140.00/visit
QC - Client	No fee if disability; income scaled with cost from $0-12.25/hr		No Charge	
QC - System	$21.00/hr for public funded staff $14.00-15.00/hr for private contractor, minus client fee recovery		Data Not Available	
NB - Client	Two programs: EMP = No charge for short-term service. SD = Income scaled hourly rate		No Charge	
NB - System	EMP: $129.00/visit for all services SD: $16.00/hour (homemaking and personal care only) minus client fee recovery			
NS - Client	Income scaled: @12.10/hr to a maximum of $121.00 to $605.00/month		No Charge	
NS - System	$45-50.00/hr minus client fee recovery		$75-85.00/visit	Data Not Available
PEI - Client	No Charge for Services			
PEI - System	Data Not Available			
NFLD - Client	Subsidizes $3,325.00/month for older adults and $4,750.00/month for adults with disabilities		No Charge	
NFLD - System	Data Not Available			
YT/NT/NU - Client	No Charge for Services			
YT/NT/NU - System	Data Not Available			
Source: Keefe et al. (2014), Interviews with represntatives from NL and NS				

Based on the data in Figure 16, the provinces of Manitoba, Prince Edward Island and Ontario, as well as the NWT, Yukon and Nunavut provide full funding coverage to HCC clients for homemaking, personal care, nursing, and allied health services. The remaining

[36] Adapted based on initial analysis completed by Reg Toews for the Future of Home Care Services in Manitoba.

provinces typically charge a fee for homemaking services, and also personal care services in some provinces are charged a fee. There is typically no charge for nursing or allied health services in these other provinces.

MNP also notes that private out of pocket home care services (home support and nursing services) are available as an alternative in most Canadian provinces, but typically not in any of the territories.

Summary of Environmental Scan Completed by Johnson et al[37]

The following key themes were identified at the provincial/territorial level from the environmental scan completed by Johnson et al in 2017:

- There are inconsistent definitions of what home care means for seniors across the provinces/territories. It generally reflects services that allow seniors and some people with mental or physical challenges to live at home and receive required supports.
- There is little clarity around complex care needs in home care. Alberta, Ontario, and Nova Scotia have used the concept as it relates to home care.
- All the provinces and territories have funded home care programs although there is great variation in services and programs available with varying levels of assessment and care coordination. The extent of coverage and costs vary.
- British Columbia has moved forward with the concept of an ombudsman in an attempt to help protect older adults.
- Home care jurisdiction is primarily in the Department of Health although there is discussion in New Brunswick where home care services are currently subsumed in the Department of Social Services.
- Home care services are funded through a combination of provincial and territorial funds, federal funds, private insurance, and payments by individual Canadians – some provinces use tests to determine eligibility.
- Increasing discussion and implementation of new health care models to encourage aging in place and decrease pressures on informal caregivers.
- Growing indication of disparities and unmet home care needs–specific research on this relates to immigrant and Indigenous seniors.
- Role of technology is beginning to enter dialogue to improve home care.
- Well recognized that provincial and territorial spending on home care will increase and needs to be better integrated into the continuum of care.

[37] Based on Homecare in Canada, an Environmental Scan (Johnson et al, October 2017).

Trends Related to Indigenous Home and Community Care Services

Many Indigenous communities across Canada deliver their own HCC programs and services which are funded directly through funding agreements with the Federal government through FNIHB. MNP has assisted multiple Indigenous Health Authorities funded directly by FNIHB located in Northwestern Ontario, Manitoba, Saskatchewan, and Alberta with planning for and reviewing HCC service delivery. This includes working with legally incorporated Indigenous health authorities (legal corporations with boards of directors), as well as an Indigenous community health centre that reports directly Chief and Council. All of these communities and organizations have limitations on the HCC services they provide, due to the scope of services funded through funding agreements with FNIHB. Figure 17 provides a summary of the types of services delivered to HCC clients in different communities.

Figure 17: Summary of HCC Services Provided by a Sampling of Indigenous Health Authorities Across Canada[38]

Type of Service	NW Ontario	Manitoba	Saskatchewan	Alberta
Case Management	X	X	X	X
Homemaking (meal preparation, light housekeeping, heavy housekeeping)	X	X	X	X
Personal Care (bathing, dressing, oral care, transferring)	X	X	X	X
Basic Foot Care	X	X	X	X
Respite and Palliative Care	X limited	X limited	X limited	X limited
Other Professional Services (OT/PT)	X limited	X limited	X limited	X limited
Adult Life Enrichment (activities, fun, socialization)	X	X	X	X
Appointments (escort high needs clients to appointments, translation services)	X	X	X	X
Assistance with Errands/Shopping	X (varies by community)	Not offered, but performed by some staff	Not offered, but performed by some staff	Unsure
Medical Transportation (provided through separate Medical Transportation funding)*	X (varies by community)	X	X	X

* Medical transportation provided through separate program area, not HCC program. Transportation provided to and from medical appointments in and outside of the community, as well as for transporting HCC clients to HCC organized activities.

The following are common themes from evaluations of HCC programs and services conducted for Dilico Anishinabek Care (Northwest Ontario Communities) and Opaskwayak Health Authority (Manitoba):

[38] Based on MNP's experience conducting work with Dilico Anishinabek Care, Opaskwayak Health Authority, Onion Lake Health Board, and Saddle Lake Health Care Centre.

- Transportation and assistance for running errands and shopping is a gap for seniors and elders in all communities. The provision of HCC support for running errands and shopping is limited to care plans for Northwestern Ontario communities, and not formally supported in Manitoba (although some staff go out of their way to provide this in Manitoba).
- Elders and seniors receiving HCC in all communities want more frequent visits from HCC staff.
- There is a need to improve the provision of supports for respite care and palliative care in the home.

MNP notes that most Indigenous health authorities and/or health centres operate medical transportation vans that are funded through a separate program area. This service is not only provided to HCC clients, but to all community members requiring transportation to and from medical appointments.

5.2 MODELS, STANDARDS AND PRACTICES IN SELECT JURISDICTIONS

To inform the HCC Review from a leading practices perspective, MNP conducted a targeted review of models, standards, trends, innovations and best practices in other jurisdictions that have HCC programs in place to support individuals to stay in their own homes.

The jurisdictional research consisted of document, literature and data reviews, as well as targeted interviews with representatives from the following jurisdictions, as requested by the DHSS:

- Alberta (Fort McMurray);
- Newfoundland;
- Nova Scotia;
- Ontario (the North West Local Health Integration Network); and
- Manitoba (Northern Health Region).

The sections that follow highlight our findings for each targeted jurisdiction.

Key Findings from Alberta (Fort McMurray)

Currently, anyone with a valid healthcare card can receive home care services in Alberta, as long as their needs can be met safely in their place of residence. Home care provides help with activities of daily living that the client cannot do themselves or cannot get help with from another source. Home care services include[39]:

[39] Based on https://www.albertahealthservices.ca/assets/info/seniors/if-sen-home-care-brochure.pdf.

- Personal care including personal hygiene (bathing and grooming), dressing, toileting and incontinence management, mobilization and transferring, assisting with dining, oral care, and assistance with medications.
- Professional health services including prevention, screening and intake, assessment of health status and/or medical conditions, performing treatment and procedures, rehabilitation to maximize function, medication administration, palliative or end-of-life care, teaching and supervising self-care, teaching care and procedures to family members and other caregivers, and teaching and supervising home support service providers providing individual care and performing assigned activities.
- Caregiver supports including information and help to access services, education, skills training, and respite care.

In Alberta, a case manager works directly with the client and is responsible for assessing the client's needs and ensuring the overall coordination of care and services. Together with the client and their caregivers, case managers create personalized care plans[40]. Case Managers may be RNs, OTs/PTs, or social workers.

Case managers have the support of a team of local healthcare professionals that assist in the care of clients. Depending on client needs, the healthcare team may include a family physician, nurses, physiotherapists, pharmacists, healthcare aides, and others.

Alberta Health Services uses the interRAI Assessment tool to measure clinical status. This tool is the foundation of a comprehensive assessment of client health needs that is completed by a case manager and a team of health-care professionals to make an objective recommendation. interRAI, along with input from the client's family and the professional judgment of the case manager and the client's team of health-care providers, helps meet the needs of the client in the right place[41].

Self-Managed Care Option[42]

A self-managed care option is available for HCC clients in Alberta. It provides clients with the option to receive funding to directly pay for and manage personal care and home care support services by themselves.

Anyone living in Alberta with a healthcare card and living in a community setting is eligible for self-managed care and must:

[40] Based on https://www.albertahealthservices.ca/cc/Page15488.aspx.
[41] Based on https://www.albertahealthservices.ca/assets/info/pf/if-pf-cc-living-options-assessment.pdf.
[42] Based on https://www.albertahealthservices.ca/assets/info/seniors/if-sen-self-managed-care-brochure.pdf.

- Have an assessed unmet health care need consistent with AHS Provincial Home Care Service Guidelines;
- Have stable health and predictable care needs;
- Need ongoing personal care and home care support services (e.g. longer-term needs); and
- Be willing and able to assume the responsibilities and risks associated with contracting services for their own or a loved one's personal or home care support services (a legal representative may do this on behalf of a client).

Under the Alberta program, family members, friends, and informal caregivers are not allowed to be hired as paid care providers for self-managed care. Clients, caregivers, or legal representatives are responsible for:

- Recruiting, training, supervising, and scheduling and directing the employees in the provision of care.
- Developing a back-up plan to ensure that care can be provided at short notice if the regular employee is unavailable.
- Evaluating employees' performance, and, when necessary, terminating employees.
- Managing salary and payroll for care employee.
- Completing and submitting reports to Alberta Health Services that confirm the self-managed care funds spent each quarter.
- Meeting Canada Revenue Agency (CRA) federal tax regulations (e.g. register for a business number, withhold income tax, make Canada Pension Plan and Employment Insurance contributions from employees' wages); and meet Alberta employment standards for all employees.
- Notifying the Alberta Health Services home care case manager within 72 hours if there is any change in the client's health status, care needs or living arrangements, such as hospitalization.
- Ensuring the proper documentation is in place if the person responsible is the caregiver's or client's legal representative (e.g. guardian under the Adult Guardianship and Trusteeship Act, agent under the Personal Directive Act, trustee under the Adult Guardianship and Trustee Act or attorney under the Powers of Attorney Act).

Fort McMurray Area Home Care Services

Home care services in the Fort McMurray area are provided through the Thickwood Medical Plaza. According to Alberta Health Services, home care services include[43] personal care, nursing care, care from OT/PT, nutritional services, social services and counselling, advanced care planning, respite care, meals on wheels, medical equipment support provided by Alberta Aids to Daily Living Program, and palliative care services.

Adult day programs and designated supportive living services are also available in the area through the Northern Lights Medical Centre. Adult Day Programs are designed for adults over the age of 18 who may have physical and/or memory challenges or are living with a chronic illness.[44] Designated Supportive Living (DSL) is a setting that provides clients with a home where you can enjoy privacy and independence with the comfort of knowing that their health and personal care supports are on site when needed. DSL provides accommodation, meals, housekeeping, linen, and recreational services as well as a higher level of personal care supports, compared to home care, onsite for scheduled and unscheduled care needs according to the plan of care.[45]

Key Findings from Newfoundland

In Newfoundland, home support programs are delivered through private agencies or family caregivers, and clinical care such as nursing care or OT/PT services are delivered through Regional Health Authorities (RHAs). Eligibility for publicly subsidized home support services is based on the need for service, financial eligibility, and place of residence. The completion of a clinical assessment/reassessment determines both home support needs and eligibility.

In Newfoundland, clinical assessments are generally completed by CHNs for seniors and social workers for non-seniors. During the year, periodic reassessments are performed when there is a change in health status. There is a policy mandated annual reassessment that occurs whether or not clinical status has changed[46]. Assessment and care plan development is done with the interRAI tool in most regions; however, as of 2016, the tool had not been completely rolled out to all communities.

Financial assessments are conducted on all new referrals to the program, and financial reassessments are performed on an annual basis at a minimum or can be requested by the client at any time if there is a substantial change in their income. Support allocation is based on the informal support network that can meet the needs of clients, and what formal support is needed from care providers. Then, the government determines the hours required for formal support. Currently, the government is trying to move to an hours-based

[43] Based on https://www.albertahealthservices.ca/findhealth/Service.aspx?id=7622&serviceAtFacilityID=1115040#contentStart.
[44] Based on https://www.albertahealthservices.ca/cc/Page15504.aspx.
[45] Based on https://www.albertahealthservices.ca/cc/Page15490.aspx.
[46] Based on review conducted by Deloitte in 2016: Provincial Home Support Program Review.

framework for maximum services levels. Currently the government of Newfoundland subsidizes seniors with up to $3,325 a month for home support services and subsidizes adults with disabilities with up to $4,750 a month for home support services.

There are 3 service delivery options for home support services for clients in Newfoundland including:

- **Agency-based care:** Client chooses to get home support services through an approved agency in their community.
- **Self-managed care (SMC):** Client chooses and employs their caregiver. Clients hire their own HSW(s) and are responsible for coordinating and managing their support services.
- **Paid family caregiving option:** Client chooses their care provider to be a family member. Spouses and common-law partners are not included.

Regardless of service delivery option selected by the client, the RHAs maintain responsibility for monitoring service plans and client outcomes.

Based on discussions from the Newfoundland Department of Health and Community Services, approximately 40% of clients employ their own home support care through self-managed care or family caregivers. They felt that these 2 options were valuable in remote communities, where agencies do not want to provide home support services.

Key Findings from Deloitte Review[47]

The following are key findings from the review of Newfoundland home care support services conducted by Deloitte in 2016:

- There is a lack of available agency-based service options in isolated communities which may adversely impact client choice.
    - Agencies cited the attraction and retention of qualified HSWs and long travel times to client homes as key challenges in operating within isolated communities.
- There is insufficient monitoring of home support services by the RHAs.
- There is a need to establish service levels for the home support services delivered by the agencies and have them included in service level agreements between the RHAs and the agencies in their region.
- HSWs lack a defined set of qualifications and a viable career path relative to other occupations. This creates challenges in staff attraction and retention and adversely impacts the consistent provision of quality supports.

[47] Based on review conducted by Deloitte in 2016: Provincial Home Support Program Review.

- The wage differential between HSW and Personal Care Attendants (PCAs) results in little incentive for care providers to further their HSW skills through certificate programs like that offered by the College of the North Atlantic.
- Consultations with stakeholders revealed concerns on the quality and variability of service quality of HSWs, and with an inability for the program to be responsive to client needs through matching HSW skills and competencies to the complexity of care requirements.
- SMC is recognized by a wide range of consulted stakeholders to be critical to supporting clients living in rural and isolated communities and enabling client choice and flexibility in worker selection.
- Stakeholder consultations suggested that lack of oversight of SMC HSWs may also lead to an increased risk of abuse for vulnerable clients.
- Challenges with respect to monitoring client outcomes and the effectiveness of home support services in agency-based care. This also applies to SMC arrangements, and challenges may be exacerbated under these arrangements.

Findings from Nova Scotia

In Nova Scotia, Continuing Care Services, including a range of home and community care and long-term care services, are administered and delivered by the provincial health authority, and funded by the Department of Health and Wellness (DHW).[48]

Home Care services in Nova Scotia are intended to help people of all ages who need assistance to maintain their optimal well-being and independence at home. It serves clients with varying degrees of short- and long-term illness or disability and support needs, including acute, chronic, and palliative needs. Services are meant to add to the help people receive from others, such as family, friends, or community. Home care services in Nova Scotia include:

- **Home support:** personal care, meal preparation, essential housekeeping, respite.
- **Nursing:** dressing changes, catheter care, and intravenous therapy, etc.

There is no cost for nursing services. Home support fees are based on income and family size.

Like Alberta and Newfoundland, Nova Scotia also provides a self-managed care option. This program assists persons with physical disabilities to increase control over their lives by helping them develop their own care plans and directly arrange and administer their own home support service needs. Funds are provided to eligible clients so that they may directly employ care providers for the purpose of meeting their approved service needs. Clients

[48] Based on https://novascotia.ca/dhw/ccs/documents/Living-Wel-%20Continuing-Care-Services.pdf.

may appoint a third-party "care manager" to carry out the management and administrative duties of their care.

Other key feature of Nova Scotia home care services includes:

- **A Supportive Care Program:** This program supports low-income seniors with cognitive impairments, and their substitute decision makers, with funding of $500/month to purchase home support services that would otherwise be delivered through the provincial Home Care program. Some clients may also be eligible for reimbursement of snow removal expenses to a maximum of $495 each year.
- **Caregiver Benefit**: This program recognizes the important role of caregivers and is designed to sustain the caregiving relationship. It is for low-income care recipients who have a high level of disability or impairment as determined by a home care assessment. If the caregiver and the care recipient both qualify for the program, the caregiver will receive $400 each month.
- **Respite Beds**: This program provides caregivers with a planned and temporary break from their care giving responsibilities. There are respite beds across the province. There is a daily fee that can be reduced for low-income families. Caregivers can use the bed for up to 60 days each year.
- **Home First Funding Program:** Funding is provided to the health authority to support care options for clients who require support or services greater than or different from regular home care services, to avoid admission to hospital or to be discharged from hospital. The objective is for individuals to receive care at home, in their communities, where decisions about longer term care can occur.
- **Instrumental Activities of Daily Living (IADL) Program:** Funding is provided to the health authority to provide services, such as transportation, yard work, heavy house cleaning, and assistance with errands, to maintain individuals in their own homes, thus eliminating, reducing, or delaying the need for long-term care. These services also increase independence in the community and quality of life.
- **Adult Day Programs:** These programs maintain persons with physical disabilities and/or cognitive impairments or restore them to their optimum capacity for self-care. These programs include the provision of personal assistance, supervision, and health, social, and recreational activities in a supportive group setting. The programs can also be used to provide respite care, training, and informal support to family caregivers. There may be a daily fee charged by the provider.
- **Community Occupational Therapy and Physiotherapy:** This program maintains persons with physical and mental health concerns in the home to promote, develop, restore, improve, or maintain optimum levels of functioning in the area of self-care, productivity, and leisure.
- **Challenging Behaviours Program:** This program enhances capacity for continuing care service providers to address care needs for home care and nursing home clients who may exhibit or are at risk of expressing responsive behaviour.

- **Equipment Assistance and Loan Programs:** This includes the Personal Alert Assistance Program (up to $480 each year for the purchase of a personal alert assistance service), Home Oxygen Program, Community Bed Loan Program, Seniors' Community Wheelchair Loan Program, and the Specialized Equipment Program.
- **Adult Protection Services:** To offer help and support to persons 16 years and older who are living in a situation of significant risk of self-neglect or are experiencing abuse or neglect by others which results in serious harm to them and the inability to protect themselves from the abuse or neglect by reason of mental or physical incapacity. DHW adult protection workers can intervene and offer services to help those in need of protection.
- **Protection for Persons in Care:** The *Protection for Persons in Care Act* requires health facility administrators and service providers to promptly report all allegations or instances of abuse. Inquiries into and investigations of abuse or risk of abuse of persons 16 years and older living in health care facilities are carried out by DHW.
- **Palliative Home Care:** Palliative home care is compassionate end-of-life care which is provided to an individual who is terminally ill. Palliative home care services include nursing services, home support services, and medication coverage.

Findings from Northwestern Ontario[49]

Home and community care services in Ontario are provided through the province's 14 Local Health Integration Networks (LHINs). The North West LHIN extends from Hudson Bay in the north to the United States border, and from the Manitoba border to just west of White River. The communities of the North West LHIN are spread across 458,010 square kilometers. This makes the North West LHIN the largest LHIN in terms of land mass across all Ontario health regions, accounting for approximately 47% of the entire province. The region also has the largest proportion of Indigenous people of all Ontario LHINs at 21.5%.

Home care services in the North West LHIN include nursing, personal support (e.g. bathing and getting dressed), physiotherapy, occupational therapy, speech-language therapy, social work, nutritional counselling, medical supplies and equipment, as well as information about and referral to additional health and social services in the community.

Community services are also available in the North West LHIN and contribute to enhanced independence, enjoyment and relaxation as well as much-needed caregiver support. These services include meal delivery and dining programs, homemaking and home help, transportation services, community dining, and friendly visits. Community services also include community clinics (staffed by specialized nurses) that provide services which

[49] Based on http://healthcareathome.ca/northwest/en/Getting-Care/Getting-Care-at-Home/Home-Care-Services.

address specific health-care needs like IV therapy, wound care, or rehabilitation therapy. Visits are arranged by the North West LINH and are by appointment only. Other community services include specialized services offered by community healthcare providers for people with specific conditions or care needs.

Although a self-managed care option is available in some LHINs in Ontario, it does not appear to be available for North West LHIN home care clients.

Home care clients in the North West LHIN also have access to specialized nursing services such as:

- **Rapid Response Nurses:** Support adults and children with high care needs as they transition home from hospital. Services may include a home visit within 24 hours of discharge from the hospital, medication review, comprehensive nursing assessment, patient and family education, and ensuring appropriate follow-up appointments are scheduled.
- **Hospice Palliative Care Nurse Practitioners:** Act as a bridge to connect, support, and care for patients who have a life-limiting illness. Nurses help people and families understand their options and provide support so that as a patient reaches closer to the end of their life, they are able to live their remaining days comfortably at home for as long as possible.
- **Telehomecare Nursing**: This service is supported by the Ontario Telemedicine Network (OTN). This innovative program trains registered nurses to provide clients with health coaching and monitoring over the phone or online. If clients require chronic disease self-management, this could mean the difference between managing successfully at home, and frequent hospital and emergency visits.

Other services available include adult day programs and respite care.

Key Findings from 2014 Community Engagement[50]

The following are key findings from community consultations conducted in the North West LHIN in 2014 regarding gaps in care for seniors:

- **Insufficient options for housing:** These correlate specifically to the size of community: the smaller the community, the fewer the options. Seniors who might choose to live at home can be challenged to access contractor services to make necessary modifications to support them at home (e.g. ramps, bathroom safety features).

[50] Informing Care for Seniors in the North West Local Health Integration Network, 2014.

- **Shrinking volunteer base:** Ultimately, the reduction in the volunteer base within the community has great impact not only on health service providers but on other services such as Seniors Centres or Elderly Persons Centres.
- **Non-Urgent Transportation:** Safe, affordable and accessible transportation is a significant issue to many seniors, health service providers, and partners throughout the North West LHIN regardless of the size or location of the community. Participants identified that transportation services are needed to enable seniors to travel within their community and between communities for health care related needs, social needs, or instrumental activities of daily living such as grocery shopping and bill payments. Seniors identify that they are also challenged to find transportation home following evening or night-time discharge from an emergency department or inpatient hospitalization. While some communities offer a few options for transportation, participants indicated that they often only operate during daytime hours on weekdays.
- **Respite Services:** Based on its unique situation, each community identified a specific form of respite service that needs to be enhanced, but overall, there is a greater preference for home-based respite care as co-payments and transportation are not required. However, this form of respite can be particularly challenging to deliver in communities where human resources are scarce.
- **System Navigation:** Seniors frequently experience the health care system as difficult to navigate. Seniors and families are unclear about "who does what" and what options are available for care and services after regular business hours. As a result, local hospitals and the Emergency Medical System (EMS) become the default options.
- **Support with Instrumental Activities of Daily Living:** To enable them to age in place, participants indicated that seniors require assistance with IADLs, such as shopping, banking, laundry, housecleaning, meal preparation, snow shoveling, grass cutting, and home maintenance. Seniors who receive personal care may be entitled to some assistance with IADLs, but this is inconsistent and, with rare exception, does not extend to services outside the home.
- **Home Care Services:** Participants identified many problems with the current model of home care service delivery. Eligibility criteria and service timelines, frequency, quantity, dependability and reliability all contribute to a model that many describe as ineffective and inefficient. This is particularly evident in small rural communities where human resources are scarce. Participants described access to home care services as inconsistent throughout the North West LHIN, often dependent on the size of the community, its remoteness and rurality, and the availability of professional human resources. When home care is not available, people report that they often access local hospitals by default.
- **Health Human Resources Challenges:** A declining population and outmigration of the work force have contributed to challenges in the health and human resource sector for services provided by personal support workers and regulated health

professionals of all disciplines. The existing health work force is further challenged by the need to acquire expert knowledge to care for specialty populations, as the current client complexity often surpasses the skills of a generalist.

The following opportunities for improving care for seniors were identified:

- **Aboriginal Seniors Strategy:** A collaborative strategy needs to be developed to address the needs of Aboriginal Seniors living in urban, rural, and remote communities, paying attention to transitions in care, such as admission to and discharge from hospital. Partners to the strategy would involve the North West LHIN, Health Canada, and various First Nation partners.
- **Seniors Mental Health Strategy:** This strategy needs to comprehensively address the mental health and addictions needs of seniors, including the early identification, treatment, and management of dementias.
- **Use of Technology:** Opportunities exist to leverage the full scope of existing technologies to enable consultation with specialists and to expand the tele-home care model.
- **Shared Electronic Medical Records:** Gaps in communication could be mitigated through shared electronic records which would lead to better communication and decisions at transition points.
- **Mobile Care:** There is opportunity to enhance the role of mobile care delivery in rural areas. Hearing and vision screening, blood pressure screening, dental care, foot care, and other health promotion/illness prevention activities could all be incorporated.
- **Continual Community Supports for Frail Seniors Following Hospitalization:** In this service, high risk frail seniors discharged from hospital would be transitioned home with 24-72 hours of "around the clock" care to enable a successful discharge. New prescriptions would be filled, old ones removed, groceries purchased, personal care delivered, clinical status monitored, appointments made, and transportation arranged, to list a few activities that might prevent readmission.

Key Findings from Manitoba

Home care services in Manitoba are provided through the regional health authorities (RHAs). According to the Government of Manitoba: "*home care provides community-based support and services to eligible individuals, regardless of age, who require health services or assistance with activities of daily living. Home care works with individuals and provides assistance to help them stay in their homes for as long as is safely possible.*"[51] Residents of Manitoba may refer an individual to their local RHA to request an assessment for home care services. To be eligible for home care in Manitoba, an individual must:

[51] https://www.gov.mb.ca/health/homecare/guide.pdf.

- Be a Manitoba resident who is registered with Manitoba Health, Seniors and Active Living;
- Require assistance with activities of daily living or require health services;
- Require service to stay in their home as long as possible; and
- Require more assistance than that available from existing supports and community resources.

Home care services in Manitoba include:

- **Personal Care Assistance:** Assistance with mobility, such as walking, transferring to and from a wheelchair, and with personal care such as bathing, dressing and toileting.
- **Home Support:** Assistance with activities such as meals, light housekeeping, and laundry.
- **Health Care:** Nurses may provide health teaching, counseling, and nursing care. Physiotherapists may provide education on special exercises, and occupational therapists may assist with planning for activities of daily living.
- **Respite Care:** In-home short-term relief or longer-term respite on an alternate setting.
- **Supplies and Equipment:** Supplies and equipment needed for care available through case coordinators.
- **Adult Day Programs:** Programs to meet other people and enjoy recreational activities.

Home care services are either administered by the RHA, or through a Self and Family Managed care option, based on the mutually agreed upon care plan developed in collaboration by the case coordinator and the client/family.

Key Findings from 2016 Manitoba Home Care Review[52]

A comprehensive review of the Manitoba Home Care system was completed in 2016. Key findings from the review included:

- Family and informal caregivers are an essential component of home care but may be a diminishing resource in the future.
- Home care is not standardized across the province to the degree it should be.

[52] Future of Home Care Services in Manitoba, Reg Toews, December 2016.

- Home care is under continuing pressure to facilitate the discharge of patients from the hospital. This has the effect of pushing home care in the direction of a health/medical service model.
- Self and Family Managed Care (SFMC) program is growing and seniors, in addition to younger adults with physical disabilities, are making increased use of it.
- The complexity and acuity of client need is continuing to increase.
- Nurses are delegating more tasks to Home Care Attendants (HCAs).
- The lack of continuity in the assignment of HCAs and insufficient time allocated to complete the assigned task remains an issue.
- Information Communication Technology (ICT) programs currently available in home care are generally inadequate – frequently what does exist is old.
- The Continuing Care Branch (CCB) is unable to fulfill its assigned role due to insufficient resources.
- Recruitment and retention of home care personnel is a constant challenge – at any one time, there is a vacancy rate of 8-10%.

Manitoba Self and Family Managed Care Program

The Self and Family Managed care option in Manitoba provides HCC clients and/or their families with the following sub options[53]:

- **Self-Managed Care:** Enables clients with assessed Home Care needs to accept full responsibility for their personal care as Self Managers.
- **Family Managed Care:** Enables the families of clients with assessed home care needs to accept full responsibility for their family member as a Family Manager.

Under either option, the Client or Family Manager are responsible for coordinating, managing, and directing the non-professional services they need to continue living at home and in the community. The level of funding provided for care is based on the level of care documented in the client's care plan and initial assessment. For example, if a client is assessed as requiring 30 hours of care per week, then they receive 30 hours of funding. The approved hours of care relate to home support services, and not professional care services (i.e. nursing and OT/PT). Professional care services are provided by the RHA. Responsibilities of Self Managers or Family Managers include[54]:

[53] http://www.wrha.mb.ca/community/homecare/self-and-family-managed-care.php
[54] http://www.wrha.mb.ca/community/homecare/self-and-family-managed-care.php

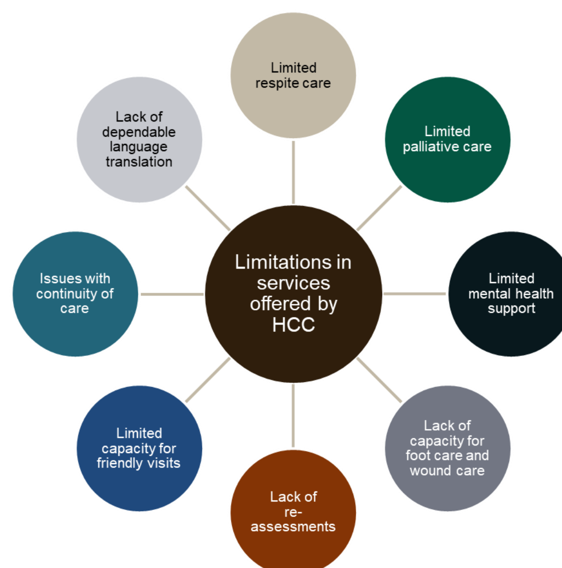
- Purchasing services or employing staff with the approved level of funding to provide services at a level consistent with the formal assessment and signed contract with the RHA.
- Having reassessments completed as determined by the RHA Home Care Coordinator.
- All Self/Family Managers will be required to set up and maintain a separate bank account. This account is used solely for receiving and expending Self/Family Managed Care funds and will be subject to semi-annual reports and audit reviews by the RHA.
- As per Manitoba Health and Healthy Living policy, hiring of family members is not allowed, except in unique circumstances.
- The Self/Family Manager will arrange to meet the needs of the client in accordance with the RHA SFMC contract.
- In the event of a violation of the SFMC contractual agreement, the contract with the RHA Self/Family Managed Care Program may be terminated and alternate home care services will be arranged dependent on eligibility.
- A Self/Family Manager may choose to hire an agency to provide the funded home care services, may choose to directly employ their own staff. If they choose to employ staff, a Self/Family Manager takes on full responsibilities as an employer including registering with Canada Revenue Agency, Employment Insurance, Workers Compensation, making required payroll deductions, etc. A payroll company may be hired to assist with these employer obligations. Alternatively, managers may choose to engage a personal care agency to provide the care.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 KEY CONLUSIONS AND THEMES

Conclusions were drawn based upon areas where both quantitative and qualitative data existed to substantiate findings, or where strong perceptions by a majority of stakeholders existed in the absence of quantitative data.

1. **Overall, HCC program spending represented 3.2% of the total DHSS budget in 2017/18.** This is significantly lower than spending on HCC programs in other provinces such as Manitoba, Alberta and Newfoundland.
    a. Currently, HCC services are funded by Department core funding as well as FNIHCC funding through FNIHB. The Department core funding is allocated based on historical levels rather than need.
    b. The Department currently has a five-year agreement with FNIHB for the FNIHCC funding that expires March 31, 2025.
2. **The delivery of HCC services across the NWT is fragmented and inconsistent.** The services delivered by each HSSA/region vary and are dependent on the size of each community and the resources that exist to provide services. The service provider mix levels and the distribution of service hours by activity varied between the HSSAs/regions, consistent with stakeholder perceptions of inconsistent service delivery between HSSAs/regions.
3. **There are disparities and inequities in the delivery of HCC services between HSSAs/regions.** These were perceived to be due to the historical funding approach for HCC services rather than having a funding approach that is based on need. The ratio of nursing and HSW staff per 1,000 people varied by HSSA/region, suggesting that stakeholder perceptions of disparities in service delivery may be valid.
4. **All communities report difficulties with hiring and retaining long-term HCC staff.** This has resulted in several limitations in services offered by the NWT HCC program.



    a. **Limited respite care:** Respite care was identified as a contributing factor to helping clients stay in their homes. However, communities reported that the lack of respite beds meant clients are only left with the option to leave the community to obtain respite care causing further burden on caregivers.
    b. **Limited palliative care:** A lack of palliative care services was

attributed to a lack of staff, especially during evenings and weekends.

c. **Limited mental health support:** Staff reported that there was a lack of support for clients' mental health and that there were challenges to hire mental health and social workers.

d. **Lack of capacity for advanced foot care and advanced wound care:** HCC staff from all HSSAs reported a lack for capacity for providing advanced foot care and adequate territorial supports for providing advanced wound care to HCC clients.

e. **Lack of clinical/needs re-assessments:** Staff reported difficulties with keeping clinical and needs assessments up to date, and a lack of regular clinical/needs re-assessments due to capacity.

f. **Limited capacity for friendly visits:** Clients expressed the desire for regular check-ins. While staff identified the effectiveness of friendly check-ins, the HCC visit planning processes do not always incorporate them into scheduling in part due to capacity.

g. **Issues with continuity of care:** Turnover resulting from rotating staff was noted as negatively impacting continuity of care and ultimately quality of care offered.

h. **Lack of dependable language translation:** Language barriers between HCC workers (mostly nurses) and seniors and elders were reported to cause difficulties with providing proper care. The lack of a translation program placed the burden on HCC workers.

5. **Management and oversight for HCC services in the smaller remote communities in the NWT is inconsistent and sometimes insufficient.** For example, nursing oversight is provided by CHNs and not a dedicated Home Care Nurse in many communities in the NTHSSA Beaufort-Delta, Dehcho and Sahtu regions, as well as the Tlicho CSA, and the direction provided by CHNs to HSWs is either limited because the CHN has to attend to emergencies at the health centre or inconsistent with the direction provided by the regional Continuing Care Manager or Home Care Nurse. This creates confusion for the HSWs working in these communities.

6. **Management and oversight for HCC services in the larger regional communities is more effective than what is experienced in the smaller remote communities in the NWT.** In the larger communities, oversight for HCC services is provided by dedicated HCC nurses, which was perceived to be effective by HCC staff in those communities. This model for oversight should continue.

7. **Similar to other jurisdictions in Canada, the acuity and complexity of HCC clients is perceived to be increasing in the NWT and is expected to increase in the future.** Accordingly, the NWT HCC program will require a highly skilled team of HSWs and nursing staff who are properly trained to treat more complex issues in the home/community, as well as improved service integration with other health professionals including physicians, CHNs, advanced wound care specialists, allied health professionals and medical social workers.

8. **The demand for HCC services in the NWT is projected to increase.** As shown in Section 4.3, the number of HCC clients is projected to increase from 1,558 clients in 2018 to 2,908 clients in 2035.
9. **The hours of operation for HCC services is not aligned with the needs of clients in some communities.** To mitigate this, some HSSAs/regions indicated that they already provide extended hours for evening as well as weekend services. However, there is a need for more resources in order to expand services and hours of operation.
10. **There are training gaps for HSWs and nurses impacting quality of care.** For example, a portion of HSWs in the NWT have gone through a formal certification training program, while other HSWs have not, leading to inconsistent skill sets and a varying knowledge base.
11. **There is a need to collaborate with more expert resources to support the NWT HCC program.** This includes specialists and professionals in geriatrics, psychology, advanced wound care and advanced foot care, palliative care, medical social work and allied health.
12. **Most regions lack a coordinated escort program to support HCC clients travelling outside of their community for medical care.** This leads to HCC clients sometimes travelling with escorts who are unreliable and do not attend medical appointments with them in Yellowknife or Edmonton, or to situations where HCC clients have to travel outside of the community for medical care without any escort for support. This was a major concern for HCC clients, especially those who are seniors and elders.
13. **The current Continuing Care Standards related to HCC service delivery are documented at too high of a level to effectively guide consistent HCC service delivery across the NWT.** In addition, there are no territorial policies or guidelines in place related to HCC service delivery to support the Continuing Care Standards. This was perceived to contribute to inconsistent service delivery for HCC across the territory. Within the implementation of HCC standards, flexibility would be crucial so that the unique needs of the various communities can still be met.
14. **Charting and documentation processes are inconsistent.** HCC staff and managers reported that charting and documentation processes can be inefficient, are inconsistently applied, and lack smooth integration between different care providers (e.g. paper charts for HCC versus EMR for other health service providers). As a result, there are gaps in the coordination of care between different care providers (e.g. acute care, mental health care, OT/PT) and within hospital discharges.
15. **Data collection and reporting processes are inconsistent, and the Health Suite system is time-dated and no longer functional as a reporting tool to inform decision-making for the DHSS.** The data reported in Health Suite is inconsistent and unreliable, resulting in data sets that under-represent the actual level of services provided to clients, creating challenges for planning and decision-making regarding HCC program resource and funding allocations.
16. **There are limited reporting requirements for HCC funding.** This includes no requirements to report on HCC activities and outcomes for the core HCC funding, and

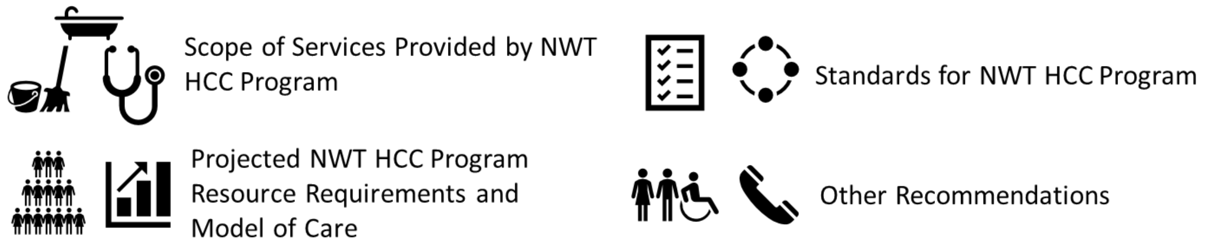
limited reporting requirements for the FNIHCC funding. This lack of reporting further creates challenges for decision-making regarding HCC program resource and funding allocations.

17. **HCC resources are currently being used to fill gaps in community based services such as community transportation in some NWT communities.** As a result, there is less time available for staff to provide HCC services to clients in the home.
18. **Across the different HSSAs and regions, there is minimal communication on eligibility for HCC and the types of services offered.** This creates confusion in many communities regarding the scope of services offered by the NWT HCC program, and how to access the program.
19. **HSSAs and regions vary in the extent they use technology, and in opportunities existing to take greater advantage of technology.** For example, telehealth is underutilized in some remote communities, and could be better utilized to improve the continuity of care for HCC clients.
20. **There is a need to improve the communication between the HCC program and external organizations to help clients stay in their homes and communities longer.** Improved collaboration with social services staff/agencies (especially with regards to reporting elder abuse), indigenous organizations and the NWT Housing Corporation could help clients stay in their homes and communities longer.

6.2 RECOMMENDATIONS

MNP has provided 22 recommendations for improving the HCC program in the NWT. These recommendations are aligned with an "aging in the community approach" to care, which is an expectation of NWT residents.

The recommendations have been organized into four categories as follows:



Scope of Services provided by NWT HCC Program

The following five (5) recommendations are specific to defining the scope of services to be delivered by the NWT HCC program.

1. **The defined scope of services to be provided by the NWT HCC program should be based on a common set of principles.** MNP used the Harmonized Principles for Home Care, developed by the Canadian Home Care Association, as a guide for recommending a defined scope of services for the NWT HCC program in recommendation 2. The principles, which have been adapted for the NWT context specifically, include the need for:
    - **Client and family-centred care**
    - **Consistency and equity** in the types of appropriate HCC services available across the NWT
        - Approved services will be the same across the NWT
        - HSSAs and regions will have flexibility in the levels of approved services based on assessed client need
    - **Evidence-informed care –** based on clinical expertise
        - Levels and types of approved services based on client assessments by health professionals
    - **Sustainable care –** care improves client experience and outcomes in a cost-effective manner
        - Formal "client contracts" with HCC clients and families that articulate the agreed-upon types and levels of services
    - **Integrated care –** coordinated planning and delivery of services
    - **Accountable care –** clear strategy for managing, delivering and reporting on client, provider and system outcomes

    MNP recommends that these principles be taken into consideration when defining the scope of services for the NWT HCC program.

2. **Define the scope of services to be provided by the NWT HCC program.** Defining the scope of services provided by the NWT HCC program should improve the consistency of services provided by the HCC program in HSSAs/regions across the NWT, as well as help set expectations for NWT residents and clients of the HCC program regarding the types of services to be provided through the HCC program.

    The recommended scope of services to be provided by the NWT HCC program has been divided into four (4) categories as follows.

Personal Care Services (ADLs) and Homemaking Services (IADLs)

This category of services includes providing assistance for activities performed by individuals on a daily basis necessary for independent living at home or in the community based on assessed need. The recommended services in this category include:

ADLs and IADLs – Personal Care and Homemaking Services

ADL - Personal Care Services (based on assessed need)	IADL - Homemaking Services (based on assessed need)
Feeding/Nutrition – Assistance with the ability to feed oneself (does not include meal preparation)	Light Housekeeping – Assistance with dishes, dusting, and sweeping, maintain a hygienic residence
Toileting – Assistance with getting on and off the toilet and cleaning oneself	Laundry – Assistance with washing clothes, bedding and towels as required
Mobility/Lifts/Transfers – Assistance with moving oneself from seated to standing, and getting out of bed	Meal Preparation – Assistance with meal planning, cooking, clean up and storage
Bathing/Dressing/Grooming – Assistance with bating/showering, nail care, oral care and the ability to dress oneself.	Shopping/Errand Support – Assistance with shopping and running errands if no other option exists for the HCC client.

Nursing Care Services

This category of services includes clinical treatment services provided by nurses in the client's home or other community settings that allow clients to remain living at home and thrive in the community while receiving treatment based on assessed need. The recommended services in this category include:

Nursing Care Services

Nursing Care Services (delivered based on community capacity and availability of resources)	
Post Hospital Acute Care	Home Care Nursing Assessments/Reassessments
Care Planning	Medication Management Support
Infusion Therapy	Home Oxygen Support
Continence Care	Ostomy Care
Chronic Disease Care	In-Home End of Life Care

Referral and Case Management Support (Clinical and Community Services)

This category of services includes making referrals to and coordinating consultative clinical services with other integrated health service providers in the NWT health and social services system. Consultative services will be delivered based on available community capacity.

This category also includes activities to coordinate services with other service delivery agents that support IADLs. The recommended services in this category include:

Referral and Case Management Support (clinical and community services)

Consultative Clinical Services (delivered based on community capacity and availability of resources)	
Physiotherapy Services	Adult Social Worker Services
Occupational Therapy Services	Dietician Services
Nurse Practitioner Services	Speech Language Services
Advanced Foot Care	Advanced Wound Care
Dental Services	Physician Services (Specialty and Family Medicine)
Coordination of Services to Support IADL	
Community transportation	Snow clearing/woodcutting
Home repairs/maintenance	

Other HCC Services

This category of services includes additional activities/services that support clients in being able to remain at home or in the community as long as possible. However, the ability to deliver these services will be dependent on available capacity in each community. The recommended services in this category include:

Other HCC Services

Other Programs and Services (delivered based on community capacity and availability of resources)	
In-Home Respite Care	Accessing Medical Supplies/ Equipment Loans
Day Programming	Meals on Wheels/Community Meals

3. **Define the services that are out of scope for the NWT HCC program.** Defining the services which are not provided by the NWT HCC program should also improve the consistency of services provided by the HCC program in HSSAs/regions across the NWT, as well as help set expectations for NWT residents and clients of the HCC program regarding the types of services not available through the HCC program.

   It is recommended that the services identified in the graphic be out of the scope of the HCC program, as they could be provided by family members, the community (local government agencies), and/or other service delivery agencies.

4. **Improve communication of which services are within scope and out-of-scope of the HCC NWT Program.** It is recommended that the scope of the NWT HCC program be communicated to NWT residents. Communicating which programs are within scope and out-of-scope of the NWT HCC program should improve the consistency of services provided by the HCC program in HSSAs/regions across the NWT, as well as help set expectations for NWT residents and clients of the HCC program.
5. **Further explore the feasibility of expanding the hours of the HCC program operations in each HSSA/region.** Stakeholders from many HSSAs/regions in the NWT felt that further consideration should be given to expanding the hours of HCC services in most HSSAs/regions to better meet the needs of HCC clients. Some HSSAs/regions indicated that they already provide extended hours for evening as well as weekend services. Given the additional projected staffing requirements for HSWs and nursing staff in recommendations 8 and 10, there might be an opportunity to schedule staff to provide HCC services during evenings and weekends, similar to what occurs in other Canadian jurisdictions. The DHSS should pilot an extended-hours model for HCC services in additional communities (larger communities first where staff oversight is not as big a challenge) to test the feasibility of the model.

Projected NWT HCC Program Resource Requirements and Model of Care

The following eight (8) recommendations are specific to projecting the future resource requirements for the NWT HCC program model of care.

6. **The DHSS should plan for an 80% increase in demand for HCC services by the year 2035.** As demonstrated in projection model 2 in Section 4.3 above, the demand for HCC Services in the NWT is projected to increase by 80% from 1,558 in 2018 to 2,809 in 2035. A breakdown of the projected demand for HCC services by age group and HSSA/region is provided in Figure 18 below. MNP recommends using this projection demand model for future HCC program resource planning purposes.

Figure 18: Recommended Projected Demand Model for HCC Services by Age Group and HSSA/Region in the NWT

HSSA/Region/Age Group	Current	Projected HCC Caseload					
	2018	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	**144**	**233**	**254**	**284**	**294**	**310**	**333**
0 - 59 years	19	35	33	32	32	31	30
60 - 74 years	46	74	88	94	93	90	86
75+ years	79	124	133	158	169	189	217
NTHSSA Dehcho Region	**193**	**136**	**154**	**169**	**189**	**196**	**217**
0-59 years	33	17	17	16	16	15	15
60 - 74 years	75	46	49	52	53	55	51
75+ years	85	73	88	101	120	126	151
NTHSSA Sahtu Region	**106**	**97**	**103**	**110**	**117**	**123**	**130**
0-59 years	13	13	13	12	12	12	12
60 - 74 years	27	26	31	31	32	31	31
75+ years	66	58	59	67	73	80	87
NTHSSA Yellowknife Region	**826**	**850**	**976**	**1,123**	**1,240**	**1,383**	**1,549**
0-59 years	324	329	324	321	323	324	327
60 - 74 years	266	287	344	370	367	376	369
75+ years	236	234	308	432	550	683	853
Tlicho CSA	**86**	**88**	**92**	**97**	**105**	**109**	**118**
0-59 years	24	16	16	16	15	15	15
60 - 74 years	21	24	28	28	29	31	32
75+ years	41	48	48	53	61	63	71
Fort Smith Region	**88**	**112**	**129**	**143**	**146**	**161**	**173**
0-59 years	5	13	12	12	12	12	12
60 - 74 years	41	35	37	36	39	38	35
75+ years	42	64	80	95	95	111	126
Hay River Region	**115**	**180**	**205**	**229**	**253**	**267**	**289**
0-59 years	24	19	19	18	18	18	18
60 - 74 years	41	57	67	70	68	64	61
75+ years	50	104	119	141	167	185	210
NWT Total	**1,558**	**1,696**	**1,913**	**2,155**	**2,344**	**2,549**	**2,809**
0 - 59 years	442	442	434	427	428	427	429
60 - 74 years	517	549	644	681	681	685	665
75+ years	599	705	835	1,047	1,235	1,437	1,715

7. **Develop guidelines regarding the average hours of care per year provided by HSWs to HCC clients assessed as requiring a combination of personal care services (ADLs) and homemaking services (IADLs).** It is recommended that the DHSS plan future HSW resource requirements based on the following guidelines for average hours of care:
   - HSWs provide an average of 140 hours of care per year to HCC clients aged 75+, and an average of 102 hours of care per year to HCC clients aged 0-74, assessed as requiring a combination of personal care services (ADLs) and homemaking services (IADLs).
   - The actual level of care provided by HSWs to each HCC client will vary and should be based on assessed client need and documented in client care plans.
8. **The DHSS should plan for recruiting additional HSWs annually to meet the growing demand for HCC services in the NWT to the year 2035.** The requirements for HSWs is projected to grow significantly from 59.13 FTEs in 2019 to 128.41 FTEs in 2035 in order to meet the growing demand for HCC services in the NWT. MNP recommends the NWT plan its requirements for additional HSW staffing complements, according to the staffing projection in Figure 19, which is based on projection model 2 in Section 4.3.

Figure 19: Projected HSW Staffing Complements by HSSA/Region from 2020 to 2035

HSSA/Region	Current	Projected HCC HSW FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	15.53	15.53	16.27	18.63	19.53	21.07	23.26
NTHSSA Dehcho Region	10.00	12.78	14.65	16.25	18.40	19.15	21.54
NTHSSA Sahtu Region	8.70	9.26	9.46	10.39	11.03	11.71	12.47
NTHSSA Yellowknife Region	11.30	18.48	22.51	27.30	31.11	35.75	41.15
Tlicho CSA	6.10	8.20	8.53	9.07	9.96	10.34	11.29
Fort Smith Region	2.50	3.40	4.05	4.63	4.68	5.30	5.84
Hay River Region	5.00	7.02	8.02	9.26	10.64	11.55	12.86
NWT Total	**59.13**	**74.67**	**83.49**	**95.53**	**105.35**	**114.87**	**128.41**

HSSA/Region	Projected Additional HCC HSW FTE Staff Requirements					
	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	0.00	0.74	3.10	4.00	5.54	7.73
NTHSSA Dehcho Region	2.78	4.65	6.25	8.40	9.15	11.54
NTHSSA Sahtu Region	0.56	0.76	1.69	2.33	3.01	3.77
NTHSSA Yellowknife Region	7.18	11.21	16.00	19.81	24.45	29.85
Tlicho CSA	2.10	2.43	2.97	3.86	4.24	5.19
Fort Smith Region	0.90	1.55	2.13	2.18	2.80	3.34
Hay River Region	2.02	3.02	4.26	5.64	6.55	7.86
Total Projected Additional HSW Staffing	**15.54**	**24.36**	**36.40**	**46.22**	**55.74**	**69.28**

9. **Develop guidelines regarding the average hours of care per year provided by nurses to HCC clients assessed as requiring nursing care supports.** It is recommended that the DHSS plan future HCC nursing resource requirements based on the following guidelines for average hours of care:

    - Nurses provide an average of 12 hours of care per year to HCC clients aged 75+, and an average of 14 hours of care per year to HCC clients aged 0-74, assessed as requiring nursing care supports.
    - The actual level of care provided by nurses to each HCC client will vary and should be based on assessed client need and documented in client care plans.

10. **The DHSS should plan for recruiting additional nurses annually to meet the growing demand for HCC services in the NWT to the year 2035.** The requirements for nurses who provide nursing care and assessment services to HCC clients is projected to grow significantly from 24.78 FTEs in 2019 to 44.18 FTEs in 2035 in order to meet the growing demand for HCC services in the NWT. MNP recommends the NWT plan its requirements for additional HCC nursing staff complements, according to the staffing projection in Figure 20, which is based on projection model 2 in Section 4.3.

Figure 20: Projected HCC Nurse Staffing Complements by HSSA/Region from 2020 to 2035

HSSA/Region	Current	Projected HCC Nursing FTE Staff Requirements					
	2019	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	2.53	3.71	4.05	4.50	4.65	4.88	5.20
NTHSSA Dehcho Region	2.00	2.16	2.03	2.22	2.47	2.56	3.37
NTHSSA Sahtu Region	1.00	1.53	1.63	1.73	1.84	1.92	2.03
NTHSSA Yellowknife Region	13.00	14.07	16.06	18.29	20.01	22.15	24.59
Tlicho CSA	1.25	1.40	1.47	1.54	1.66	1.72	1.86
Fort Smith Region	2.00	2.00	2.03	2.23	2.28	2.50	2.67
Hay River Region	3.00	3.00	3.24	3.60	3.95	4.15	4.46
NWT Total	**24.78**	**27.87**	**30.51**	**34.11**	**36.86**	**39.88**	**44.18**

HSSA/Region	Projected Additional HCC HSW FTE Staff Requirements					
	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	1.18	1.52	1.97	2.12	2.35	2.67
NTHSSA Dehcho Region	0.16	0.03	0.22	0.47	0.56	1.37
NTHSSA Sahtu Region	0.53	0.63	0.73	0.84	0.92	1.03
NTHSSA Yellowknife Region	1.07	3.06	5.29	7.01	9.15	11.59
Tlicho CSA	0.15	0.22	0.29	0.41	0.47	0.61
Fort Smith Region	0.00	0.03	0.23	0.28	0.50	0.67
Hay River Region	0.00	0.24	0.60	0.95	1.15	1.46
Total Projected Additional HCC Nurse Staffing	**3.09**	**5.73**	**9.33**	**12.08**	**15.10**	**19.40**

11. **The DHSS will need to secure additional funding for the HCC program either through the core homecare funding envelope and/or the FNIHCC funding envelope to fund additional HSW and nursing positions.** The projected need for additional HSW (recommendation 7) and HCC nursing staff (recommendation 8) will require the DHSS to secure additional funding. The projected funding requirements for the additional HSW and nursing staff requirements, in 2019 dollars (does not account for inflationary increases to salaries), is projected to be approximately $1.79 million in

2020, and $8.73 million by 2035 (Figure 21). Key assumptions for the additional funding requirement projection, provided in Appendix F, include:

- All HCC nurses on average will be paid at the mid-point hourly rate for a CHN in the NWT ($53.78 per hour) to encourage recruitment and retention of HCC nurses.
- All HSWs will be paid at the mid-point hourly rate for a HSW in the NWT ($34.18 per hour).
- All HSWs and nursing staff will receive the current Northern Allowance rate for the region they work in (see Appendix F for applied rates).
- All HSWs and nursing staff will receive benefits at an average rate of 22% of gross salaries.

Figure 21: Projected Additional Funding Required for Additional HSW/Nursing Staff

HSSA/Region	Projected Additional Funding for Additional HCC HSW and Nursing Staff					
	2020	2023	2026	2029	2032	2035
NTHSSA Beaufort-Delta Region	$174,468	$294,282	$582,604	$689,362	$868,095	$1,121,220
NTHSSA Dehcho Region	$270,770	$419,516	$589,113	$816,262	$895,893	$1,223,165
NTHSSA Sahtu Region	$135,635	$170,407	$276,215	$355,334	$433,752	$524,549
NTHSSA Yellowknife Region	$751,441	$1,358,539	$2,062,081	$2,614,514	$3,293,335	$4,076,604
Tlicho CSA	$203,963	$242,392	$299,156	$393,349	$434,770	$536,949
Fort Smith Region	$77,682	$137,859	$215,080	$226,185	$309,574	$379,268
Hay River Region	$173,544	$291,897	$447,089	$612,957	$718,171	$872,619
Total Projected Additional Funding Requirements	**$1,787,503**	**$2,914,892**	**$4,471,338**	**$5,707,963**	**$6,953,590**	**$8,734,374**

12. **The DHSS should further explore the requirements for other HCC program clinical service resource supports including allied health professionals, advanced wound care specialists, advanced foot care specialists, and medical social workers.** Based on direction provided by the DHSS, the scope of the NWT HCC review did not include the development of projections for allied health professionals, advanced wound care specialists, advanced foot care specialists, and medical social workers. However, based on feedback received from stakeholders, there is a need to enhance the level of services provided by advanced wound care/foot care specialists, allied health professionals and medical social workers.

13. **The DHSS should strengthen the service delivery model in remote communities, to be more consistent with the service delivery model in larger regional communities.** Nursing service delivery and oversight provided to HSWs in most remote communities in the NTHSSA Beaufort-Delta, Dehcho and Sahtu regions as well as the Tlicho CSA is provided by CHNs, and not a dedicated Home Care Nurse, which is the model used in the larger regional centres.

    The CHN service delivery and oversight model was reported to create challenges with limited and/or inconsistent direction. However, the dedicated HCC nurse service delivery and oversight model used in the larger regional centres was reported to be more effective. Accordingly, it is recommended that dedicated HCC nurse service delivery and oversight model continue to be used in the larger regional communities,

and that a similar model be implemented in the smaller communities as well. Two recommended options have been provided to improve HCC oversight and nursing care in the smaller remote communities including:

- **Option 1:** Creating dedicated HCC nursing positions (RNs or LPNs) with a primary focus to provide HSW oversight and HCC nursing care, and a secondary focus to assist with community health centre nursing needs when not busy with HCC nursing tasks. This should improve HCC nursing oversight and care in these communities, as well as create additional capacity to provide palliative care when needed. It would also provide some additional capacity to provide nursing care in the community health centre.
  - MNP has found that LPNs are being used for case management, nursing care, and HSW oversight in other jurisdictions such as Alberta[55], Yukon[56], and the Northern Health Region in Manitoba[57]. Accordingly, it is recommended that the DHSS consider using LPNs for these positions.
  - If considered, this model should be piloted in some smaller communities in the NTHSSA Sahtu or Beaufort-Delta region to test the effectiveness and feasibility of the model, before rolling out to all of the communities.
- **Option 2:** Creating dedicated regional HCC nursing positions (RNs or LPNs) to provide HSW oversight at a distance (via telehealth) and in person through monthly visits to communities (assign 2 communities per nurse). This would require frequent and consistent communication about client charts with the local CHN when these HCC nurses are not in the community. Each nurse would require 1-2 weeks of travel per month.
  - If considered, this model should be piloted to test the effectiveness and feasibility of the model. The model could be tested by having 2 dedicated HCC nurses (RNs or LPNs) based in Norman Wells (NTHSSA-Sahtu region), who provide oversight to HSWs in the Sahtu region.

---

55 https://www.clpna.com/wp-content/uploads/2018/07/care_magazine_Summer_2018.pdf

56 https://www.cbc.ca/news/canada/north/yukon-lpns-can-do-more-medical-tasks-1.953785 and www.hss.gov.yk.ca/pdf/recruitment_nurse_lpn.pdf

57 MB Homecare Review

Standards for NWT HCC Program

The following five (5) recommendations are specific to standardizing HCC service delivery in the NWT.

14. **Continue with implementation of interRAI.** It is recommended that DHSS continue with the implementation of interRAI. Over time, it will improve the consistency of clinical assessments, the management of clients, and continuity of care in the HCC program and the entire continuum of care in the NWT. Some of the noted benefits of the system include:

    - It is an evidence-based standardized clinical assessment tool designed to identify clients at risk of adverse outcomes across care setting.
    - It provides real-time feedback on client risks and needs for care planning.
    - It provides comparable data in all home care service recipients.
    - It supports planning for resources to provide services to diverse home care populations.

    Although the implementation of interRAI will eventually improve the standardization and consistency of HCC assessment criteria, care planning, client charting, and continuity of care across the NWT; adoption and use of interRAI will take time and there is a need to improve standardization of the NWT HCC program before interRAI is fully rolled out. Accordingly, recommendations 15 to 18 have been provided to improve the consistency of HCC service delivery while interRAI is in the process of being implemented.

15. **The DHSS should consider reviewing and adopting Accreditation Canada Standards for HCC service delivery.** Accreditation Canada assesses organizations against Home Care Services and Home Support Services standards developed by its affiliate, the Health Standards Organization. The DHSS and the HSSAs in the NWT should consider reviewing and adopting these standards as guidelines for HCC service delivery in the NWT. This would improve consistency to adjust for local needs while allowing for some flexibility in how services are delivered.

    In addition, the DHSS should also consider having the HCC program in Yellowknife and Hay River accredited as pilot sites to assess how HCC service delivery could be better standardized in the NWT.

16. **The DHSS should consider standardizing HCC program forms across the NWT.** As reported in Section 3.3, there is variation between HSSAs and regions regarding the usage of forms for documenting assessments, referrals, care planning, client contracts, charting, and policies/processes/procedures. Although the content for some forms such as care plans is similar, the forms used are not consistent. It is recommended that the DHSS work with the HSSAs and regions to adopt and implement the use of the same forms for HCC assessments, referrals, care plans, client contracts, charting, and policies/procedures/processes.

17. **Ensure that all HSWs are certified and receive consistent training.** Currently, there are training gaps for HSWs that are impacting the quality of care provided to HCC clients. For example, a portion of HSWs in the NWT have gone through a formal certification training program, while other HSWs in other have not, leading to inconsistent skill sets and a varying knowledge base. Accordingly, it is recommended that:
    - The DHSS implement a consistent training program for all HSWs in the NWT and ensure that all HSWs are certified to deliver HCC services in the NWT.
    - Have annual or biennial training events for HCC nurses and HSWs in the NWT to ensure skills are up to date and best practices are being shared.
18. **Improve data collection to more accurately monitor HCC service delivery across the NWT.** It is recommended that the DHSS improve HCC program data collection now while interRAI is being implemented. There is a need to improve data collection to better monitor HCC service delivery across the NWT for measures such as: the hours of care by age group and type of service (i.e. homemaking services, personal care, nursing care, wound care, foot care, and other/allied health services), the level of care of clients, active monthly client caseload numbers by age group, and monthly admissions and discharges. The following should be considered for implementing data collection:
    - The DHSS should consider implementing a new temporary system for data collection, or a template in addition to Health Suite to ensure the data required to track performance and make funding decisions is collected appropriately.
    - Data collection should be tracked more frequently (monthly or quarterly), to improve the quality of data collection.

Other NWT HCC Program Recommendations

The following four (4) recommendations should also be considered for improving HCC program service delivery in the NWT.

19. **The DHSS should proceed with test-piloting a paid caregiver support model in the NWT.** It is recommended that the DHSS proceed with its plan to test pilot a paid caregiver support option in some rural/remote areas of the NWT. In this option, caregivers in the NWT could be paid to assist with providing some home support services to HCC clients such as:
    - Shopping/running errands
    - Snow clearing
    - Wood cutting
    - Heavy housecleaning assistance
    - Translation services at appointments
    - Transportation to community events

- Transportation to medical appointments

Assessment and oversight would still be required by HCC nurses in each HSSA and region.

20. **Increase use of telehealth services for the HCC program.** It is recommended that the HCC program make better use of telehealth services for services with physicians, nurse practitioners, advanced wound/foot care specialists, OT/PT, adult medical social workers, and dietitians.
21. **Continue to improve communication with hospitals.** It is recommended that the HCC program continue to improve communication with Stanton Hospital and other hospitals in Alberta to better coordinate discharges of patients into the HCC program. This will help ensure proper HCC staffing and resources are available in the community when a HCC client returns.
22. **Improve communication and coordination of services with GNWT departments and other organizations/agencies.** It is recommended that the HCC program improve communication and coordination with:
    - NWT Housing Corporation to ensure:
        - HCC clients are aware of NWT Housing Corporation programs; and
        - That housing repair/maintenance needs are communicated to NWT Housing Corporation appropriately.
    - Local community government administration and agencies – could provide services for transportation to and from medical appointments and community events, snow clearing, wood cutting assistance, etc.

APPENDICES

APPENDIX A – REVIEW MATRIX

Review Area	Indicator(s)	Quantitative Evidence	Qualitative Evidence	Method/Data Source
I – Supply-Side Analysis and Current State Assessment of NWT HCC Services				
1. Types of HCC programs and services provided across the NWT.	• Inventory of HCC programs/services provided in NWT • Availability of HCC services by NWT region/community	• Inventory/descriptions of NWT HCC services by region/community	• Perceived types of HCC services available to community members	**Interviews/ Focus Group/ Survey** • Clients/families • HSSA management and staff • DHSS management and staff **Data/ Documents** • HCC Year-End Reports • Health Suite Data • HCC Contribution Agreements • interRAI Survey Monkey Results
2. Utilization of HCC programs and services across the NWT.	• Utilization of NWT HCC services	• Caseloads by client type and age demographic (by region and community) • Hours of service by client type (by region and community)	• Perceived frequency that services are used by clients • Perceived number of clients using HCC services	**Interviews/ Focus Group/ Survey** • Clients/families • HSSA management and staff • DHSS management and staff **Data/ Documents** • HCC Year-End Reports • Health Suite Data • HCC Contribution Agreements

Review Area	Indicator(s)	Quantitative Evidence	Qualitative Evidence	Method/Data Source

3. Effectiveness of HCC service delivery across the NWT.	• Staffing compliments by service area and region/ community
	• HCC operating plans and reports
	• HCC data collection and performance measurement
	• Service delivery agreements between DHSS and HSSAs
	• Consistency of HCC service delivery across the NWT
	• Processes and tools used to deliver HCC services in the NWT
	• Management and oversight of HCC service delivery
	• Perceived effectiveness of HCC service delivery
		• HCC staffing compliments (full-time equivalents (FTE)) by position for each region/community
		• Documented HCC operating plans and reports (DHSS and HSSAs)
		  ○ Frequency of HCC reporting
		• Types and consistency of data collection
		• Documented service delivery agreements between DHSS and HSSAs
		• Documented assessment criteria
		  ○ Types of assessment tools used for HCC
		• Case management tools used for HCC
		• Documented operational guidelines
		• Documented roles and responsibilities for management and oversight of HCC services
		• Documented partnerships and dependencies
			• Perceived effectiveness of current HCC staffing model
			• Perceived effectiveness of HCC planning and reporting processes
			• Perceived effectiveness of HCC service delivery agreements
			• Perceived effectiveness of operational guidelines
			• Perceived effectiveness of HCC referral and assessment tools/ processes
			• Perceived effectiveness of case management tools
			• Perceived consistency of HCC service delivery
			• Perceived effectiveness of data collection and performance measurement for HCC services
			• Perceived need for partnerships to deliver HCC services
			• Perceived effectiveness of HCC services management and oversight
			• Perceived effectiveness of HCC services
			  ○ Perceived strengths/ successes
			  ○ Perceived opportunities for improvements
				Interviews/ Focus Group/ Survey
				• Clients/families
				• HSSA management and staff
				• DHSS management and staff
				Data/ Documents
				• HCC Year-End Reports
				• HCC operating plans
				• Health Suite Data
				• HCC Contribution Agreements
				• interRAI Survey Monkey Results
				• Continuing Care Services Action Plan
				• Operational guidelines and procedures
				• DHSS Continuing Care Standards
				• HCC organizational/reporting structures
				• Management roles and responsibilities

Review Area	Indicator(s)	Quantitative Evidence	Qualitative Evidence	Method/Data Source
4. Efficiency of HCC service delivery across the NWT.	• Variance analysis (budget versus actual costs) • Funding sources	• Variance analysis (budget versus actual costs) • Level of funding by funding sources	• Perceived efficiency of the delivery of HCC services in the NWT	**Interviews/ Focus Group/ Survey** • HSSA management and staff • DHSS management and staff **Data/ Documents** • HCC Year-End Reports • HCC budget and expense data
II – Demand-Side Analysis				
5. Projected demand for HCC services in NWT.	• Demographics of NWT • Projected population and demographics of NWT • Physical and cognitive disabilities by region • Projected caseload requirements • Service integration with other health and social services providers • Perceived demand and need for HCC services.	• NWT current demographic data • NWT population projections • NWT disability prevalence • NWT disability projections • Referral source breakdown from admission data • Current HCC caseload, utilization and staffing data • Ancillary services supporting HCC delivered by other health and social services providers • Jurisdictional scan findings regarding service delivery models and trends	• Perceived resource gaps in HCC service delivery • Perceived trends in HCC service delivery • Perceived needs of clients/ families in the NWT in the future • Perceived frequency that clients need to leave community to receive services • Perceived opportunities to integrate service delivery with other health and social services programs and services	**Interviews/ Focus Group/ Survey** • Clients/families • HSSA management and staff • DHSS management and staff **Data/ Documents** • HCC Year-End Reports • HCC Contribution Agreements • interRAI Survey Monkey Results • Continuing Care Services Action Plan • Our elders: Our Communities • Strategic Plan for NWT Health and Social Services System • NWT Disability Strategic Framework • NWT Long-Term Care Program Review • NWT Summary of Community Statistics • NWT Bureau of Statistics Population Project Data

Review Area	Indicator(s)	Quantitative Evidence	Qualitative Evidence	Method/Data Source
6. Financial and resource requirements to meet future demand	• Staffing and management requirements to meet projected demand and caseloads • Tools and technology required to support future HCC service delivery • Guidelines and procedures required to support future HCC service delivery • Performance measurement requirements	• HSSA FTE staffing compliment required to meet projected demand • HSSA FTE management required to provide oversight for future HCC services • DHSS staffing requirements to support HCC services • Costs associated with DHSS and HSSA staffing and management requirements • Costs associated with tools, technology and performance measurement requirements	• Perceived gaps related to HCC oversight and management • Perceived gaps related HCC staffing • Perceived gaps related to providing DHSS support for HCC services • Perceived requirements for guidelines and procedures • Perceived requirements for tools, technology and performance measures to support future HCC service delivery	**Interviews/ Focus Group/ Survey** • Clients/families • HSSA management and staff • DHSS management and staff **Data/ Documents** • HCC Year-End Reports • HCC budget and expense data • HCC Contribution Agreements • interRAI Survey Monkey Results • Continuing Care Services Action Plan • Our elders: Our Communities • Strategic Plan for NWT Health and Social Services System • NWT Disability Strategic Framework
III – Jurisdictional Analysis				
7. Best practices, trends, and innovative solutions from other jurisdictions for providing HCC programs/services that support elders with aging in place.	• Best practices, trends and innovations from other Canadian jurisdictions (3 max) • Best practices, trends and innovations from other countries (2 max)	• Review of data, documents and reports sourced through internet research. • Review of documents and reports sourced from stakeholder consultations	• Interview feedback with jurisdiction representatives	**Interviews** • Jurisdictional representatives **Data/ Documents** • Data, documents and reports for each jurisdiction

Review Area	Indicator(s)	Quantitative Evidence	Qualitative Evidence	Method/Data Source
IV – Communication Review				
8. Effectiveness of communication methods and tools used to promote HCC programs and services in the NWT.	• Communication tools and methods currently in use by DHSS and HSSA's • Perceived effectiveness of communication tools and methods used to promote HCC services • Self-referral frequency	• Review of communication tools used by DHSS an HSSAs • Proportion of admissions from self-referrals	• Perceived effectiveness of HCC communication in NWT	**Interviews/ Focus Group/ Survey** • Clients/families • HSSA management and staff • DHSS management and staff **Data/ Documents** • HCC communication tools and messaging used by DHSS and HSSAs

APPENDIX B – INTERVIEW GUIDES

This section of the report will provide the following documents:

- ***DHSS Management and Staff – Preliminary Interview Guide***
- ***HSSA/NWT Committee Management and Staff – Preliminary Interview Guide***
- ***HCC Clients and Families – Secondary Consultation Guide***
- ***HCC Staff and Managers – Secondary Consultation Guide***

Preliminary Interview/Focus Group Questions – DHSS Staff/Management

The Government of the Northwest Territories, Department of Health and Social Services (DHSS), commissioned MNP LLP (MNP), a Canadian accounting and consulting firm, to conduct a review of the Northwest Territories Home and Community Care (HCC) program.

The review will inform options and decision based on the best and most current data regarding optimal allocation of resources and the future program investments to HCC programs and services. More specifically, the scope of work will include:

- Conducting a comprehensive review of HCC services by region and community across the NWT.
- Conducting a demand side analysis by region and community across the NWT.
- Conducting a targeted jurisdictional review of models, standards and practices in provincial/territorial jurisdictions.
- Conducting a supply side analysis of the current HCC programs and related services in the NWT.
- Conducting a gap analysis that identifies gaps in HCC programs and services in the NWT.
- Identifying communication tools and methods to ensure the NWT is maximizing the use of existing resources.

To better understand the contextual background for conducting the review, we are conducting preliminary consultations with DHSS management and staff, and HSSA management and staff familiar with HCC service delivery in the NWT.

Confidentiality Statement: The Government of Northwest Territories (GNWT) Department of Health and Social Services (DHSS) has engaged MNP LLP (MNP) as an independent third party to conduct this review. Individual responses will be held strictly confidential by MNP and will not be released to DHSS or any other party. The results of the review will be reported in aggregate, with no ability to identify individual respondents. All information provided to MNP, including completed responses, will be used solely for the purposes of this review. More information about MNP can be found at www.mnp.ca

Please note: This question guide will be used to guide the discussion. Questions may not be asked in the order detailed below and given that the questions will be asked in-person, there will be ample opportunity for the interviewer to probe and rephrase questions as may be necessary for each stakeholder group.

History and Involvement with NWT HCC Services

1. Please describe your history and involvement with HCC programs and services in the NWT.
    - When did you become involved with HCC programs/services in the NWT?
    - How has your role evolved over time?

Current State of NWT's HCC Services

2. From your perspective, what are the priorities for HCC services in the NWT?

    Information for interviewer: *HCC provides individuals with nursing care and support for personal care and daily living activities when they are no longer able to perform these activities on their own. These services help people to stay in their own homes rather than go to a hospital or long-term care facility when they need nursing care or help with daily living activities. HCC includes services such as:*
    - *Home support for bathing and making meals;*
    - *Nursing services for wound care and health checks;*
    - *Help with organizing and taking medications;*
    - *Palliative care for those who are dying and want to be at home;*
    - *Loan of equipment, such as bathroom equipment or a walker; and*
    - *Respite care to help in the home, so caregivers can get a break.*

3. Based on your experiences to date, to what extent have these priorities been met (not at all, to some extent, to a large extent)? Please explain why.

4. How would you describe the current delivery of HCC program and services in the NWT (good, fair, poor)?
    - What types of services are available across the territory?
        - Is there a documented inventory of HCC programs/service available by HSSA? Are the types of programs and services provided best sourced from the HSSAs?
    - Is service delivery consistent and equitable between HSSAs and communities? Why or why not?
        - Are there documented territorial wide standards and guidelines for HCC services in the NWT?
    - What is the process for developing HCC operating plans?

  - Are plans developed on a territorial and/or HSSA level? How frequently? Are documented plans available?

- How would you describe current HCC program performance measurement in the NWT?
  - Is the level of performance measurement consistent across HSSAs?
  - What type(s) of activity data (e.g. service utilization, hours of service, etc.) is tracked by DHSS and HSSAs?
    - Is this type of data available to inform the HCC Review? How can this data be sourced?
  - What type(s) of financial data is tracked by DHSS and HSSAs?
    - Is this type of data available to inform the HCC Review? How can this data be sourced?
- Is there supporting collaboration across the HSSAs for providing complimentary resources that fall outside of the 'core' HCC services (e.g. dietician services)?
  - Are there any gaps? What is driving those gaps?

5. Thinking about the future delivery of HCC services in the NWT, are there any practices in other Canadian jurisdictions that you feel merit consideration and additional research as part of this review? Please explain.
   - Are you aware of literature available that describes these practices?
   - Is there anybody MNP should contact to learn more about these practices?
6. In your opinion, who are they key stakeholder groups that should be consulted in conducting the NWT HCC review?
7. Are there specific issues you believe should be considered by this review?
   - Is there reliable information and data available to allow MNP to assess these issues?
   - Is there capacity within the system to provide the information and data required to complete the HCC review?
8. Is there anything else you think is important for us to know about in conducting the NWT HCC review?

Preliminary Interview/Focus Group Questions – HSSA and NWT Committee Staff/Management

The Government of the Northwest Territories, Department of Health and Social Services (DHSS), commissioned MNP LLP (MNP), a Canadian accounting and consulting firm, to conduct a review of the Northwest Territories Home and Community Care (HCC) program.

The review will inform options and decision based on the best and most current data regarding optimal allocation of resources and the future program investments to HCC programs and services. More specifically, the scope of work will include:

- Conducting a comprehensive review of HCC services by region and community across the NWT.
- Conducting a demand side analysis by region and community across the NWT.
- Conducting a targeted jurisdictional review of models, standards and practices in provincial/territorial jurisdictions.
- Conducting a supply side analysis of the current HCC programs and related services in the NWT.
- Conducting a gap analysis that identifies gaps in HCC programs and services in the NWT.
- Identifying communication tools and methods to ensure the NWT is maximizing the use of existing resources.

To better understand the contextual background for conducting the review, we are conducting preliminary consultations with DHSS management and staff, and HSSA management and staff familiar with HCC service delivery in the NWT.

Confidentiality Statement: The Government of Northwest Territories (GNWT) Department of Health and Social Services (DHSS) has engaged MNP LLP (MNP) as an independent third party to conduct this review. Individual responses will be held strictly confidential by MNP and will not be released to DHSS or any other party. The results of the review will be reported in aggregate, with no ability to identify individual respondents. All information provided to MNP, including completed responses, will be used solely for the purposes of this review. More information about MNP can be found at www.mnp.ca

Please note: This question guide will be used to guide the discussion. Questions may not be asked in the order detailed below and given that the questions will be asked in-person, there will be ample opportunity for the interviewer to probe and rephrase questions as may be necessary for each stakeholder group.

History and Involvement with NWT HCC Services

1. Please describe your history and involvement with HCC programs and services in the NWT.
    - Which HSSA/organization do you currently work with?
    - When did you become involved with HCC programs/services in the NWT?
    - How has your role evolved over time?

Current State of NWT's HCC Services

2. From your perspective, what are the priorities for HCC services in the NWT? How about your HSSA/organization?

    <u>Information for interviewer:</u> HCC provides individuals with nursing care and support for personal care and daily living activities when they are no longer able to perform these activities on their own. These services help people to stay in their own homes rather than go to a hospital or long-term care facility when they need nursing care or help with daily living activities. HCC includes services such as:

    - *Home support for bathing and making meals;*
    - *Nursing services for wound care and health checks;*
    - *Help with organizing and taking medications;*
    - *Palliative care for those who are dying and want to be at home;*
    - *Loan of equipment, such as bathroom equipment or a walker; and*
    - *Respite care to help in the home, so caregivers can get a break.*

3. Based on your experiences to date, to what extent have these priorities been met (not at all, to some extent, to a large extent)? Please explain why.

4. How would you describe the current delivery of HCC program and services in the NWT (good, fair, poor)? How about your HSSA?
    - What types of services are available in your HSSA?
        - Is there a documented inventory of HCC programs/service available in HSSAs? Could this list be made available to the NWT HCC Review?
    - Is service delivery consistent and equitable between HSSAs and communities? Why or why not?
        - Are there documented territorial wide standards and guidelines for HCC services in the NWT?
    - What is the process for developing HCC operating plans in HSSAs?

- Are plans developed on a territorial and/or HSSA level? How frequently? Are documented plans available?

- How would you describe current HCC program performance measurement in HSSAs?
  - Is the level of performance measurement consistent across HSSAs?
  - What type(s) of activity data (e.g. service utilization, hours of service, etc.) is tracked by DHSS and HSSAs?
    - Is this type of data available to inform the HCC Review? How can this data be sourced?
  - What type(s) of financial data is tracked by DHSS and HSSAs?
    - Is this type of data available to inform the HCC Review? How can this data be sourced?
- Is there supporting collaboration across the HSSAs for providing complimentary resources that fall outside of the 'core' HCC services (e.g. dietician services)?
  - Are there any gaps? What is driving those gaps?

5. Thinking about the future delivery of HCC services in the NWT, are there any practices in other Canadian jurisdictions that you feel merit consideration and additional research as part of this review? Please explain.
   - Are you aware of literature available that describes these practices?
   - Is there anybody MNP should contact to learn more about these practices?
6. In your opinion, who are they key stakeholder groups that should be consulted in conducting the NWT HCC review?
   - Is there somebody we can work with to organize focus groups and interviews in your HSSA region?
7. Are there specific issues you believe should be considered by this review?
   - Is there reliable information and data available to allow MNP to assess these issues?
   - Is there capacity within the system to provide the information and data required to complete the HCC review?
8. Is there anything else you think is important for us to know about in conducting the NWT HCC review?

Secondary Focus Group Questions – HCC Clients and Families

The Government of the Northwest Territories, Department of Health and Social Services (DHSS), commissioned MNP LLP (MNP), a Canadian accounting and consulting firm, to conduct a review of the Northwest Territories Home and Community Care (HCC) program.

Home and community care services in the NWT include, but are not limited to:

- Home support for bathing and making meals;
- Nursing services for wound care and health checks;
- Help with organizing and taking medications;
- Palliative care for those who are dying and want to be at home;
- Loan of equipment, such as bathroom equipment or a walker; and
- Respite care to help in the home, so caregivers can get a break.

The review will inform options and decision based on the best and most current data regarding optimal allocation of resources and the future program investments to HCC programs and services. More specifically, the scope of work will include:

- Conducting a comprehensive review of HCC services by region and community across the NWT.
- Conducting a demand side analysis by region and community across the NWT.
- Conducting a targeted jurisdictional review of models, standards and practices in provincial/territorial jurisdictions.
- Conducting a supply side analysis of the current HCC programs and related services in the NWT.
- Conducting a gap analysis that identifies gaps in HCC programs and services in the NWT.
- Identifying communication tools and methods to ensure the NWT is maximizing the use of existing resources.

To better understand the current state of HCC service delivery, and future needs for HCC services in the NWT, MNP is conducting focus groups with HCC clients and families from different communities and regions in the NWT.

Draft

Confidentiality Statement: The Government of Northwest Territories (GNWT) Department of Health and Social Services (DHSS) has engaged MNP LLP (MNP) as an independent third party to conduct this review. Individual responses will be held strictly confidential by MNP and will not be released to DHSS or any other party. The results of the review will be reported in aggregate, with no ability to identify individual respondents. All information provided to MNP, including completed responses, will be used solely for the purposes of this review. More information about MNP can be found at www.mnp.ca

Please note: This question guide will be used to guide the discussion. Questions may not be asked in the order detailed below and given that the questions will be asked in-person, there will be ample opportunity for the interviewer to probe and rephrase questions as may be necessary for each stakeholder group.

1. What have you liked about the home and community care services you receive in your community?
    - What types of services are provided by those who visit you in your home?
    - How often do workers come to visit you (i.e. once per week, other)?
    - Do you like the services you are receiving?
2. What types of services do you need to allow you to live in your home or community longer?
    - What types of services are not available in your community which would allow to stay in your home or community longer?
3. Do you have any stories or comments that you would like to share about your experiences with home and community care staff in your community?

Draft

Secondary Focus Group Questions – HCC Staff in Communities

The Government of the Northwest Territories, Department of Health and Social Services (DHSS), commissioned MNP LLP (MNP), a Canadian accounting and consulting firm, to conduct a review of the Northwest Territories Home and Community Care (HCC) program.

Home and community care services in the NWT include, but are not limited to:

- Home support for bathing and making meals;
- Nursing services for wound care and health checks;
- Help with organizing and taking medications;
- Palliative care for those who are dying and want to be at home;
- Loan of equipment, such as bathroom equipment or a walker; and
- Respite care to help in the home, so caregivers can get a break.

The review will inform options and decision based on the best and most current data regarding optimal allocation of resources and the future program investments to HCC programs and services. More specifically, the scope of work will include:

- Conducting a comprehensive review of HCC services by region and community across the NWT.
- Conducting a demand side analysis by region and community across the NWT.
- Conducting a targeted jurisdictional review of models, standards and practices in provincial/territorial jurisdictions.
- Conducting a supply side analysis of the current HCC programs and related services in the NWT.
- Conducting a gap analysis that identifies gaps in HCC programs and services in the NWT.
- Identifying communication tools and methods to ensure the NWT is maximizing the use of existing resources.

To better understand the current state of HCC service delivery, and future needs for HCC services in the NWT, MNP is conducting focus groups with HCC staff and management from different communities and regions in the NWT.

Draft

Confidentiality Statement: The Government of Northwest Territories (GNWT) Department of Health and Social Services (DHSS) has engaged MNP LLP (MNP) as an independent third party to conduct this review. Individual responses will be held strictly confidential by MNP and will not be released to DHSS or any other party. The results of the review will be reported in aggregate, with no ability to identify individual respondents. All information provided to MNP, including completed responses, will be used solely for the purposes of this review. More information about MNP can be found at www.mnp.ca

Please note: This question guide will be used to guide the discussion. Questions may not be asked in the order detailed below and given that the questions will be asked in-person, there will be ample opportunity for the interviewer to probe and rephrase questions as may be necessary for each stakeholder group.

1. What has been your involvement with HCC programs and services in the NWT? How long have you been working in HCC?

2. How would you describe the current delivery of HCC program and services in your community (good, fair, poor)? Think of access to care and quality of care.

3. What types of services do you typically provide to HCC clients in your community?

    - Are the types of HCC services provided meeting the needs of HCC clients in your community? Why or why not?

    - What services are you unable to provide? For example, are there clients in your community being placed in Yellowknife or the South because you are unable to provide the supports they need?

    - Is there a need to standardize the bucket of HCC services provided in the NWT to provide more consistency?

        i. What is the balance of standardization/versus flexibility required?

        ii. Which services should be standardized?

4. Does your region/community have the staffing resources required to provide the HCC services required by clients in your community?

    - If no, what are the gaps for HCC staffing?

    - Are these gaps due to a need for more positions, or a lack of stability in retaining staff in existing positions?

    - How could staff training improve the current situation?

5. How effectively are HCC services being communicated to people in your community? Please explain?

    - Do community members understand the types of HCC services that are and/or are not available to them?

    - How could this communication be improved?

6. What is the process for providing HCC services in your community for the following:

    - Making referrals to the HCC program?

    - Assessing referrals for the HCC program?

    - Developing care plans for HCC clients?

        i. Who develops the care plan?

Draft

    ii. How frequently are these reassessed?

- Managing HCC client cases? Who does this?
- Scheduling home visits?
- Charting patient activities and entering activity data?
- Having other service providers (i.e. OT/PT, Dieticians, other) visit HCC clients?

7. How effective are the current processes for providing HCC services? How can they be improved?
8. Do staff have the tools and technology to support the services they are providing HCC clients in the home?
    - Moving forward, what types of tools/technology would be required to better support HCC service delivery?
9. Who is currently responsible for providing oversight to HCC staff in your region/community? Is this effective? Why or why not?
    - What is needed to better support those providing oversight (i.e. training, territorial specialist resources, other)?
10. Do you have any stories or comments that you would like to share about your experiences with home and community care clients in your community?
11. Thinking about the future delivery of HCC services in the NWT, are there any practices in other Canadian jurisdictions that you feel merit consideration and additional research as part of this review? Please explain.
12. What changes they would like to see going forward in the way HCC is delivered?
13. Is there anything else you think is important for us to know about in conducting the NWT HCC review?

Draft

APPENDIX C – FORM INVENTORY AND CATEGORY DEFINTIONS

Definitions of Categories

All of the documents were sorted into 12 different categories. Brief descriptions of each of these categories are as follows:

- **Communication Material:** Client facing documents providing information on program offering and personal care guidance (e.g.: HCC program offering brochure, personal footcare informational brochure).
- **Policies, Procedures, & Guidelines:** Region specific and NTHSS wide policies, procedures, and guidelines for home and community care (e.g.: Admission criteria, client identification policy).
- **Intake/Admission Forms:** Forms relating to initial client contact including intake and admission (e.g.: HC referral form, HC admission form).
- **Care Plans:** Documents outlining actions to be taken to address the needs of clients (e.g.: home care plans, wound care plans).
- **Assessments:** Forms used to assess personal health and environmental conditions of clients and their homes (e.g.: general assessment form, home safety assessment).
- **Checklists:** Forms used to track patient care (e.g.: Palliative Care Checklist).
- **Client Consent and Agreement Forms:** Client care contracts and agreements for client information release (e.g.: HC Client care contract).
- **Handbooks and Reports:** Reference documents and reports from external organizations (e.g.: home support worker handbook, reports on working with unregulated care providers).
- **Flow Sheets:** Tracking documents for specific areas of client care (e.g.: HC flow sheet, footcare flowsheet).
- **Client Information Forms and Charts:** Forms and documents used to track general patient care (e.g.: medication record, discharge record).
- **HC Operations Tracking:** Documents used for internal management of HCC operations (e.g.: inventory tracking, client visit schedule).
- **Applications:** (e.g.: Volunteer application).

Inventory of Region Specific and NTHSS Forms, Policies, Procedures, and Documents by Region:

Key	
✓	Region uses this document
✓*	NTHSS Document
✓✓*	Region specific and NTHSS Documents

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
Communication Material						
• Footcare	✓		✓	✓*		
• General HCC	✓		✓	✓* (EN&FR)		
• Meals on Wheels	✓					
• Volunteering Info Pamphlet	✓					
• Client Responsibilities	✓					
• Home Care Algorithm Diagram		✓				
• Personal footcare brochure guide			✓			
• Buying footwear brochure guide			✓			
• Eating Well for Wound Healing Guide			✓			
• Yellowknife Palliative Care – Information for Families Handout			✓			
• Client Drain and Dressing (Bandage) Instructions Handout			✓			
• IV Home Therapy (EN & FR)				✓*		
• Ostomy and Stoma Care				✓*		
• Palliative Care (EN & FR)				✓*		
• Staying Independent – Fall Risk Awareness					✓	
• Home Support Services			✓	✓✓*		
• Admission Criteria			✓	✓		

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• Home Safety Risk Assessment			✓	✓*		
• Home Support Services and Long Term Care Food Safety			✓			
• Working Alone or in Isolation			✓			
• Waitlist Management			✓			
• Client Identifiers			✓	✓*		
• Risk Assessments and Definitions			✓			
• Fall Prevention Strategy			✓	✓*		
• Guide for Frontline Workers Home Visit Safety			✓			
• Client/Patient and Family Role in Safety			✓			
• Employee Guide to Home Visits			✓			
• Hand Hygiene Program			✓*	✓*		
• Hand Hygiene Compliance Auditing			✓*	✓*		
• Suicide Risk Assessment			✓*			
• Wound Care Strategy			✓*	✓*		
• Disclosure Guidelines				✓*		
• Equipment Loan Program				✓*		
• Client Files				✓*		
• Discharge from HC				✓*		
• Admission Process				✓		
• After Hours Admissions				✓		
• Initial Client Contact				✓*		
• Transportation				✓		
• Documentation Guidelines				✓*		
• Delegation of Nursing Tasks to Unregulated Care Providers				✓*		

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• Clinical Practice Standards				✓*		
• HC Intravenous Therapy Program- Program Delivery				✓*[10]		
• HC Footcare				✓*[7]		
• Assessment for Home Support Services				✓*		
• Housecleaning Services				✓*		
• HSW Pharmacology Certification				✓*		
• HSW Simple Wound Care Management Certification				✓*		
• HSW Food Safety Certification				✓*		
• OPSWA – Oxygen Administration				✓		
• OPSWA – Tube/Gastric/Pump Feedings				✓		
• Single Use Devices				✓*		
• Medication Reconciliation				✓*		
• Palliative Care Services				✓✓*[4]		
• Palliative Care – On Call Nursing				✓*		
• Death at Home				✓*		
• HCC Storage Handing and Administration				✓*		
• Anaphylaxis Management				✓		
• Pressure Ulcer Risk Assessment				✓*		
• Wound Care Management				✓✓*[11]		
• Nunavut Client Approval Process				✓*		
• Out of Territory (non-Nunavut) Client Approval Process				✓		
• Referrals to OT/PT				✓*		
• Referrals for Respite Services				✓		
• Care of Suprapubic Catheter				✓*		
• Chronic Health Monitoring				✓*		

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• Tracheostomy Care				✓		
• PleurX Catheter System				✓		
• Nephrostomy Tube Care				✓*		
• Infection Control – MRSA				✓		
• Infection Control – Cleaning Equipment				✓		
• Infection Control – Care and Sterilization of Equipment				✓		
• Covenant Health – Hypodermoclysis (HDC) Administration				✓		
Intake/Admission Forms						
• HC Referral	✓*		✓			
• Footcare Program Referral Form	✓					
• Meals Program Application	✓*					
• HC Admission		✓			✓	
• Approval for HC Clients Residing in The Nunavut				✓*		
• Home Care Approval for Home Care Clients Residing in Nunavut				✓*		
Care Plans						
• HC Plan and Service Record	✓✓*		✓*	✓*	✓	
• Client Nursing Care Plan		✓				
• Methotrexate Care Plan			✓			
• Peripheral IV Care Plan			✓			
• Palliative Medication Care Plan				✓		
• Wound Care Plan and Service Record				✓*		
Assessments						
• General	✓*	✓	✓*			

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• Focal Assessment	✓*		✓*			
• Priority Screening Tool	✓			✓		
• Footcare	✓			✓*		
• Braden Pressure Ulcer Risk Assessment	✓		✓			
• Homecare Falls and Risks Assessment	✓					
• Falls Risk Assessment			✓	✓		
• Environmental/Home Safety Assessment			✓	✓	✓	
• Suicide Assessment Record (& Psychologist Statement)			✓*			
• Bates-Jensen Wound Assessment Tool			✓			
• Expected Death at Home Assessment Form				✓*		
• Home Safety Risk Assessment: Pre-Visit and Onsite Visit				✓		
• Client Environment Safety Snapshot				✓		
Checklists						
• Long Term Care Assessment & Application Package Cover Sheet			✓			
• Chart Audit Tool – Wound Care			✓*			
• HCC Audit				✓*		
• Home IV Therapy Client Education Checklist				✓		
• Home IV Therapy Referral Checklist				✓		
• Palliative Care Checklist				✓		
• Home Care IV Referral Checklist				✓*		
• HSW Workday Checklist				✓		
Client Consent and Agreement Forms						
• HC Client Contract	✓✓*	✓	✓		✓	
• Footcare Program	✓			✓*		

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• Authorization for Release of Information	✓					
• Photograph Release Permission Form			✓			
• Home IV Therapy Admission Criteria and Consent				✓		
• HCC Donated Equipment Waiver				✓		
• Consent for Release of Personal Information				✓*		
• Home Care Fee Schedule – Out of Territory Clients				✓*		
• NTHSSA Outside NWT/Canada Travel Authorization				✓		
• Home IV Therapy Admission Criteria and Consent				✓		
Handbooks and Reports						
• Home Support Worker Handbook			✓			
• Fall Prevention Program			✓			
• CPSI Canadian Disclosure Guidelines				✓		
• CRNBC Assigning and Delegating to Unregulated Care Providers				✓		
• College of Nurses Ontario – Authorizing Mechanism (Guidelines)				✓		
• College of Nurses Ontario – Legislation & Regulation				✓		
• College of Nurses ON – Working with Unregulated Care Providers				✓		
• Fraser Health – Dehydration				✓		
• CVAD Quick Reference Guide				✓		
• RN of Alberta – Medication Guidelines				✓		
• WPG Regional Health Authority – Subcutaneous Insertion Guide				✓		
• Sapphire Infusion Pump User Manual				✓		
• 3M Coban 2 Compression System (PPT)				✓		

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• 3M Coban 2 Compression System for Leg and Foot				✓		
• Wound Ostomy & Continence Nurses Society – Urinary Catheters				✓		
• European Association of Urology Nurses – Catheterisation				✓		
• Vacuum Assisted Closure – Clinical Guidelines				✓		
• Yellowknife Wound and Ostomy Care Management				✓		
• NWT Continuing Care Standards				✓*		
Flow Sheets						
• HC	✓*	✓	✓			
• Footcare	✓			✓*		
• Wound Care			✓*	✓*		
• Ostomy			✓*	✓*		
• Chronic Program			✓			
• Diabetic Program			✓			
• Hypertension			✓			
Client Information Forms and Charts						
• Narrative Record	✓*					
• HC Medication Reconciliation	✓					
• Wound Care Client Record	✓					
• Home Care Client Form – Community Health Service Report		✓*				
• Current Population Profile			✓			
• Discharge Record				✓*		
• Medication Record				✓*		
• GNWT Death Registration Record				✓		

Document Type	Region					
	Hay River	Sahtu Region	Beaufort Delta	Yellow-knife	Tlicho	X
• Month Medication Inventory				✓		
• HC Palliative Medication Schedule				✓		
• Coumadin Tracking Record				✓		
• HITP Home Care Medication Administration Record				✓		
HC Operations Tracking						
• Weekly Home Support Client Schedule			✓			
• Waitlist			✓			
• Disclosure Documentation Form & Template				✓*		
• Medical Equipment Homecare Inventory				✓		
• Certification and Training Tracking for HCC Workers				✓		
Applications						
• Volunteer Application	✓					

APPENDIX D – KEY ASSUMPTIONS FOR PROJECTION MODEL 1

Key assumptions utilized to develop projection model 1 are as follows:

- **Total Client Caseloads:** Assumptions were broken down into rural/remote NWT (i.e. NTHSSA Beaufort-Delta, Dehcho, Sahtu, and Fort Smith regions, as well as Hay River HSSA and Tlicho CSA) and NTHSSA Yellowknife region.
    - Rural/Remote NWT[58]
        - 0.62% of those aged 0-59 will be clients of the HCC program
        - 9.86% of those aged 60-74 will be clients of the HCC program
        - 53.15% of those aged 75+ will be clients of the HCC program
    - NTHSSA Yellowknife region[59]
        - 1.67% of those aged 0-59 will be clients of the HCC program
        - 10.97% of those aged 60-74 will be clients of the HCC program
        - 72.17% of those aged 75+ will be clients of the HCC program
- **Client Caseloads for HSWs and Nursing Staff:** Assumptions were made for the percentage of clients receiving HSW care or nursing care by age group and HSSA/region.
    - Key assumptions for HSW care caseloads:
        - NTHSSA Sahtu and Dehcho regions, and Tlicho CSA[60]
            - 61.6% of HCC clients aged 0-59 receive services from HSWs
            - 77.8% of HCC clients aged 60-74 receive services from HSWs
            - 75.8% of HCC clients aged 75+ receive services from HSWs
        - NTHSSA Beaufort-Delta region[61]
            - 32.4% of HCC clients aged 0-59 receive services from HSWs
            - 41.2% of HCC clients aged 60-75 receive services from HSWs
            - 59.5% of HCC clients aged 75+ receive services from HSWs
        - NTHSSA Fort Smith region and Hay River HSSA[62]

[58] Based on estimated caseload levels for 2017/18 (based on revised DHSS data)
[59] Based on estimated caseload levels for 2017/18 (based on revised DHSS data)
[60] Based on 2017/18 service levels for the NTHSSA Sahtu region (based on revised DHSS data)
[61] Based on the average 2017/18 HSW service levels for the NTHSSA Sahtu region and Hay River HSSA (based on revised DHSS data). This takes into the consideration of HSW caseload distributions for Inuvik (modelled like Hay River) and the remote communities in the regions (modelled like the NTHSSA Sahtu region).
[62] Based on the 2017/18 HSW service levels for the Hay River HSSA (based on revised DHSS data)

Draft

        - 16.7% of HCC clients aged 0-59 receive services from HSWs
        - 17.1 % of HCC clients aged 60-74 receive services from HSWs
        - 38% of HCC clients aged 75+ receive services from HSWs
      - NTHSSA Yellowknife region[63]
        - 7.5% of HCC clients aged 0-59 receive services from HSWs
        - 27.5% of HCC clients aged 60-74 receive services from HSWs
        - 22.9% of HCC clients aged 75+ receive services from HSWs
    - Key assumptions for nursing care caseloads
      - NTHSSA Beaufort-Delta, Dehcho, Sahtu, and Fort Smith regions, and Tlicho CSA[64]
        - 43.2% of HCC clients aged 0-59 receive HCC nursing services
        - 29.4% of HCC clients aged 60-74 receive HCC nursing services
        - 18.1% of HCC clients aged 75+ receive HCC nursing services
      - NTHSSA Fort Smith region and Hay River HSSA[65]
        - 66.7% of HCC clients aged 0-59 receive HCC nursing services
        - 43.9% of HCC clients aged 60-74 receive HCC nursing services
        - 42.0% of HCC clients aged 75+ receive HCC nursing services
      - NTHSSA Yellowknife region[66]
        - 48.8% of HCC clients aged 0-59 require HCC nursing services
        - 28.2% of HCC clients aged 60-74 receive HCC nursing services
        - 26.7% of HCC clients aged 75+ receive HCC nursing services
- **Hours of Care per Client:** Assumptions were made for the average hours of care provided by HSWs and nursing staff (i.e. for wound care and nursing care). Key assumptions include:
    - HSWs will provide an average of 40 hours of care per year to all clients assessed as requiring a combination of home making services and personal care services[67].

---

[63] Based on the 2017/18 HSW service levels for the NTHSSA Yellowknife region (based on revised DHSS data)
[64] Based on the average 2017/18 nursing service levels for the NTHSSA Sahtu region and Har River HSSA (based on revised DHSS data)
[65] Based on the 2017/18 nursing service levels for the Hay River HSSA (based on revised DHSS data)
[66] Based on the 2017/18 HSW service levels for the NTHSSA Yellowknife region (based on revised DHSS data)

[67] Estimated based on revised data provided by DHSS for 2017/18

  - Nurses will provide an average of 25 hours of care to all clients assessed as requiring nursing care services, including wound care services[68].

- **Nursing/HSW Staffing Assumptions:** Assumptions related to hours per FTE, percentage of time spent on clinical activities, and staff vacancy rates
  - HSW staff
    - 1 FTE works 1,950 hours per year
    - 60% of time is spent on clinical activities
    - 20% vacancy rate, based on current active staffing complements provided by representatives from each HSSA/region
  - Nursing staff
    - 1 FTE works 1,950 hours per year
    - 50% of time is spent on clinical activities
    - 20% vacancy rate, based on current active staffing complements provided by representatives from each HSSA/region

Draft

[68] Estimated based on revised data provided by DHSS for 2017/18

APPENDIX E – KEY ASSUMPTIONS FOR PROJECTION MODEL 2

Key assumptions utilized to develop projection model 2 are as follows:

- **Total Client Caseloads:** Assumptions were broken down into rural/remote NWT (i.e. NTHSSA Beaufort-Delta, Dehcho, Sahtu, and Fort Smith regions, as well as Hay River HSSA and Tlicho CSA) and NTHSSA Yellowknife region.
    - Rural/Remote NWT[69]
        - 0.62% of those aged 0-59 will be clients of the HCC program
        - 9.86% of those aged 60-74 will be clients of the HCC program
        - 53.15% of those aged 75+ will be clients of the HCC program
    - NTHSSA Yellowknife region[70]
        - 1.67% of those aged 0-59 will be clients of the HCC program
        - 10.97% of those aged 60-74 will be clients of the HCC program
        - 49.52% of those aged 75+ will be clients of the HCC program
- **Client Caseloads for HSWs and Nursing Staff:** Assumptions were made for the percentage of clients receiving HSW care or nursing care by age group and HSSA/region.
    - Key assumptions for HSW care caseloads:
        - NTHSSA Sahtu and Dehcho regions, and Tlicho CSA[71]
            - 61.6% of HCC clients aged 0-59 receive services from HSWs
            - 77.8% of HCC clients aged 60-74 receive services from HSWs
            - 75.8% of HCC clients aged 75+ receive services from HSWs
        - NTHSSA Beaufort-Delta region[72]
            - 32.4% of HCC clients aged 0-59 receive services from HSWs
            - 41.2% of HCC clients aged 60-75 receive services from HSWs
            - 59.5% of HCC clients aged 75+ receive services from HSWs
        - NTHSSA Fort Smith region and Hay River HSSA[73]

[69] Based on estimated caseload levels for 2017/18 (based on revised DHSS data)
[70] Based on estimated caseload levels for 2017/18 (based on revised DHSS data) for the 0-59 and 60-74 age groups, and the average caseload percentage for Yellowknife (i.e. 72.17%) and Manitoba (26.87%) for the 75+ age group.
[71] Based on 2017/18 service levels for the NTHSSA Sahtu region (based on revised DHSS data)
[72] Based on the average 2017/18 HSW service levels for the NTHSSA Sahtu region and Hay River HSSA (based on revised DHSS data). This takes into the consideration of HSW caseload distributions for Inuvik (modelled like Hay River) and the remote communities in the regions (modelled like the NTHSSA Sahtu region).
[73] Based on the 2017/18 HSW service levels for the Hay River HSSA (based on revised DHSS data)

Draft

        - 16.7% of HCC clients aged 0-59 receive services from HSWs
        - 17.1 % of HCC clients aged 60-74 receive services from HSWs
        - 38% of HCC clients aged 75+ receive services from HSWs
      - NTHSSA Yellowknife Region[74]
        - 7.5% of HCC clients aged 0-59 receive services from HSWs
        - 27.5% of HCC clients aged 60-74 receive services from HSWs
        - 22.9% of HCC clients aged 75+ receive services from HSWs
  - Key assumptions made for nursing care caseloads
    - It is assumed that 100% of HCC clients in all HSSAs/regions and age groups will receive nursing care services, to compensate for the under-reporting of these hours in Health Suite in many HSSAs/regions.
- **Hours of Care per Client:** Assumptions were made for the percentage of clients receiving HSW care or nursing care by age group and HSSA/region, as well the average hours of care provided by HSWs and nursing staff (i.e. for wound care and nursing care). Key assumptions include:
  - HSWs will provide an average of 140 hours of care per year to clients aged 75+ and 102 hours of care to clients aged 0-74 assessed as requiring a combination of homemaking services and personal care services[75].
  - Nurses will provide an average of 14 hours of care to clients aged 0-74 and 12 hours of care to clients aged 75+ assessed as requiring nursing care services, including wound care services[76].
  - **Hours of care sample calculation** for 2020 HSW hours of care for 75+ age group in NTHSSA Beaufort-Delta region.
    - Projected number of HCC clients in 2020 in the 75+ age group: 234 people aged 75+ (Table 14) x 53.15% = 124 HCC clients
    - Projected HSW hours of care for 75+ age group: (124 HCC clients x 59.5% (number of clients receiving HSW services)) x 140 hours of care per year per client = 10,326 HSW hours of care
    - HSW FTE calculation for 2020 (based on assumptions below): (14,592 hours (total HSW hours for all age groups in 2020 for BD / 1,950 hours x 60% (portion of time spent on service deliver)) x (1 + 20% (to account for the 20% vacancy rate)) = 14.97 FTEs

[74] Based on the 2017/18 HSW service levels for the NTHSSA Yellowknife region (based on revised DHSS data)
[75] Based on Manitoba HCC projection analysis.
[76] Based on Manitoba HCC projection analysis.

Draft

- **Nursing/HSW Staffing Assumptions:** Assumptions related to hours per FTE, percentage of time spent on clinical activities, and staff vacancy rates
    - HSW staff
        - 1 FTE works 1,950 hours per year
        - 60% of time is spent on clinical activities
        - 20% vacancy rate, based on current active staffing complements provided by representatives from each HSSA/region
    - Nursing staff
        - 1 FTE works 1,950 hours per year
        - 50% of time is spent on clinical activities
        - 20% vacancy rate, based on current active staffing complements provided by representatives from each HSSA/region

Draft

APPENDIX F – KEY ASSUMPTIONS FOR RECOMMENDATION 9

Key assumptions utilized to develop the additional funding requirement projection, are as follows:

- 1 FTE HSW and nurse will work 1,950 hours per year
- All HCC nurses on average will be paid at the mid-point hourly rate for a CHN in the NWT ($53.78 per hour), to encourage recruitment and retention of HCC nurses.
- All HSWs will be paid at the mid-point hourly rate for a HSW in the NWT ($34.18 per hour).
- All HSWs and nursing staff will receive the current Northern Allowance rate for the region they work in as follows[77]:
    - NTHSSA Beaufort-Delta Region – 19% of salary pay
    - NTHSSA Dehcho Region – 12% of salary pay
    - NTHSSA Sahtu Region – 24% of salary pay
    - NTHHSA Fort Smith Region – 7.5% of salary pay
    - NTHSSA Yellowknife Region – 5.2% of salary pay
    - Tlicho CSA – 9% of salary pay
    - Hay River HSSA – 6.9% of salary pay
- All HSWs and nursing staff will receive benefits at an average rate of 22% of gross salaries.

Draft

[77] Based on https://www.fin.gov.nt.ca/en/services/position-and-salary-information/search/home%20care