



Canada's most vulnerable

Improving health care for First Nations, Inuit, and Métis seniors



About the artist

The illustrations in this report are by Winnipeg artist Leah Fontaine, who has a BA (Theatre Design), a BFA (with Honours), and an MA (Native Studies). She connects her education with her Dakotah/Anishinaabe/Métis heritage to create the iconography and world view that are displayed in her work.

About the Health Council of Canada

Created by the *2003 First Ministers' Accord on Health Care Renewal*, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal. The Council provides a system-wide perspective on health care reform in Canada, and disseminates information on innovative practices across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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For the last three years, the Health Council of Canada has been reporting on the health disparities between First Nations, Inuit, and Métis populations^a and non-Aboriginal Canadians, and on what can be done to reduce these gaps.

In 2013, we set out to learn more about the health challenges of older Aboriginal people, and the ways in which Aboriginal communities, health care providers, and governments are working to improve health care services for First Nations, Inuit, and Métis seniors. Little attention has been paid to the health care needs of Aboriginal seniors in either research or public policy, and this has created some growing concerns.^{1,2,3,4}

a Section 35 of Canada's Constitution Act, 1982 recognizes three distinct Aboriginal Peoples in Canada: First Nations (Indian), Inuit, and Métis.

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Section 1

Commentary
by the
Health Council
of Canada



The pressing needs of First Nations, Inuit, and Métis seniors

First Nations, Inuit, and Métis seniors are among Canada's most vulnerable citizens. In comparison to the larger Canadian population, a significantly larger proportion of Aboriginal seniors live on low incomes and in poor health, with multiple chronic conditions and disabilities.²⁻⁶ Many are in poorer physical and mental health due to the disruption of their way of life caused by colonization, particularly the intergenerational effects and trauma of the residential school experience.^{5,7-10}

The health needs of Aboriginal seniors are magnified by determinants of health such as poverty, poor housing, racism, language barriers, and cultural differences. First Nations, Inuit, and Métis seniors are also more likely than younger generations to live in rural and remote communities where the majority of the population is Aboriginal, and where they can be connected to their culture.⁸ Many First Nations seniors live on-reserve. The result is that Aboriginal seniors have more complex health needs but are often living in regions where it is more challenging and expensive to provide care.²

In interviews conducted for this report, we heard that most seniors need to travel to urban areas for anything beyond the most basic care, with significant disruption to their lives and at great cost to governments (which cover medical travel for status First Nations and Inuit populations) or themselves (non-status First Nations and Métis). In addition, because many Aboriginal seniors don't have the same level of care in their communities as non-Aboriginal Canadians, their health conditions can become more severe, increasing the amount of care they need.^{2,10}

These factors are often needlessly complicated by jurisdictional disagreements about who is ultimately responsible for providing health services to Aboriginal people.^{1,9,10} First Nations, Inuit, and Métis seniors continue to face gaps in receiving the health care and other supports they need because there is little or no coordination and communication between health care services provided by the federal government, provincial/territorial governments, health authorities, and Aboriginal communities.^{1,4,9,10}

Interview respondents raised concerns that:

- ▶ First Nations seniors on-reserve are not receiving the home care and continuing care support, including long-term care, that they need to stay in their communities. Instead, many seniors must leave their communities and live the rest of their lives in institutions that are not culturally sensitive or safe, often hundreds of miles or more from their communities and families.
- ▶ The very small, isolated, and northern communities where Inuit seniors live create a unique set of circumstances and health care delivery challenges that affect seniors' ability to remain in their homes.
- ▶ The needs of the Métis population are not well understood or addressed. Métis people were described as the "hidden" Aboriginal group, which is reflected in significant gaps in policy, programming, and services. Métis seniors lack access to programs available to both First Nations and Inuit populations, and the barriers they face are often distinct from those experienced by First Nations and Inuit populations. We heard that this needs to be recognized as an issue.

Researchers and Aboriginal leaders are urging governments to address these problems now, before a larger proportion of the population reaches their senior years.^{1,3,10} Census data show that the Aboriginal population is growing at a rate almost double that of the overall Canadian population, and an increasing number of seniors is part of this trend (see *An aging population*, page 7).^{8,11}

About this report

To gather information for this report, the Health Council conducted interviews with senior officials from provincial, territorial, and federal governments and from First Nations, Inuit, and Métis organizations. We also hosted regional meetings across Canada to learn what is being done for seniors in their communities and where problems still exist. Many participants were health professionals and members of First Nations, Inuit, or Métis communities; some were seniors as well (see *Methodology*, page 64).

Although social, economic, and historical factors are widely recognized as the primary cause of health disparities, participants told us about system problems that are getting in the way of good health care for seniors in their communities. These are described in the section *Pressure points and politics*.

Many identified innovative practices that are breaking through these barriers and improving the care of Aboriginal seniors. We have synthesized key findings from these practices in the section *Changing landscapes and key approaches*.

In the final section, *Partnerships and progress*, 12 innovative programs are presented through a series of interviews with health care providers and policy-makers. As their stories demonstrate, change often begins with questioning the status quo and reaching out to build new partnerships.

At the cross-country sessions, participants told us that hearing from others who had resolved similar problems gave them a sense of hope, possibility, and determination to discuss new ideas back in their own communities. The Health Council hopes this document will stimulate similar discussions about the care of Aboriginal seniors across the country, and inspire new directions from governments, communities, and health care providers.

Use of terms

The specific designations of *First Nations*, *Inuit*, and *Métis* are used whenever possible. When the discussions for this report or supporting literature did not differentiate between First Nations, Inuit, or Métis populations, the term *Aboriginal* is used.

The term *community* is used to refer either to a geographic First Nations, Inuit, or Métis community or to a population, depending on the context.

The term *senior* is used throughout this report unless a change has been specifically requested. The term *elder* is used in some communities to describe all seniors. In others, the term is used specifically to identify an older person who is recognized and respected in their community for their wisdom and cultural knowledge, and in this case *Elder* is capitalized. Métis seniors are called *senators*.

An aging population

Overall, First Nations, Inuit, and Métis seniors have poorer health than non-Aboriginal seniors, with higher rates of chronic diseases and other conditions.^{S1} As the number of older Aboriginal people continues to grow, researchers predict there will be greater challenges in providing health care services.^{S1}

The Aboriginal population is generally a demographically younger population in comparison to the non-Aboriginal population. However, the relative size of the senior population is increasing.^{S1}

In the 2006 census, nearly 5% of Aboriginal people were aged 65 and older.^{S1} This is expected to increase to 6.5% of the total Aboriginal population by 2017.^{S2}

This percentage varies among the different populations. By 2017, the First Nations senior population will reach 6% of all First Nations people, and the Inuit senior population will reach 4% of all Inuit.^{S2} The Métis senior population will experience the largest growth, to 8% of the total Métis population.

Although age 65 is typically considered the start of senior years, some organizations and health care providers offer seniors' services to Aboriginal people age 55 and older, largely because statistics show an earlier onset of chronic conditions and a lower life expectancy compared to other Canadians.^{S3-S5}

Different communities, common challenges

Despite differences among seniors in First Nations, Inuit, and Métis communities, participants said they share many common experiences that affect their health:

- ▶ Several Inuit and First Nations participants from northern communities said that in the last decades, their communities have moved from a diet composed entirely of nutrient-dense wild foods to one that is predominantly Western, which is believed to be contributing to a higher incidence of disease.¹² Many seniors cannot afford to buy healthy foods (especially in the North, where food is extremely expensive) and struggle simply to have enough to eat. This makes it difficult for them to maintain the nutritious diets they need to manage chronic conditions. In addition, the consumption of less expensive and more readily available processed foods, which are typically high in fat and sugar, often leads to obesity. Traditional cultural foods, such as wild meat, fish, and berries, are extremely important to the diet of seniors, providing both nutritional value and cultural continuity. Some seniors rely on family or other community members to supply them with traditional foods, but these are less readily available than they were in the past.
- ▶ There is a severe shortage of housing in many communities, particularly in those that are remote or in the North, and what is available is often in poor condition. Many First Nations, Inuit, and Métis seniors live in overcrowded conditions, which creates stress for all family members and, coupled with poor nutrition, puts everyone at higher risk for diseases such as tuberculosis. Poor housing conditions can also make it difficult or impossible to receive home care services. In addition, many seniors are not able to pay to adapt their homes for medical equipment or to accommodate disabilities, and have difficulty covering the costs of heating their homes. Wood is the main source of fuel for many Aboriginal seniors, which is not the case for the general population.¹ If the community is not able to provide support (for example, by hauling and chopping a seasonal supply of wood), many seniors are not able to stay in their homes.

The lasting effects of colonization and residential schools have been described as a form of post-traumatic stress disorder.

- ▶ Participants spoke a great deal about elder abuse, defined as the financial, emotional, and physical neglect or abuse of First Nations, Inuit, or Métis seniors. They said that financial abuse is the most widespread. In small communities with few economic opportunities, a senior who receives Old Age Security may be the only family member with a reliable income. Sharing is a core value and practice in many Aboriginal cultures, and many seniors will share whatever they have (housing, food, money) with family members, even if it means that they will not be able to take care of their own needs. Many communities are trying different strategies to intervene if family members abuse this generosity. Participants said this is challenging, as elder abuse is a complex problem that is usually hidden. Seniors who do experience abuse are often reluctant to talk about it or report it to health providers or others. This makes it difficult to intervene and help.
- ▶ The lasting effects of colonization and residential schools—described as a form of post-traumatic stress disorder¹³ for whole communities and cultures—have left many seniors socially isolated. Families are less able to care for seniors because they have their own challenges, including mental health issues, addictions, poverty, and family violence. A number of participants added that family members whose own childhoods were dysfunctional are often reluctant to care for their parents.
- ▶ Out-migration is an issue, particularly in Northern communities. As one participant noted, “If your children leave, who looks after you? Our young are getting educated and not going back to the community. What you’re left with then in the communities are the neediest—those on welfare, and the elderly.”
- ▶ A significant proportion of First Nations, Inuit, and Métis seniors may not have literacy skills in English or French. Participants reported that seniors often do not fully understand information about their health conditions. They said that seniors may be reluctant to discuss their needs with service providers or ask for help. In addition, although all seniors are eligible for Old Age Security pensions, many First Nations, Inuit, and Métis seniors have not applied because they lack the documents (such as birth certificates), or because of language and literacy barriers.
- ▶ Many First Nations, Inuit, and Métis seniors suffer from significant emotional and mental health concerns due to the traumatic legacy of residential schools, grief associated with aging (including the loss of their own independence, as well as the loss of family members and friends), and the desperate state of youth and families in their communities. Several participants shared stories of seniors who were struggling to cope with the suicides of their grandchildren. We heard that mental health is not formally assessed or treated, and culturally appropriate services are often difficult to find. For example, a stigma associated with dementia results in late diagnosis for some seniors.¹⁴

Participants stressed that despite these challenges, many seniors are resilient and serve as primary caregivers for grandchildren as well as cultural touchstones in their communities. A growing number of innovative practices demonstrate the importance of rebuilding what was stripped away from Aboriginal people, such as knowledge of their language and traditions, pride in their culture, and self-determination, in order to heal from the past.⁷ There are strong links between these factors and health status.¹⁵ We heard that communities are at different stages of healing, and that seniors are an important part of these efforts because many have retained knowledge of their language and cultural traditions. Losing Elders and seniors to distant long-term care facilities can be a cultural blow to entire communities.

The importance of culturally safe care

Several Elders who attended our sessions shared their residential school experiences with grace and courage, helping participants to better understand the lasting physical, emotional, and spiritual pain of many Aboriginal seniors and why it is critical to provide culturally safe care.

Colonization and residential school experiences, along with continuing experiences of racism in Canadian society, have created a significant mistrust of mainstream institutions, including the health care system. Participants said many seniors delay seeing a health care professional about their symptoms until they are seriously ill because they are afraid their diagnosis will mean they will be sent away for care and never return. And if care is not culturally safe, a senior may not return for an appointment or continue a treatment plan.

Participants said that most health care providers have little understanding of the historic experiences or the practical realities of everyday life for First Nations, Inuit, and Métis seniors. As a result, they make inaccurate assumptions about seniors' ability to care for themselves, and their access to services

and resources. In addition, health systems often fail to provide Aboriginal seniors with opportunities to communicate in their own languages, participate in ceremonies, and eat traditional foods. Participants stressed that these cultural supports are not just "nice to have"; they are critically important to maintaining the health and well-being of seniors.

The Health Council's 2012 report, *Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care*, further explains the importance of cultural safety and provides examples of successful initiatives.



Pressure points and politics

The health care of First Nations, Inuit, and Métis people is complicated—and, many participants said, compromised—by poor communication, disputes, and a lack of collaborative problem-solving between governments or between government departments and agencies. This creates overlaps, gaps in service, and a lack of transparency, sending Aboriginal seniors and their families through a jurisdictional maze, with detrimental effects on their health and quality of life. Many of these problems have been well documented.^{1,9,10,13,16}

The roles and responsibilities for the health care of First Nations, Inuit, and Métis seniors vary significantly across the country, based on agreements between the federal government, provincial/territorial governments, and individual Aboriginal communities (see *A complex environment for Aboriginal health*, page 20). We heard that the root of many of these problems is confusion and disagreement about the role of the federal government, and the degree of their responsibility for the health of Aboriginal populations. The exclusion of First Nations people from some provincial programs available to all other provincial residents, on the grounds of their First Nations status, is also contentious. In addition, Métis people do not have access to federal programs available to both First Nations and Inuit, or to provincial programming that meets Métis-specific needs.

The federal government directly funds some health and social services through Aboriginal Affairs and Northern Development's Assisted Living Program and through Health Canada's First Nations and Inuit Health Branch.^{17,18} Beyond these limited programs, the federal government assists provinces and territories in funding health care for all their residents (including First Nations and Inuit) by means of an annual transfer of funds under the Canada Health Transfer, based on a per capita calculation using population estimates that include First Nations and Inuit residents.⁹ However, the provinces and territories argue that this per capita calculation is based on outdated population estimates and does not take into account the actual cost of delivering health care services to remote communities or to Aboriginal populations with complex care needs.⁹

What does this complex mix of jurisdictional arrangements look like on the front lines of care? Participants identified key pressure points that they believe are compromising the quality of care, and quality of life, for Aboriginal seniors:

Too many seniors need to travel for care that could be offered in their communities

Next to the determinants of health, the need to travel for most health care services was identified by participants as one of the most significant issues affecting the quality of life of seniors and their families. There are minimal health care services in many Aboriginal communities, particularly those that are rural, remote, and in the North, with limited access to medical technology, equipment, supplies, and medication.

Medical travel is physically, emotionally, and often financially challenging for Aboriginal seniors. Medical travel for pre-approved appointments is covered by the federal government for status First Nations and Inuit populations, but both the application process and transportation logistics can be complicated. Métis seniors, many of whom also live in remote and rural areas with limited access to services, are not covered for federally funded medical travel. Participants stressed that a lack of affordable medical transportation can be a particular barrier to seniors receiving timely and appropriate care.

With very high unemployment in some communities, many families do not have their own vehicles and must rely on other forms of transportation. In many remote communities, the only way out is by air. Canadian winters wreak havoc on travel schedules, particularly in the North, causing missed appointments and delayed treatment.

Even if health care services exist in the community, there are often constant problems with recruitment, retention, and training of health professionals, leaving some communities with only limited access to primary care. In addition, participants said that a significant proportion of health care workers serving First Nations, Inuit, and Métis communities do not have adequate training or experience to meet the complex needs of seniors.

We heard a number of examples of telehealth and other virtual or mobile health care programs (see *Partnerships and progress*, page 35) that help bring health care to communities. Participants said these technologies could, and should, be used more widely, but acknowledged that part of the challenge is that communities do not always have adequate information and communications technology and other infrastructure to reliably deliver these programs.

One participant shared the example of a provincial mobile dialysis unit that could not provide care in one on-reserve community because of a series of challenging living conditions in the community, including a lack of health infrastructure. As a result, people travel up to five hours each way for treatment at a city hospital, and often need overnight accommodation. We heard that the federal government has said that these seniors must move permanently to the city because it has exhausted its transportation budget for First Nations in that community. The participant believes the federal government is responsible for this situation because it has not provided sufficient support to the community. There were many such examples of a lack of mutual problem-solving by jurisdictions.

Poor communication and coordination between governments, urban health care services, and on-reserve, remote, or northern communities

Criticisms of poor communication and coordination applied at all levels: between provincial ministries, health regions, and health care services; between the different federal government departments with responsibility for First Nations and Inuit populations; and particularly between the federal government, the provinces, and Aboriginal communities.

Aboriginal people, and particularly seniors, tend to move back and forth between urban areas and their communities, depending on their health needs.^{10,19}

Participants in the Health Council's consultations expressed frustration that in the absence of coordinated services, vulnerable seniors are expected to navigate complex health care systems and government bureaucracies by themselves. Many are struggling with chronic illness and disability, living in poverty, and mistrustful of mainstream society. Unless there is a case manager, Aboriginal patient navigator, translator, other health care provider, or family member who actively coordinates and oversees their care, seniors are fearful and likely to experience problems when they travel for care. Non-existent or weak links between services mean that frail, vulnerable seniors end up without support and at risk for neglect.¹⁰

In the absence of coordinated services, vulnerable seniors are expected to navigate complex health care systems and government bureaucracies by themselves.

In particular, many participants spoke about the gaps in care that happen when a senior is sent home from hospital. They said that hospitals often send frail patients home to their communities without checking if there are appropriate support services or home accommodations in place, because they historically have viewed Aboriginal communities as "federal territory" and outside of their jurisdiction. This is a well-recognized challenge that can be addressed with the help of Aboriginal discharge planners who link hospitals and communities.⁹ We heard a number of successful examples of this role, but it is not yet widespread.

The lack of consistent medical records is also a significant problem. Participants said that each health care provider or institution involved in a senior's care typically has a different paper record. While this issue affects many Canadians, it is a particular concern when First Nations and Inuit seniors are moving back and forth between health care and support services offered by the province or territory, federal government, and their communities. Participants said that while electronic record-keeping is now being used at many sites, health systems and providers often use different electronic systems that are difficult to integrate. This is a recognized problem among health care services offered by the provinces and territories, and it is further complicated by the fact that on-reserve communities and federally run services also have different systems, both paper-based and electronic. Key information about a senior's health does not get passed along to all the people involved in his or her care.

A number of participants stressed that communication and coordination need to improve in ministries of health and regional health authorities to ensure that Aboriginal communities are involved in health planning and policy. They said that provincial health reforms are often started without recognition that they can place serious pressures on communities.^{1,20}

Participants shared several examples of the consequences of these provincial reforms. Many provinces are sending patients home from the hospital at an earlier stage in their recovery, with the expectation that home care programs will provide more extensive support. This may save money in hospital and provincial budgets but it inadvertently downloads costs to First Nations communities, whose home care programs are either run by the community (self-government) or (under) funded by the federal government. This is a long-standing problem.²⁰ Participants also said that provincial privacy policies or legislation that restrict the sharing of patient information are slowing down and complicating the exchange of information.

Finally, InterRAI, a well-established health assessment and planning tool,^{21,22} was recognized by many participants as a valuable way to help providers across sectors and jurisdictions organize care. However, there were many concerns about communities losing control of the information, and for this reason several participants had decided not to use it. We heard that the First Nations and Inuit Health Branch–Alberta region has successfully piloted the RAI-HC (Resident Assessment Instrument for Home Care), consistent with the First Nations principles of OCAP (ownership, control, access, possession), and that a toolkit is now available nation-wide for all First Nations.

Insufficient home and community care for seniors to live out their lives in their communities

The majority of seniors want to live at home as long as their health permits, and there is a growing trend in Canadian society to support this as much as possible. For First Nations, Inuit, and Métis seniors, this can be more of a challenge. The pressures on communities can be enormous: as one example, 44% of First Nations adults over age 55 require one or more home care services.²³

Many seniors live in communities where only limited home care and community services are available to help them manage their health and stay in their homes. In addition, in many rural, remote, and/or on-reserve communities, there is a severe shortage of housing, and seniors have difficulty getting access to the medical technology, equipment, supplies, and medications that they need.

Sending patients home from the hospital at an earlier stage of recovery may save money in provincial budgets but it inadvertently downloads costs to First Nations communities.

The federal government's First Nations and Inuit Home and Community Care program (FNIHCC) works with First Nations and Inuit communities to develop home and community care services that help people with chronic and acute illnesses receive the care they need in their home or community. Services may include nursing care, personal care such as bathing and foot care, home support such as meal preparation, and caring for someone while family members have a rest (respite).²⁴

While many participants spoke favourably about the FNIHCC program, they said that current funding is not sufficient to provide seniors with the services they need. In addition, some communities accessing the FNIHCC program find it difficult to retain qualified nursing staff because some provinces pay a higher wage scale, and because it can be difficult to recruit nurses to rural and remote communities.

We heard that the lack of evening and weekend coverage by FNIHCC for First Nations people on-reserve is a particularly significant gap, and a glaring disparity in provinces where such extended coverage is available to other residents. Depending on provincial or regional health authority policies, some on-reserve communities can access provincial services, such as home care or respite care, to bridge the gaps. But many cannot. For example, some provinces offer First Nations seniors the same access to home care services as other people in the province; some provide access only for services not provided through FNIHCC, or have struck independent agreements with communities; and others do not provide any home care services at all, maintaining that on-reserve home care is entirely the responsibility of the federal government.²⁵

If services aren't available in on-reserve First Nations communities, and the province can't or won't provide additional services on-reserve, seniors may need to leave the reserve permanently in order to access provincial health care services. One participant said that in his health region, on-reserve First Nations people who move off-reserve to access either palliative care or respite face a residency requirement of six months to a year before they are eligible for these services, which effectively prevents on-reserve seniors from accessing them.

In its 2011 report, the FNIHCC program indicates that it needs to prepare for an increase in the number of First Nations and Inuit who will need services, based on projected increases in aging and acute and chronic illnesses, as well as government attempts to reduce expenditures and contain costs.²⁵ The report notes that these trends will have an impact on the design and delivery of health and social services, and that spending may need to be reviewed because it has not changed significantly over the past decade.²⁵

Discussions about home and community care also identified a growing focus on shared caregiving in communities. The ability of a senior to stay safely at home is dependent on more than the availability of a home care program. He or she needs access to healthy food; safe, good-quality housing; and support services such as transportation to appointments. Many Aboriginal seniors also need someone to haul wood and water, to chop wood for fuel, and to help maintain their homes.^{1,26} An increasing number of communities are providing a range of support services, often in partnership with provincial services, that enable seniors to stay in their homes longer.

Challenges preventing seniors from staying in their homes

A 2004 study by the Government of Canada and First Nations and Inuit organizations showed that:

- ▶ Aboriginal seniors prefer care in their own homes, in their own communities, and usually from family members.
- ▶ Clients have very limited ability to pay for services.
- ▶ Housing is an issue for many clients; it may be overcrowded, in a poor physical state, or, in some cases, very isolated.
- ▶ Caregivers do a great deal of work and have a high potential for burnout.
- ▶ More care, including respite, is needed on evenings and weekends.
- ▶ Services need to be designed to address the need for higher levels of care, including long-term and short-term care in facilities.

- ▶ Supportive housing can fill some of the gaps at lower levels of care.
- ▶ Funding issues need to be addressed to meet the increased demand and growing need for higher levels of care, taking into account the size and location of the community, as well as factors such as culture and language requirements.^{S17}

A working group of representatives from First Nations and Inuit communities, the Assembly of First Nations, Inuit Tapiriit Kanatami, Indian and Northern Affairs Canada, and Health Canada was established to review recommendations from the 2004 study and develop policy options.

They concluded that “jurisdictional disagreements around who is responsible for the provision of continuing care has resulted in a lack of responsiveness to the needs of First Nation communities, significant gaps in services to these communities, and a lack of long-term planning and development of services. Any attempts to address these issues within the current policy context have had limited success.”^{S15}

Palliative care

Many participants said the lack of culturally appropriate and safe palliative care in communities is a significant gap. There is no funding for palliative/end-of-life care through the First Nations and Inuit Health Branch, and Health Canada’s First Nations and Inuit Home and Community Care program is unable to provide 24-hour support for palliative clients and their families due to limited staffing and funds.

Some research with seniors to define culturally appropriate end-of-life care yields a very different perspective from the Western model. In some Aboriginal cultures, death is part of life,

and the care and comfort of heart and spirit take precedence over medical procedures and protocols. The end of life is an important time for families and communities to gather, and for traditional practices.^{S15,S16}

If palliative care is not available in communities, culturally safe guidelines and environments need to be available for Aboriginal seniors who die in health care facilities.^{S15,S16} We heard that Lakehead University in Thunder Bay is currently developing a model for culturally appropriate and safe palliative care services.

There is a lack of both funding and understanding of Aboriginal communities' needs for appropriate long-term care.

Not enough culturally safe long-term care

Many Aboriginal seniors lack family support and/or live in communities that are too small, remote, or struggling to provide adequate support to people with health challenges. Participants said that small communities don't receive enough funding for full programs, as the amount of federal money that they receive is based on factors that include the size of the population.²⁷ As a result, many Aboriginal seniors need assisted living or long-term care at an earlier stage and younger age than other Canadian seniors. Even those who are benefitting from coordinated care in their communities may eventually have health needs that are too great for the community and their family to manage, and will need to consider a long-term care facility.

Inuit seniors who need long-term care must leave their small and remote communities for facilities available in larger towns. Most are able to remain in Inuit territories, where the culture and language are familiar and telehealth is used to connect them with their families and communities.

This is less likely to be the case with First Nations seniors. Less than 1% of First Nations on-reserve communities have long-term care facilities,⁹ and the federal government has restrictions on the approval of any new facilities on reserves.^{1,20} This means that most First Nations people requiring care are placed in mainstream provincial facilities that are likely to be a great distance from their own communities.⁹ Leaving their homes for long-term care isolates First Nations people from family, friends, and their communities. It also makes them vulnerable to inappropriate care because of language barriers.

These factors can lead to depression and decreased quality of life.^{1,9} Understandably, First Nations seniors do not want to live out their days away from families, communities, and cultural traditions.¹⁰

Participants said that cultural safety must be in the forefront of all discussions about long-term care facilities. They stressed that while First Nations communities are culturally safe for seniors, most mainstream long-term facilities are not. They shared stories of people from remote communities who were sent to long-term care facilities in large cities far away from their homes; they never saw their families again, and were removed from all their cultural touchstones of traditional food, ceremonies, and language. For some, being taken from their homes and sent to an institution triggered memories of residential school and caused them to relive the trauma. Long-term care facilities need to be culturally safe, with respectful staff who offer traditional foods and medicines, cultural activities, interpreters, and the ability to link by video conference with remote families and communities.

Researchers have identified that the demand for long-term care will grow rapidly over the next decades due to the increase in the number of Aboriginal people who are aging, and the disproportionately high rates of chronic disease, mental health issues, brain injury (as a result of trauma or substance abuse), and disability.¹ Whether more long-term care homes should be built in Aboriginal communities is an ongoing point of discussion, complicated by the federal restriction on funding any additional long-term care facilities on reserves.¹ Although Aboriginal Affairs and Northern Development's Assisted Living/

Adult Care program funds limited institutional support and extended care for those requiring 24-hour medical or nursing support, this funding is thinly spread.¹ As a result, on-reserve facilities are being pressured to provide higher levels of care so that clients can remain in the community.¹³ We also heard that some First Nations personal care homes must now meet provincial regulations in order to be licensed, but they were not built to those standards originally and there are no funds to bring them up to code.¹³

In general, there is a lack of both funding and understanding of Aboriginal communities' needs for appropriate long-term care.¹

Denials and delayed approvals for health benefits and medical travel

The Non-Insured Health Benefits program (NIHB) is a federal program for eligible First Nations and Inuit populations that provides coverage for a specified range of medically necessary drugs, dental care, vision care, medical supplies and equipment, mental health crisis counselling, and medical transportation.²⁸

The NIHB's services, policies, and processes were a source of frustration for many participants. It was described as an underfunded and bureaucratic program with excessive restrictions and rules that are hard to understand. These same criticisms have been well documented elsewhere.²⁹ NIHB officials told the Health Council that they are working to make improvements, but based on what we heard across the country, few of these changes appear to have reached the front-line of care.

Delays in approvals for medicine, supplies, and medical travel were a major point of contention. Participants said delays in these services place seniors at risk for worsening illness, admission or readmission to hospital, and reduced quality of life.

Many participants also expressed concern about the number of applications for NIHB benefits that are turned down, leaving seniors—many of whom live in poverty—without any other way to get the supplies or medications that they need. Some turn to their province for help. People can also appeal the decision through NIHB, which often results in coverage, but this is an extra step that front-line staff say is an unnecessary delay in care and extra work for staff. They are particularly frustrated when coverage is refused simply because the form was not completed properly. Front-line health care providers spoke about the volume of paperwork; the levels of approval required; the need for physicians' signatures for most approvals, which is particularly onerous in rural and remote areas with few physicians; and the length of time it takes to process claims and approve travel.

The NIHB requires approval of coverage in advance of all medical travel or transportation, and must approve a non-medical escort, such as a family member or translator, who accompanies the patient. The approval process can take time and, in some cases, significantly delays care. Escorts are not always approved, leaving seniors vulnerable when they are travelling for care. The medical travel process itself can also leave seniors stranded. Adding to the complexity is that many First Nations and Inuit seniors have only a limited understanding of what is eligible for coverage or how to navigate the NIHB system. Most need support from health care professionals who are already stretched beyond capacity, particularly in the North or in remote and rural areas.

The Health Council spoke with representatives from the NIHB program, who are well aware of these concerns and working to resolve them. One example is the work ongoing in the Atlantic region (see page 52) as well as a new federal quality improvement strategy for the First Nations and Inuit Health Branch, including the NIHB.^{24,30}

Some regions in Canada are taking different approaches to managing the NIHB program. In BC, authority for health benefits has recently been transferred to the new First Nations Health Authority (FNHA). This will allow the FNHA to gradually redefine the NIHB program to improve efficiency and effectiveness and allocate money according to their own priorities.³¹ Out of the four Inuit Land Claim regions, Nunatsiavut has chosen to operate under a self-governing model and their NIHB program is directly managed by the Nunatsiavut government.³² Front-line staff in Nunatsiavut told us this arrangement benefits seniors because resources can be moved across departments to meet needs in a way that is not possible when the federal government is managing the program. In Nunavut and the Inuvialuit Settlement Region, the NIHB is administered by the respective territorial governments, and in Nunavik, the program is the responsibility of the Nunavik Regional Board of Health and Social Services.

We also heard that some regions and organizations, such as the Council of Yukon First Nations, have NIHB navigators in place to help seniors find their way through the program and get support. They are also investigating whether the self-governing Yukon First Nations should take on administration of the program.³³

In BC, authority for health benefits has recently been transferred to the new First Nations Health Authority, allowing them to allocate money according to their own priorities.

A complex environment for Aboriginal health^b

Provinces provide hospitals, physicians, and public health programs for all Canadians, including First Nations, Inuit, and Métis populations, but generally do not operate direct health services for First Nations on-reserve.

Territories deliver insured health services to all their citizens, including First Nations, Inuit, and Métis populations. However, the federal First Nations and Inuit Health Branch (FNIHB) provides additional funding for home and community care, as well as health promotion and disease prevention programs to First Nations (including those that are self-governing) and Inuit populations in the territories.

Health Canada funds primary care in 85 remote/isolated First Nations communities. It also funds public health nursing, health promotion/disease prevention programming, environmental health services, and a First Nations and Inuit Home and Community Care program in more than 600 communities.^{S5,S6}

Health Canada also administers the National Insured Health Benefits (NIHB) program, which provides eligible First Nations and Inuit populations,^c regardless of where they live, with supplementary health benefits for certain medically required services where these individuals do not have coverage from other public or private programs. Items covered include prescription drugs, medical supplies and equipment, dental care, vision care, short-term mental health crisis counselling, and medical transportation.^{S6} In BC, responsibility for

administering benefits has been transferred to the new First Nations Health Authority.^{S7} In the Northwest Territories and Nunavut, the program is delivered in partnership with the territorial governments. In the Inuit region of Nunatsiavut in Labrador, the NIHB is directly managed by the Nunatsiavut government.^{S8}

Aboriginal Affairs and Northern Development Canada funds an Assisted Living Program that provides non-medical social support services and an Income Assistance Program for First Nations seniors on-reserve in all provinces and the Yukon.^{S4,S9,S10}

First Nations and Inuit communities have taken on various levels of responsibility to direct, manage, and deliver a range of federally funded health services.^{S11} Over the past two decades, First Nations and Inuit communities have assumed an increasingly prominent role in the design and delivery of a wide range of community health services, through a series of transfer arrangements and contribution agreements with the federal government.^{S12} Delivery of health services can be administered in a variety of ways, from direct delivery of services by the First Nations and Inuit Health Branch through to transferred health services or ultimately self-government, where communities have full control and responsibility for all aspects of providing government services.^{S11}

It is well documented that when initiatives are developed, led, and managed by First Nations and Inuit, there is the greatest potential for success in improving health care for their people.^{S12} They have the flexibility to tailor care to meet community-specific needs within the local social, cultural, and geographic context.^{S12}

b Unless otherwise noted, information in this sidebar has been excerpted from *A complex environment for Aboriginal health*, found in Health Canada's 2012 First Nations and Inuit Health Branch Strategic Plan, *A Shared Path to Improved Health*.

c The federal government does not provide programs for Métis people.

However, a number of participants in the Health Council meetings said that when communities assume more responsibility and control, they also need time and support to build infrastructure, services, capacity, and partnerships, and that often seniors' needs exceed the communities' ability to provide care. There is an important role for governments to play in improving community infrastructure, increasing capacity, and helping communities sustain their services.^{S12}

Taking on responsibility for community health care is complicated for many communities. Participants noted that it is not uncommon for a community to be located across two or more regional health authorities, each with its own way of doing business—which complicates trying to build better links and access to services for their people. There are also First Nations communities that cross not only regional health authority boundaries but also provincial boundaries.

Some participants emphasized that although they value the programs funded by Health Canada and Aboriginal Affairs and Northern Development Canada, these are chronically underfunded and there is little coordination between them. The result is significant gaps in services, leaving many seniors without the very basic kind of health care and supports available to other Canadian seniors.^{S4,S10,S13}

Many participants noted the landmark shift in British Columbia, where authority for health care for First Nations in the province has been transferred to a provincial First Nations Health Authority. In the words of the chair of the First Nations Health Council, "This strong partnership ensures that this is not a 'dump and run' administrative arrangement—it's an arrangement that recognizes that BC First Nations are best positioned to make decisions about the health and wellness of their people, supported and funded by the Government of Canada."^{S7} The federal government has indicated that they see BC as a model for other jurisdictions.^{S14}

Distinct perspectives

FIRST NATIONS

Participants said that First Nations sovereignty and treaties^d form a unique political context for health care delivery to First Nations people and communities. Differences in how First Nations and various levels of government interpret the rights and responsibilities associated with health care delivery have generated significant gaps in care and services for First Nations people and communities.

Participants said that federal and provincial governments should agree on and clarify their roles in health care for First Nations people and establish policy that puts seniors first in cases where it is not clear who has jurisdictional responsibility. They said that a “first contact–first pay” principle should apply. They also called for an increase in the number of flexible agreements between First Nations and federal funders, such as allowing tribal councils to maximize resources by pooling funding from different federal initiatives.

MÉTIS

Respondents said that Métis people comprise one-third of the total Aboriginal population,^{S18} yet they tend to be the “hidden” Aboriginal population, which is reflected in significant gaps in policy, programming, and services. Participants said the needs of Métis seniors are often neglected by governments. They said that a large barrier to good health for Métis seniors is a lack of access to provincial and federal programs offered to First Nations and Inuit populations, particularly the Non-Insured Health Benefits program, which provides coverage for items such as prescription drugs and medical transportation.^{S19} The federal government does not fund or provide health care services or health benefits specifically to Métis people,^{S19} and we heard that most provincial and territorial health-related programming for Aboriginal populations tends to focus on First Nations or Inuit.

We heard that Métis seniors often live in rural, remote, or northern communities (many of which are adjacent to First Nations communities) and struggle with many of the same disparities in health determinants and the same health care challenges that First Nations and Inuit seniors do, but there are no specific Métis programs and providers don’t understand Métis issues. Costs such as medication and medical travel are at their own expense unless they have access to support services such as those run by the Métis Nation of Ontario (see page 48). There is also little access to culturally appropriate and safe services in urban areas; most Aboriginal health centres have a focus on First Nations.

Participants wanted to see a Métis-specific focus in health care planning at the provincial and regional levels to ensure that Métis seniors are recognized and included.

INUIT

The Health Council held sessions in three of the four Inuit regions: Nunavut, the Inuvialuit Settlement Region in the Northwest Territories, and Nunatsiavut in Labrador (the fourth region is Nunavik in northern Quebec).

The Nunavut Territorial Government delivers health care to Inuit in Nunavut. The Nunatsiavut Government was formed in 2005 and delivers some aspects of health care to Inuit in Nunatsiavut. Inuvialuit in the Northwest Territories and Nunavik in Quebec are working towards self-government; they currently share management responsibilities with their respective territorial or provincial government and the federal government.

While each Inuit region is different, they share similar barriers in delivering health care in the very small, isolated communities where seniors live. While most communities have health centres and some have telehealth, there is very little access to specialized services. Travel is required for anything beyond the most basic health care services. We also heard about a dangerous lack of emergency care in some remote communities, including no 911 system, paramedics, emergency supplies, or ambulances.

^d Along with Aboriginal rights, which are also held by Inuit and Métis peoples.

Health care providers are very limited in the North. Nurses may be on staff to provide services, but physicians only fly in to most communities. Staff turnover is high. Specialists may be flown in a few times a year, but typically there are long waiting lists for their services and little or no follow-up due to the lack of consistent health providers in communities. Many remote communities in the North cannot use telehealth because they don't have the infrastructure needed for many of these medical consultations.

Medical travel from small Inuit communities to southern cities results in tremendous financial costs to the health care system and diminished quality of life for seniors, their families, and communities. In Nunavut alone, the costs of medical travel and treatment provided in facilities outside of the territory consumes one quarter of the \$290 million Department of Health and Social Services territorial operations and maintenance budget.^{S20}

Participants expressed concerns about discharge planning practices for seniors who must travel to access care in Ottawa or other urban centres in the south, and how they often fall through gaps between health care systems. They discussed the burden on family members who must leave their families and jobs when seniors need care.

Since most Inuit seniors are unilingual, they typically need to be accompanied when they travel. Communication can be a challenge, as medical interpretation requires a highly specialized vocabulary and is more than just the ability to speak English and Inuktitut. Participants also noted that Inuit seniors often have low health literacy—they may not understand their diagnosis, how to manage their health conditions, or why or how to take medications that have been prescribed.

The need to travel with escorts also puts seniors at risk for financial abuse and neglect. In the words of one participant, “they are required to be escorted, and they often have little say in who does the escorting, or they choose someone who takes advantage of them.” Participants shared stories of younger relatives who accompanied the senior as an escort or translator, only to disappear into town with the majority of the money provided for their meals, accommodation, and other expenses.

The financial, emotional, and physical abuse and neglect of seniors in the North is taking a toll. Participants told us they have had confidential discussions with Inuit seniors over the years on the topic, indicating that it is a pervasive problem touching many families. Seniors Societies are emerging as a way to raise awareness of abuse, encourage open discussions, and develop strategies to deal with it.

It is important to put the health and health care delivery challenges into a broader context. The rapid change from a traditional society, in which Inuit lived on the land and moved with the seasons to follow wildlife migrations, to a modern industrialized society has affected all aspects of Inuit health and well-being. A higher-than-average incidence of suicides,^{S21} tuberculosis,^{S22} and chronic health conditions can be attributed to these changes and the social determinants of health, including poverty, poor housing, food insecurity, and poor nutrition.^{S22} Any attempts to improve the health of Inuit seniors requires acknowledging and addressing these factors.^{S22}

Participants discussed solutions to improve health care for Inuit seniors, including a new model of care that:

- ▶ supports a continuum of care for seniors in their communities;
- ▶ ensures sustainable service delivery;
- ▶ puts structures in place to ensure accountability, coordination across government departments, and processes for ongoing feedback;
- ▶ ensures cultural safety through respect for seniors' culture, language, and way of life;
- ▶ meets their language needs; and
- ▶ incorporates traditional Inuit ways into health care delivery.

Finally, participants said that governments should ensure that community-based providers have the infrastructure and capacity to implement policies and strategies.



Changing landscapes and key approaches

Although there are significant gaps and challenges in the delivery of health care for Aboriginal seniors, innovative changes are underway across the country.

We heard that federal, provincial, territorial, and regional authorities are increasingly stepping up to recognize their role in Aboriginal health and partnering with Aboriginal people and communities in developing new policies for seniors. There were many discussions about the groundbreaking transfer of health care to the First Nations Health Authority in BC, and the memorandums of understanding and other formal agreements to improve health care that were recently forged or are in development between various levels of government and Aboriginal leadership. Many regional health authorities are also working to ensure that Aboriginal people are equal partners in health planning.

Participants at our sessions shared the positive changes that are unfolding in their communities and programs. We have highlighted 12 of these practices in the next section; further examples are available on the Health Council's Health Innovation Portal (healthcouncilcanada.ca/innovation). Embedded in these stories is a sense of the changing landscapes in Aboriginal seniors' health care that are taking shape across the country.

An analysis of these innovative practices and the common themes identified in our interviews and cross-country consultations indicates that some key approaches are being used to improve the health of Aboriginal seniors. These are listed on the following pages, along with examples from selected practices that were brought to the Health Council's attention. A complete listing of practices discussed by participants can be found on page 60.

Federal, provincial, territorial, and regional authorities are increasingly stepping up to recognize their role in Aboriginal health.

The specific needs of Aboriginal seniors should be a focus in provincial healthy aging strategies.

All governments are looking at ways to better meet the needs of their aging populations, and participants noted that provincial “aging in place” strategies must include Aboriginal seniors and be responsive to their unique cultural needs.

- ▶ As one example, Ontario’s recent *Living Longer, Living Well* report, a core document informing the province’s Seniors Strategy, states that Aboriginal people are “deserving of specific recognition given their particularly unique set of experiences, challenges and needs.”³⁴
- ▶ At the regional level in Ontario, Mamaweswen, the North Shore Tribal Council, uses provincial Aging at Home funding to provide discharge planning for both First Nations and Métis seniors in the region.

Well-structured partnerships and agreements can eliminate unnecessary disparities between what is available to Aboriginal seniors and what is available to non-Aboriginal seniors.

The largest-scale example of this is in BC, where the self-governing First Nations Health Authority is forming partnerships and agreements with regional health authorities to ensure that First Nations people will have the same care as other BC residents.

Practices in **bold type** are profiled on pages 35-59. Additional information is available on the Health Innovation Portal healthcouncilcanada.ca/innovation.

Practices marked with an asterisk (*) can be found on the Health Innovation Portal.

Participants also shared several examples of partnerships that were built from the ground up:

- ▶ In Bella Coola, BC, an agreement between the Nuxalk Nation, Vancouver Coastal Health Authority, and the First Nations and Inuit Home and Community Care program ensures that everyone in the community—First Nation or not, on-reserve or off—has access to the same health care services.
- ▶ In Alberta, the Siksika Nation has a Memorandum of Understanding with the province that allows them to form partnerships with provincial services, giving their people access to a wide range of health care services without compromising their Nation’s Treaty Rights to Health.

We also heard that:

- ▶ Alberta’s Primary Care Networks are working to provide everyone with a home for primary care, and the province is working with three Treaty areas and the federal government to develop a community care model.
- ▶ The tripartite *Memorandum of Understanding on First Nations Health and Well-Being in Saskatchewan* is paving the way for improvements in seniors’ care; long-term care is one of the priority areas.
- ▶ In Nova Scotia, a Tripartite Health Committee identified disparities in access to home care for First Nations on-reserve and made this a priority issue, which led to a comprehensive continuing care strategy. One of the major findings was that health authority staff need “clear and uncluttered information about provincial programs” that they can share with communities.¹⁶ The committee also underscored the importance of close relationships among First Nations community health staff, residents, regional health authorities, and multi-jurisdictional partners so they can work together, often on a case-by-case basis, to navigate “the high level of complexity and persistent confusion” in the maze of federal and provincial policies for program eligibility and to clear up any misconceptions about access.¹⁶

Consulting with seniors about their needs and identifying community-specific requirements are indispensable parts of planning.

There is little data about the health of Aboriginal seniors in general, the services available to them, and how these compare to services offered to the non-Aboriginal population.

Participants from communities and governments that have conducted seniors' surveys and other consultations said they were surprised by some of their findings, and had changed their strategies accordingly. These findings varied by community, but participants indicated that many seniors are suffering from grief and depression because of the state of their families and communities; that basic concerns are buying and paying for wood to be split and brought into their homes and not having adequate food; and that assisted living in their community is a much-preferred option to long-term care in the community.

Some of the governments and communities that have conducted surveys to determine seniors' needs and/or developed an inventory of services include:

- ▶ Nova Scotia;^{13,16,25}
- ▶ the Council of Yukon First Nations;³³
- ▶ the Sioux Lookout Meno Ya Win Health Centre in Ontario;²⁶ and
- ▶ the North Shore Tribal Council in Ontario.

In addition, we heard that the **First Nations and Inuit Health Branch–Atlantic region**, in partnership with First Nations leadership, developed a tool to review policies through the eyes of First Nations seniors. As a result, they have simplified some long-standing procedures for medical travel.

Communities pull together and share a common approach to ensure that seniors have coordinated, comprehensive health care and safe living environments, allowing them to stay in their homes.

Shared caregiving means that families, health care providers, and community services come together, often pooling their resources, to meet seniors' full range of needs, including health care, home support and maintenance, and reducing their social isolation. Participants told us that shared caregiving reduces stress for everyone involved, particularly seniors and their families, who are often unable to provide the support their parent or grandparent requires.

We heard many examples of this approach:

- ▶ **Peter Ballantyne Cree Nation in northeastern Saskatchewan has been nationally recognized for its shared caregiving approach.**
- ▶ Siksika Nation offers a full range of seniors' services, including an Elders Lodge (assisted living) and a comprehensive home care program.
- ▶ Kahnawake Shakotia'takenhas Community Services in Quebec provides an integrated service delivery program including an Elders Day Program, Meals on Wheels, an Elders Lodge, and home care.*
- ▶ In BC, shared caregiving through the Saanich First Nations Adult Care Society has reduced hospital readmissions and improved staff retention.*
- ▶ **The self-governing Carcross/Tagish First Nation in the Yukon hires unemployed youth to shovel snow and chop wood for seniors, and tackles the sensitive problem of elder abuse.**

Many Aboriginal seniors are isolated and struggling due to multiple factors in their lives and communities; they need more intensive support than non-Aboriginal seniors.

In some cases, government is a partner in shared care. In the Northwest Territories, the Department of Health and Social Services works with other territorial departments, particularly the Northwest Territories Housing Corporation, to help seniors remain in communities by ensuring that housing, socialization, nutrition, hygiene, home care, and related health needs are met. While these efforts are relatively new, the Health Council heard that there is some evidence that they have reduced the number of seniors who have needed to leave their communities for care.

Dedicated Aboriginal health centres, case managers, discharge planners, and patient navigators are available as necessary supports to help seniors and their families make their way through the complicated maze of health care services across jurisdictions.

We heard many examples of the importance of a dedicated person or health centre to help seniors navigate the health care services and providers they need for their care, a process that is complicated by receiving care on- and off-reserve (for First Nations) and in- and out-of-province or territory.

Participants said that Aboriginal seniors need this support more than non-Aboriginal seniors due to the challenging determinants of health, greater burden of physical and mental health conditions, and the devastating effects of residential schools on family bonds and communities, which have left many seniors isolated and struggling.

Many communities and programs, including the Saanich First Nations Adult Care Society in BC and the North Shore Tribal Council in Ontario, are working with regional hospitals to improve communication related to hospital discharge, to ensure that seniors have a range of support in place when they arrive home, and to prevent hospital readmissions.

We also heard that:

- ▶ Whitehorse General Hospital has a well-established discharge planning system. It was critical to put this system into place because of the vast distances in the North, and to ensure that health information was transferred from the hospital to the health directors in self-governing communities that are responsible for organizing a patient's care. The discharge planner fulfills a community liaison role and is able to manage communication in a culturally safe manner.*

- ▶ At Alberta Health Services, the Aboriginal care coordinator role is based on the case management model. The care coordinator follows patients through the health care system, supporting coordinated care in the hospital and integrated care between the hospital and the community.*
- ▶ The Discharge Planning Toolkit developed by the Federation of Saskatchewan Indian Nations has been identified as a best practice by provincial home care consultants.
- ▶ In Ottawa, the Tungasuvvingat Inuit Family Health Team Medical Centre and the Inuit Family Resource and Health Promotion Centre bring an integrated team of primary health care to Inuit who travel to Ottawa for medical care.
- ▶ Métis Nation of Ontario community centres are important cultural and service hubs that link Métis people to each other as well as to health services and supports in their area.
- ▶ The Inuvialuit Regional Corporation and the Beaufort-Delta Health and Social Services Authority in the Northwest Territories use community wellness coordinators in a flexible role that addresses mental health and wellness, crisis intervention, health promotion, helping seniors with social and traditional activities, and health advocacy as necessary to meet community-specific needs. This program hires only temporary staff from the south to fill health and social service positions, with the goal of training and mentoring local people to move into the positions permanently.
- ▶ Providing professional development to health care providers in remote communities is often challenging. Saint Elizabeth offers a national online education program in elder care that allows health care providers to learn new information without the need to leave their communities.

Community health staff who are not regulated health professionals are recognized as playing a key support role for Aboriginal seniors in remote communities.

We heard that community staff do not need to be regulated health care providers:

- ▶ In Nunatsiavut, community health aides function as the nurses' "right hands" and as cultural bridges for southern nurses who are working in remote communities. Because they provide such extensive support, community health aides allow communities to manage with fewer nursing staff.

Increased use of telemedicine, videoconferencing, and bringing care to the community reduces medical travel and improves cultural safety.

While some participants said that technical issues currently make it difficult for them to rely on telemedicine or other mobile health care, most wanted it to be used more widely to reduce the need for medical travel. This is a particular area of emphasis in BC: participants from communities and the First Nations Health Authority said there is an increasing push to use portable equipment and travelling teams for prevention, screening, and treatment for a range of conditions such as diabetes, hearing and vision testing, podiatry, mammography, and dental care. They said that Aboriginal seniors will come for care if a program is in the community, because the environment is culturally safe. Participants identified some leading practices:

- ▶ Carrier Sekani (CS) Family Services in BC uses telemedicine to improve access to primary health services and palliative care, resulting in reduced travel and costs, improved access, and better continuity of care. This practice is receiving a great deal of attention in the province, particularly from the First Nations Health Authority.*
- ▶ A mobile chronic disease management team (kinesiologist, nurse, and pharmacist) out of Rocher-Percé, Quebec, works with clients in their remote home communities for an intensive three-month program, teaching about their diseases, food and exercise choices, and medication management. Participants are showing significant health improvements. The program, a partnership with the Government of Quebec and Pfizer, and based on an internationally recognized chronic care model, is being considered as a model by the First Nations and Inuit Home and Community Care (FNIHCC) program.

- ▶ A collaborative practice model in Saskatchewan brought together FNIHB, the Kidney Foundation (SK Branch), the Regina Qu'Appelle Health Region's chronic disease program, and three First Nations communities to care for chronic conditions on-reserve.*
- ▶ KO Telemedicine, a First Nations–operated company that serves communities in northwestern Ontario, is a nationally recognized leader in telehealth. Recently, KO expanded its in-home camera service to home care, including palliative care.
- ▶ In Nunatsiavut, a lifelike telemedicine robot allows southern physicians to visit patients virtually in a remote community health centre. Tele-oncology in the region has also been identified as a promising practice for improving clinical support, reducing travel for patients, and being cost- and time-efficient.³⁵

Acknowledging and integrating traditional culture contributes to improving the quality of care, patient safety, and quality of life for Aboriginal seniors.

While not all Aboriginal people follow traditional ways, culture is particularly important to many seniors. A culturally safe environment—one that honours their heritage and incorporates their cultural traditions—is a crucial part of their care.

- ▶ A leading example of the value of integrating traditional culture into the care of seniors is the Sioux Lookout Meno Ya Win Health Centre in northwestern Ontario, which embeds a Traditional Healing Medicines, Foods, and Supports program in both its hospital and long-term care facility. Results have included decreased medical errors and improved patient satisfaction.*

- ▶ The Wikwemikong First Nation on Manitoulin Island in Ontario provides seniors' home care and a long-term facility that follow teachings based on the medicine wheel and holistic care.
- ▶ **Significant cultural activities are integrated into all health and social services programs under the Tlicho Community Services Agency in the Northwest Territories, including continuing care and independent living programs.**
- ▶ In Saskatchewan, the Regina Qu'Appelle Health Region's home care program, nationally recognized as a leading practice, features culturally safe services that are adaptable according to clients' needs and integrated with other services to ensure clients do not fall through gaps.*
- ▶ Lakehead University in Thunder Bay is developing a model for culturally appropriate and safe palliative care services that will allow First Nations people to die in their communities. A lack of culturally safe palliative care is a recognized gap, and this work is of significant interest to participants.
- ▶ Saint Elizabeth's First Nations Elder Care Course is an example of how culture can be integrated into Western best practices to support culturally safe care.

Reducing isolation through traditional and cultural activities is part of good health care.

A number of participants said that seniors' societies and gatherings, particularly in the North, are an emerging and important development. These social activities reduce isolation and provide a low-key way to reach seniors with information about health, wellness, aging, and elder abuse. They also incorporate traditional activities and foods to keep seniors connected to their cultures.

Many health care providers and organizations have created community activities for seniors, either in person or through technology:

- ▶ The Sioux Lookout Meno Ya Win Health Centre hosts regular virtual gatherings using telemedicine technology and a big-screen TV, accompanied by a traditional meal.
- ▶ Saanich First Nations Adult Care Society and Peter Ballantyne Cree Nation connect seniors with youth, emphasizing the important role of First Nations Elders and storytelling.
- ▶ Carcross/Tagish First Nation hosts regular gatherings for all seniors in their region, First Nation and non-First Nation, forging new friendships and community bonds.
- ▶ In Pond Inlet, Nunavut, the home and community care program hosts a weekly Elders Tea aimed at reducing isolation and reconnecting seniors with traditional foods and activities, including going out on the land.*

Concluding comments

While the needs of all Canada's seniors are important, the health challenges of First Nations, Inuit, and Métis seniors are more complex and in urgent need of attention. These seniors are struggling with poor mental and physical health, the residual effects of colonization and residential schools, and continuing jurisdictional and organizational barriers that prevent them from having access to the same level of health care as other Canadian seniors.

The list of key themes outlined in the last section, along with first-hand accounts of innovative practices profiled in Section 2 of this report, should provide health care providers, policy-makers, and communities with ideas for improving the care of Aboriginal seniors.

A number of overarching findings came from this work. We heard that the best leaders—federal, provincial, territorial, community, and Aboriginal—separate politics from service delivery. They focus on building equal partnerships to resolve problems and provide First Nations, Inuit, and Métis seniors with access to the services they need.

We heard that case management is crucial at the front-line of care. Whether the person's role is case manager, patient navigator, discharge planner, or community nurse, one person needs to be the primary contact, with responsibility for coordinating services and travel when seniors must leave their communities for care. All governments should be offering support and funding for these roles, as is the case in some provinces and territories.

In addition, as governments and health care leaders address the needs of Canada's aging population, it is vital that they partner with Aboriginal leadership to ensure that new policies do not inadvertently cause problems for Aboriginal communities. It is also important to develop healthy aging strategies that contain a culturally appropriate and specific focus on the unique needs of First Nations, Inuit, and Métis seniors.

Transferring the control of health care services from governments to First Nations and Inuit communities has great potential for improving the health of their people, but participants stressed that this must be accompanied by the necessary financial and program support as communities develop the infrastructure and capacity to deliver these services. Many participants, including those in provincial governments, wanted more information about the federal government's future intentions regarding health care for First Nations, Inuit, and Métis people.

In an August 2013 presentation to the Canadian Medical Association, the federal Minister of Health said the government will continue to look for creative ways of integrating First Nations health care into the broader system, and that the creation of the First Nations Health Authority in BC provides a model of how First Nations can have a greater role in designing and delivering health care while increasing integration with provincial health systems. But participants in the Health Council consultations asked for more clarity: Is the federal government's role just to transfer funds for health care services, or is it to be involved in broader problem-solving, planning, and funding as well?

With significant inequities in health status and health outcomes between Aboriginal and non-Aboriginal seniors, and a growing population with unmet needs, governments must turn more attention to the challenges faced by Aboriginal seniors and their communities. The goal should be to improve care for seniors through partnerships that focus on collaborative problem-solving, and to resolve confusion or disagreements about which level of government is responsible for the improvements that are needed. Some jurisdictions and communities have already started this work, and we commend them for their efforts and responsible approach. Others must now join them and take up the mantle of leadership to address this critical health policy challenge.

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Section 2

Partnerships and progress:

Innovative practices
as described by
the people involved

Online education about elder care for community-based health care providers

Saint Elizabeth's “@YourSide Colleague” First Nations Elder Care Course, Canada-wide

The need

In my previous role as a nurse supervisor for a First Nations home and community care program, I saw that there were major challenges in finding affordable, accessible, and culturally appropriate health care provider training that meets the needs and realities of First Nations people. Receiving an education within the community was not often an option for health care providers, and leaving the community for education and training had several negative impacts on the health care provider and the community—it affected the continuity of care for their clients, increased the burden on the families and community, and was a financial drain on already exhausted community budgets. These problems were especially common in remote communities.

It would take community home care staff several years to obtain their Personal Support Worker certificates. They would leave their families, communities, and positions for weeks at a time. If there were a crisis or a death in a community they would return home, losing out on training and delaying their education. In addition, many times nurses come to communities without a proper understanding of the importance of culture and protocol and of building relationships within the community.

Being able to access culturally relevant health care training and education that does not require travel is a fundamental requirement in meeting First Nations realities.

The new practice

The First Nations Elder Care Course is one of several online professional development programs offered by Saint Elizabeth; it is available at no cost to community-based health care providers across Canada. The course provides evidence-based, culturally sensitive education about First Nations history and culture, as well as clinical information on health topics related to elder care, such as falls, medication, nutrition, depression, Alzheimer disease, elder abuse, and caring for yourself as a health care provider.

We were cautious not to develop a pan-Aboriginal approach. We wanted to make sure that people who take the course understand that First Nations communities are very different from one another. A key message spread throughout the course is the need to understand that every community is unique. Health care providers need to build relationships with the communities to learn more about community-specific cultural practices and protocols. They need to seek guidance from a community champion to learn about the culture, traditions, and practices within a community.

Our program uses a unique model involving First Nations health care providers, elders, and specialists in the development and review phases of our courses. Our goal was to ensure that we had comprehensive information to meet community needs and to develop relationships of mutual trust and respect. We started with a national survey of health care providers in order to determine their needs for elder care information. After we developed the course content, we put out a call for reviewers from communities across the country—nearly 50 people volunteered. In one example, a group of health care providers gathered on three separate occasions to review and provide their feedback. An elder was present at each gathering and opened the day with a prayer as a customary tradition to start off meetings in a good way. Feedback received from all reviewers was then incorporated into the elder care course. We also ran a webinar series on elder care that included presentations by specialists and elders.

Making a difference

The course was released in January 2013 and has received an enthusiastic response, as indicated by new @YourSide Colleague account creations, password resets, and multiple phone calls requesting more information on the course. Community representatives appreciate that the course provides their staff with understanding and knowledge to provide a safe environment along with respect and protocols in caring for the elders. The goal in many communities is to keep elders in their homes for as long as possible instead of moving them to long-term care facilities.

The online training means that health care providers don't have to leave their communities to develop the knowledge and skills they need to care for elders. Health care providers are sometimes intimidated by online training, but most of them know how to use Facebook and once they realize it's just as easy, they are very enthusiastic.

An elder care webinar series was delivered to promote the newly released Elder Care Course and provide additional education on the topics within the course. Three months after the webinar series was completed, we sent out a knowledge-to-practice survey to help us determine what participants had learned from the webinar and course, and the impact on client care. The results were very positive: respondents told us that the course stimulated more discussion and program planning for elders in their communities, stimulated a change in the course curriculum in a school of nursing, and reinforced to health care providers that it is important to take a holistic approach to care.

What changed

- ▶ increased knowledge utilization and uptake
- ▶ health care providers in the community no longer need to travel for elder care training
- ▶ nurses from outside who are going into communities can learn about First Nations culture and how to build good relationships with elders and communities

Key components

- ▶ a national survey of community health care providers identified learning needs
- ▶ Elders guided cultural content throughout the development of the course
- ▶ an advanced practice consultant in gerontology provided clinical content
- ▶ community reviewers ensured that content was relevant to their unique practice needs

One home care program for everyone, whether they live on-reserve or off

Bella Coola, British Columbia

The need

Bella Coola is a geographically remote community with limited resources, situated on the central coast of British Columbia. I was the federal health nurse there for years, until I went back to university. When I returned, there was a vacant RN position in the Nuxalk home care program: two community health workers had been working to provide home support services, and they had been working without supervision. Their dedication and commitment was tremendous—they kept the program operating in the absence of a nurse. I was hired by the province to set up home care in the region.

I saw that people on-reserve weren't getting services. The community was economically depressed. Younger people had left to find jobs, and they left behind an aging population. There was no structured home and community care program, and no integrated service delivery model between the services offered on-reserve and those offered by the province. We had five long-term care beds in a small community hospital, and no assisted living.

Complicating the situation were factors such as budget constraints, nursing shortages, and a lack of clarity around staff roles and responsibilities. And everyone had a different opinion about what a home and community care program should look like.

The new practice

We now have a fully integrated home and community care program situated in a new health centre on-reserve that is used by everyone in the community. We provide services 365 days a year to all community residents, both First Nations and non-First Nations, on-reserve and off-reserve.

We started with a shared vision to give people equal access to care and the option to remain at home as long as possible—not just in their community but in their own homes. We needed an integrated care program to support this vision and we wanted to build capacity for culturally sensitive care.

We started the planning by going to the Chief and Council of Nuxalk Nation and saying, "Why don't we work together and set up a program for everyone?" Always talk to the Chief and Council; they have to be behind you and working with you.

Because they knew me, there was trust and they agreed. We went out on the road talking to the community, conducting a community needs assessment, and meeting with the Nuxalk Nation Health Director, with Elders, and with the RCMP. We had a meeting between the Chief and Council, the United Church Health Services (an affiliate of Vancouver Coastal Health), Vancouver Coastal Health, and Health Canada's First Nations and Inuit Home and Community Care program (FNIHCC), which offers home care on-reserve.

We got federal and provincial funding and made just one home care program where there had been two (the province's program and the federal FNIHCC program). We made an agreement that the Nuxalk Nation would deliver services on-reserve, and they would send funding to our program.

We had full community support. In 2007, we slowly began to integrate all programs based on what the clients needed, not based on whether they lived on- or off-reserve.

Everyone in the Bella Coola area uses the on-reserve health centre, whether or not they are First Nations and whether they live on- or off-reserve. Clinic programs include foot care, wound care, blood pressure monitoring, diabetes education, and a bath program, which can be done as part of the adult day program. We use the interRAI home care assessment, make home support visits, and develop a care plan based on the assessment. We also offer an interdisciplinary palliative care program. We manage palliative clients by being kind, gentle, and respectful of their wishes, by knowing them and their environments, and by providing constant support.

The program is like a hub that offers primary health care, telehealth, pharmacy, mental health and addictions programs, public health services, social services, and an administrative office to support patient travel. We are connected to all of these services and we meet with doctors weekly to review our clients' concerns. We are also connected to specialists outside the community. For example, for wound care, we have PixaLere, a complete wound care management system. We use telehealth so we are connected virtually to highly skilled teams. We are also connected to BC's health information network and medication database, Medinet.

We work together—federal, provincial, and band-employed workers—in interdisciplinary teams with clear roles and responsibilities. There is no new money; we pooled our funding streams to work around budget constraints. By coming together, we expanded our capacity and flexibility. For instance, there is a four-hour cap on the number of hours of home support we can provide to a client in a day. But if a couple of more hours a day means that the client can stay in the community and in their home, then we provide more hours. We did this for one woman and she was able to die at home. It's good quality care, and it's cost effective for the system.

In addition, working towards and then passing the Accreditation Canada program was a huge benefit because it helped us focus on where to make improvements.

Making a difference

Before we integrated, the people on-reserve didn't have access to most of these programs. Now they do.

There is no doubt that we are making a difference to the quality of care. Some benefits include fewer emergency room visits and hospital admissions, and a decrease in the number of alternate level of care (ALC) clients at Bella Coola General Hospital. We've transitioned some people who had lived in the hospital for more than a year back into their homes. Patient travel has been reduced. And due to improved foot care, no one has had an amputation in years—that's really significant.

Seniors are remaining active at home, and they are happier and healthier. They receive culturally competent care. We try to hire local people; they go off to do further training and education and then return. Health providers are also satisfied—we don't have a high staff turnover.

Other communities are interested in developing the same type of integrated program. We tell them your standards of care are going to be the same—how you do your lower limb assessment, how you clean your tools, how you chart—but how you deliver the care might be a little different because of the culture in your community. And you have to know the community. I'm not of Nuxalk ancestry, but, you know, it just works.

Information provided by Glenda Phillips, Manager, Home & Community Support, Bella Coola General Hospital.

What changed

- ▶ two programs—the federal on-reserve home care program and the provincial program—were replaced by one integrated program in the community
- ▶ seniors living on-reserve have access to the same services as people off-reserve
- ▶ quality of care and access to care have improved
- ▶ staff shortages were eliminated, and there is clarity around roles, responsibilities, and scope of practice

Key components

- ▶ one person identified a gap and was a champion for change
- ▶ the Chief and Council were consulted first—their support was crucial
- ▶ the federal government, province, regional health authority, and band were willing to explore a different model
- ▶ staff are hired from within the community and developed
- ▶ a shared-care approach means the whole community is working together
- ▶ the Accreditation Canada program helps to drive quality improvement
- ▶ the use of technology and assessment tools improves client care

Providing integrated services to elders on-reserve

Siksika Nation, Alberta

The need

The health needs of elders are many, and so are the challenges of delivering care to them. A lack of federal investment has meant a lack of service in the communities. Aging elders are suffering from a number of health conditions—including diabetes, cancer, mental health issues, and addictions—that require a range of primary health care, acute care, and longer-term services and supports.

All levels of housing are needed, but in particular long-term care facilities, which are lacking in First Nations communities. Currently, when an elder can no longer be cared for in the community, they must be assessed for long-term care by an RN in a hospital. After the assessment has been completed, they are placed on a waiting list. Placement may take months, and the first available bed may be many miles from the community. This leads to isolation and loss of culture.

Beyond health care services, there are the social determinants of health—poverty, housing, food insecurity, and the general challenges associated with living in isolated areas with poor infrastructure. These conditions get in the way of providing good care.

The new practice

Siksika Health Services is a non-profit, incorporated entity of the Siksika Nation. With the lack of federal investment, we have had to find alternative ways to build capacity. To improve access to services, we entered into a Memorandum of Understanding (MOU), originally with the Calgary Health Region and then with the Province of Alberta (after amalgamation of the regional health authorities). The MOU delineates mutual responsibilities and accountabilities regarding the provision of health care services without disturbing Siksika Treaty Rights to Health. We also built partnerships with a range of organizations.

We are an accredited First Nations health organization offering a broad range of health care services and programs on-reserve, including a dedicated elders services area with an Elders Lodge (assisted living) and home care program. It is truly a great achievement to continue to retain accreditation status on a national basis, as it indicates to us that we are providing quality health care to our communities.

Our services include home visits for elders who are frail or recently discharged from hospital; meal delivery and homemaking; medication delivery; medical transportation and escorts for medical appointments outside of the community; case management; occupational therapy; assessments for mobility equipment needs and home assessments for home modifications; assistance with bathing at our health centre; basic and advanced foot care for elders; and palliative/end-of-life care.

Elders also receive primary health care, chronic disease prevention, and management of mental health issues, including traditional counselling, addictions programs, and social work/case management—all delivered through a team-based approach.

To address the gap in long-term care and support continuing care, we work closely with the local hospital by participating in weekly discharge planning rounds via telehealth and by attending case conferences to assist the elders and their families. To provide palliative care, we partnered with the Calgary Rural Primary Care Network.

We also partner with radiologists to provide ultrasound services on-reserve. We work closely with Aboriginal Affairs and Northern Development Canada to provide assisted-living services, and we also work closely with the Non-Insured Health Benefit program and the federal First Nations and Inuit Home and Community Care program.

Siksika Health Services has invested in information technology and formed partnerships that allow us to connect to Alberta's SuperNet so that health providers have better and faster access to telehealth, medical records, digital X-rays, and more. Siksika Health Services also uses electronic clinical information systems for medical records and for the community health immunization program. Netcare is also provided to physicians and for nursing.

Making a difference

Dramatic improvements are made when First Nations reach agreements with the federal and provincial governments and develop partnerships for new health care service delivery models. We've been very successful in improving access to home care and a continuum of integrated care for First Nations seniors in our Treaty area (Treaty 7). We are seeing evidence of this success. Outcomes include helping elders regain their independence following illness or surgery and preventing further disability. Elders are being supported upon discharge from the hospital and are remaining comfortably and safely in their homes for longer.

We have some ongoing challenges. There is limited funding to recruit and retain licensed professionals to work in home care and in the Siksika Elders Lodge, as well as to provide extended hours of care. Wages are lower for our home care registered nurses and licensed practical nurses compared with nurses who work for Alberta Health Services (AHS). And improvements still need to be made to provide access to long-term care in First Nations communities so elders are not forced to move to far-away communities. Also, as AHS hospitals continue to decrease length of stay and rely on home care to provide care after hospital discharge, we are stretched because Siksika Home Care does not receive additional funding.

At a higher policy level, a major overhaul is required for First Nations to truly realize prosperous health and positive change for future generations. The federal First Nations and Inuit Health Branch is mainly concerned with delivering programs in the short term, rather than taking a long-term, strategic approach. This results in increased health needs and costs. A stronger focus on investing in First Nations health and developing our capacity is required.

We are hopeful that some changes are underway. Three treaty areas are working with the federal and provincial governments to develop a community care model through a Health Services Integration Fund project, which is expected to be complete by 2015.

Information provided by Tyler White, Chief Executive Officer, Siksika Health Services, and Cheryl Sorenson, Team Leader, Siksika Home Care/Siksika Elders Lodge.

What changed

- ▶ improved access to a range of housing options, including home and continuing care—allowing elders to remain safely in their own communities
- ▶ improved access to a full range of health care services—allowing elders to regain their independence following illness or surgery and preventing further disability
- ▶ improved palliative/end-of-life care
- ▶ improved discharge planning, ensuring coordinated care and good communication between the hospital and the community

Key components

- ▶ MOUs and partnerships with governments, regional health services, and other organizations
- ▶ committed leadership among Siksika First Nations and Siksika Nation Health Services
- ▶ completing the accreditation process and maintaining our accreditation status
- ▶ information technology, which in turn supports the recruitment of health professionals and the continuity of care

Shared caregiving in the community

Peter Ballantyne Cree Nation, Saskatchewan

The need

The Peter Ballantyne Cree Nation (PBCN) consists of over 8,500 Woodland Cree members residing in eight largely isolated communities in northeastern Saskatchewan. Elder care is a growing priority for PBCN, as increasing numbers of seniors require higher levels of specialized health care that is offered primarily in urban centres. Managing chronic medical issues, especially in seniors over 70 years of age, is a real concern because of the lack of community-based long-term care facilities, palliative care, respite care, and after-hour care services.

This serious situation is complicated by jurisdictional disagreements over authority and financial resourcing, and by the fragmentation and lack of coordination provided by the federal government, the provincial government, and the regional health authority when it comes to providing services both on- and off-reserve. Elders travelling between their home communities and urban areas are especially vulnerable because there are no service links or communication between northern and southern services. Increasingly, PBCN Health Services is being strained to capacity and is continuously struggling to find innovative means to help the elderly.

The new practice

Many years ago, PBCN Health developed an organized and more structured home and community care program based on the needs identified by elders and their families. While this provided an excellent foundation for improved, culturally responsive services, it also became evident that we needed more networks and resources to support the diverse needs of the elderly.

We developed a Home and Community Care Service and Delivery Plan that helped identify short- and long-term strategies to enhance the federal First Nations and Inuit Home and Community Care (FNIHCC) program. Community resources were pooled for some services, and plans for serving the elderly were coordinated using all community services; a proper strategic plan for eldercare was a necessary next step. Improving access to primary health care was the critical factor for all PBCN health centres in the communities.

When an elder cannot come to the clinic, the home care staff either provides transportation or offers at-home nursing and home help; when needed, a doctor provides bedside care. When an elder needs to leave his or her community for care in the south, PBCN Health helps the caregivers, the family, and the patient bridge the north-south divide by assisting the elder's transition into the urban health care setting. PBCN Health has home care nurse assessors who advocate for, and work with, the elderly and their families to arrange long-term care or hospital care in conjunction with the home care director located in Prince Albert, which is the main urban setting for PBCN. Networking between the community health care providers and the urban (provincial) health care providers is fundamental to providing consistent, coordinated care. It is crucial for PBCN Health to help coordinate medical health information on behalf of the elderly so that the patient's most up-to-date information is shared with the urban health providers.

PBCN Health continues to ensure that trained, Cree-speaking, local home care aides and elder coordinators are available to help the elderly navigate the medical system and provide translation, transportation, and other support services.

Other focus areas include working with local agencies to help elders stay at home for as long as possible. For example, in the winter, wood and assistance with propane costs are provided to the elderly. An elder worker helps to provide transportation and organizes traditional and social activities like grocery shopping and blueberry picking.

Working together at the community level and coordinating the community and urban health providers are the crux of the shared caregiving approach.

Making a difference

From 2008 to 2010, PBCN Health did a small study on its PBCN elder care programs and services to explore how they could better facilitate the respect and dignity of the elderly during chronic and/or end-of-life care in the communities.

Results showed that the shared caregiving model helped the FNIHCC program to enhance its local services to the elderly, largely by good local planning and implementation, and by better coordinating services with urban hospitals and long-term care facilities. More elderly people in their late 80s are able to stay at home rather than being forced into urban facilities. The multi-level programs, including home care, offered in the PBCN health centres have helped promote independence in the elderly and allow them to remain at home for as long as possible. Although some elders have had to leave the community for long-term care or hospital care, PBCN health providers ensure that they don't fall through the cracks by linking community and urban health care services through coordination and advocacy.

It's noteworthy that the primary health model that PBCN promotes through the shared caregiving approach is aligned with health reforms occurring across Canada—reforms that go beyond the medical model and take into account other social and economic factors affecting health.

Research shows not only that working together can address complex jurisdictional issues, but also that broader policy and jurisdictional issues affecting local health services and infrastructure must be addressed at higher political and policy levels. The need to build long-term care facilities in the communities is a prime example, as is the need to coordinate services with the urban health care and long-term care providers. Furthermore, there has never been an Aboriginal elder care strategy at either the provincial or national level, but such a strategy is crucial for better organization, efficiency, and coordination of efforts.

Information provided by Arnette Weber-Beeds, Executive Director, Peter Ballantyne Health Services, and Bonita Beatty, Assistant Professor, Department of Native Studies and Co-Director, Graduate Studies, International Centre for Northern Governance and Development, University of Saskatchewan.

What changed

- ▶ improved quality of care for elders, including culturally safe care
- ▶ improved coordination across jurisdictions and health care providers
- ▶ better use of resources through collective efforts
- ▶ better supports for families

Key components

- ▶ a vision and focus on improving care of the elderly
- ▶ a stable, structured, and well-supported home and community care program
- ▶ enhanced services, which made a big difference
- ▶ talking with elders and their families to understand their needs
- ▶ culturally safe programming and activities
- ▶ networking and collaboration among agencies

Improving care and reducing isolation for elders

KO Telemedicine in northwestern Ontario

The need

Our catchment area includes communities in northwestern Ontario that are geographically isolated. They are culturally distinct and have less access to health care services and lower health status compared to the rest of Ontario. Most are fly-in communities without road access, which makes it more challenging and expensive to travel for health care. Some communities are so remote that sometimes clients cannot even travel to nursing stations to access telemedicine.

There is also the issue of the isolation of elders from community events as well as from their families. Many family members, such as adult children or siblings, move away from the community. It is very expensive for elders to travel, even if they are physically able to do so. Elders become lonely, and some are without caregivers to support them. If elders have difficulty leaving their homes they might not have access to care or to information about health and wellness topics, or even know which health care services are available. They need access to a full continuum of care, the opportunities to ask questions about any topic, and to be connected to their families and communities.

The new practice

KO Telemedicine is a First Nations-operated, not-for-profit organization affiliated with the Ontario Telemedicine Network (OTN). It serves 26 communities in the Sioux Lookout Zone of northwestern Ontario. It has won awards for its work, and has been recognized as a best Aboriginal practice in the country and in the world.

In our region, physicians and other health professionals visit communities if the weather permits, but it's very costly and time-consuming. Telemedicine—the use of information technology to link health care providers and patients onscreen—improves access to a range of health care services and professionals. It is especially valuable for follow-up care.

KO Telemedicine is as much about the people as the technology. In our region, community telemedicine coordinators are the cornerstone of our service. Supported by off-site health providers, they are the eyes and ears of what's happening in the community. Their roles are flexible and they are a great resource in so many ways. They often help with a range of tasks including translation, providing appointment reminders to clients, and technical assistance.

A lot of telemedicine is done at designated telemedicine sites such as nursing stations and health centres, but it can also be done in a person's home with a hand-held camera. We recently expanded this in-home service to include home care. A community telemedicine coordinator will take a camera into a client's home and move it around according to a health care provider's direction. This allows the health care provider to assess the safety of the environment and/or to see the patient up close. Assessments are done not only by doctors and nurses, but also by physiotherapists and occupational therapists who assess the need for assistive devices such as handrails, leg braces, walkers, and wheelchairs. A virtual social worker might also be involved to help explain things or to talk about the mental and emotional impact of a condition.

In-home cameras also allow us to link service providers together. For example, a home care nurse can be in the home virtually to support a personal care worker when he or she is doing a dressing change, or to provide advice on how to turn a patient. In-home cameras are being used for palliative care as well.

KO Telemedicine also plays a huge role in reducing the isolation of elders. We hold monthly Elders' Gatherings, where elders can visit virtually with family and elders who live in other communities. A medical van picks up the elders and brings them to different telemedicine locations. There, they meet onscreen with each other, family, and friends, and hear about educational health and wellness topics. It is a highly anticipated, social way of connecting with loved ones.

Making a difference

In general, elders have been accepting of telemedicine. Elders have told us there was a prophecy long ago that this type of technology would come. Telemedicine makes sense to them; they don't like to leave home, and travel is physically more challenging.

Telemedicine can make a huge difference in health care. KO Telemedicine heard from a family that wished it had known about our in-home service. An elder with diabetes and foot trouble refused to go to the nursing station because he believed they would tell him that he needed to leave the community for care. Finally, he became seriously ill and needed to have his toes amputated. He had to be medevaced out to a city hospital. The daughter stayed by his side, but the treatment took three weeks and she ended up losing her job. When they returned, they learned about the in-home service through the home care program, which could have provided wound care earlier on, and could have possibly prevented the escalation of his condition. There is more work to be done in terms of making people aware.

Telemedicine is not perfect—for example, the technology, the Internet, and the weather can sometimes make things unpredictable, but overall KO Telemedicine has had great success. Without question, telemedicine in general, and the in-home service specifically, has improved access to an integrated continuum of quality health care that's helping elders to stay in their homes longer. It also reduces costs. Overall, telemedicine reduces isolation, which improves health and well-being. In addition, providers and clients are very satisfied.

What changed

- ▶ reduced need to leave the community for care
- ▶ improved health outcomes
- ▶ improved provider, family, and patient confidence and satisfaction
- ▶ reduced isolation

Key components

- ▶ maintaining community telemedicine coordinators and a strong, supportive community team
- ▶ health care providers who realize the importance of telemedicine for elder care and who are willing to use the technology
- ▶ funding and partnerships to enable the growth and development of services

Building bridges between First Nations health care providers and the mainstream health care system

Mamaweswen, the North Shore Tribal Council, Ontario

The need

There was disconnect and a real gap in the communication flow when seniors were being discharged home from the hospital back to their First Nations community. No referrals were being made to community services to ensure follow-up care. Clients would return home after the hospital stay but community support services were not aware of the hospitalization or the need for follow-up care and assessment, homemaking services, assistive devices, and general support that would enable the clients to live independently.

The new practice

A partnership was formed between the North Shore Tribal Council (NSTC), the Indian Friendship Centre, and the Métis Nation of Ontario in Sault Ste. Marie to provide collaborative, integrated care and a client-centred case management approach to the senior population. We now have two First Nations system navigators/discharge planning nurses in place as part of the discharge teams at the hospitals in our region.

When seniors are admitted to the hospital, they are encouraged to identify as a First Nations, Aboriginal, or Métis senior—then they are referred to the service. If a client accepts our nurses' involvement, we have access to the chart and become part of their discharge team. The nurse works in collaboration with hospital staff, the Community Care Access Centre, the client and family, and the NSTC communities to assist in the client's transition back home. Some of the discharge planning nurses' roles include visiting clients at the bedside to assess needs; attending rounds and being a part of developing discharge plans; keeping clients and families informed about discharge information; helping clients to understand their conditions and how the discharge plan will help; advising the First Nations community support services of discharge dates and ensuring that services will be in place; and providing follow-up home visits to ensure that appointments with health care providers are in place and kept.

We were able to do this program because of provincial funding. The Tribal Council already has a comprehensive primary care program as well as a Community Support Services program for elders; this was a much-needed enhancement to our services. We submitted a proposal to our Local Health Integration Network (LHIN) under the province's Aging at Home Strategy. A requirement of applying for the provincial funding was to partner with other organizations. The NSTC invited both the Indian Friendship Centre and the Métis Nation in Sault Ste. Marie to be part of the provincial proposal.

We have established a very good working relationship with our LHIN and we meet regularly. When our LHIN initially started, they met with our Chief and Council and discussed programs and funding that we could access through LHINs. Our Chiefs approved working together with the LHIN, and said they would address the fiduciary responsibilities of the federal government at a different level. The politics were separated from the service delivery in order to work together to bring these services to our seniors.

Making a difference

Now when we have individuals in the hospital, we know who they are and when they are going home, and we are able to put services in place for their continued care at home. This program has also enabled us to look at what additional off-reserve services are available to wrap around their care, if required.

I think it was a real education for the hospital as well as the Community Care Access Centre to realize the level of services provided in our communities. We offer homemaking services, therapy services, and nurse practitioners, including a specialized geriatric nurse practitioner who can do assessments. We also provide linkages to mental health programs and to traditional health programs in the communities. Having us come in and be a part of discharge planning has helped break down barriers.

Our next steps are to track whether these efforts are reducing hospital readmissions. Also, we want our discharge planning services to be truly integrated within the health care system as part of the hospital admission and discharge process. Right now it's based on front-line workers' relationships; if those change, which happens because of staff turnover, then we're back to re-establishing those linkages with a new person.

It has also been difficult for one of our partner hospitals to feel comfortable with their staff asking questions about Aboriginal descent in order to identify people who need our services. It is also difficult for our seniors who go to the hospital and are asked that question for the first time. Their worry is that they will have to wait longer or that they'll receive substandard care if they say they're First Nations. There is still a perception of racism. We brought in a cultural worker to do training on cultural safety, and we're working with the hospitals around language—suggesting they say, for example, “If you are of Aboriginal ancestry, you would be eligible for this discharge planning service: would you like to receive it?” rather than “Are you an Aboriginal person?”

As part of our broader services for seniors, we are also looking at housing options in our communities. Our leadership had looked at the projected population and health issues and thought that a long-term care facility for First Nations was the answer. We commissioned a study and community consultation, and we came back with a new vision because the elders were saying, “Because of the residential school experience, we don't want to be institutionalized again. We want to stay home and we want to live in our own homes and in our own communities.” So instead, we've submitted a proposal for provincial funding for assisted living for high-risk seniors. The services would wrap around the individual's assessed needs, and there would be various levels of care in order to keep these seniors at home longer.

What changed

- ▶ improved quality of care for seniors—a smooth return home with services in place
- ▶ corrected misperceptions (by hospitals, CCAC, and First Nations and Métis clients) about services that are available on- and off-reserve
- ▶ better understanding, communication, and trust between hospital and communities

Key components

- ▶ service delivery kept separate from politics
- ▶ committed leadership
- ▶ partnerships built between on-reserve and urban service providers in order to provide hospital discharge services to First Nations and Métis seniors within the catchment area

Supporting Métis seniors and families

Métis Nation of Ontario community centres

The need

One third of all Aboriginal people in Canada are Métis. The Métis population is also one of the fastest growing populations in Canada, having doubled in the past 10 years or so. It is also an older population compared to other Aboriginal groups. From our research, we know that many of our seniors are experiencing significantly higher rates of chronic disease and other complex conditions compared to non-Métis Ontarians. Métis people also fall under a different legislative and regulatory structure than do other Aboriginal groups, and do not have access to programming supports such as the Non-Insured Health Benefits program. Many also live in more remote and rural areas.

These kinds of factors can sometimes prevent Métis seniors from receiving the proper health care and treatment they need. Many have limited incomes. Things like transportation to see doctors and specialists, as well as having the money to fill expensive prescriptions, can become a problem. Specialist care can also be an issue; for example, it can be difficult to obtain foot care for Métis people with diabetes. These kinds of services are often out of the reach of many Métis seniors because of social, geographical, and other barriers. This is especially true for those living in more rural and remote communities. Last but not least, access to culturally safe care is extremely important for our older Métis community members and, in fact, for the Métis community more generally.

The practice

It is for all these reasons and more that our Métis Nation of Ontario (MNO) community centres were developed. Situated in 18 historical Métis communities distributed across the province, MNO community centres serve as important cultural and service hubs that link our Métis citizens to each other, as well as to health services and supports in their local areas. The MNO community centres are especially important in providing our Métis seniors with the kinds of social and cultural supports they need, and with assistance in accessing medical services. Some of our centres also offer specialist services such as foot care clinics for seniors and other Métis people

suffering from diabetes. MNO community centre workers also do a lot of outreach to Métis seniors and other citizens in need of assistance, visiting their homes on a regular basis to help with things like meal preparation, house maintenance, and other tasks of daily living. As well, in some centres, we are now able to provide transportation services to help Métis seniors travel to their medical appointments. Most importantly, the MNO centres are based on a holistic, family-centred model of care for our senior citizens that has deep roots in our community-minded Métis culture and way of life. They provide much-needed and very tangible support to Métis senior citizens who are at heightened risk of falling through the cracks in our complex health care system.

Making a difference

For the many Métis seniors and other community members who are suffering from significantly higher rates of chronic diseases and conditions, MNO community centres provide a place where they meet with other Métis community members, receive appropriate support and care, and get help in linking to essential services and programs in the broader community. The centres also provide a haven for culturally safe community care.

The MNO service model is unique in the province in both its scope and conceptualization, and has been hailed as a best practice. MNO's programs and services receive provincial support through a number of ministries, including the Ministry of Health and Long-Term Care's Community Support Services Program, the Ministry of Aboriginal Affairs, and the Ministry of Children and Youth Services, among others. Programs and services are also supported by the MNO's large volunteer base, which includes the Métis Provincial Councils, the Youth Council, and Métis Senators. Together, the centres provide critical support for Métis seniors, particularly those in more rural and remote areas who might not otherwise be able to benefit from essential health services and programs because of social, cultural, and geographical barriers.

As the MNO continues to build its community centre programming, we are looking to strengthen our local care networks for Métis seniors and other citizens, as well as MNO prevention and health promotion programming and services. From our research we know that chronic disease and complex conditions are particular issues for our senior community members, and this will be an important focus area for us as we move forward, as will knowledge translation more generally. We are now providing specific training to our Community Support Services on chronic disease, for example, and are exploring ways to enhance our outreach and in-home supports to enable seniors to live independently and stay in their homes longer.

What changed

- ▶ improved health and well-being for Métis seniors
- ▶ better access to culturally appropriate and safe care for seniors, both in their communities and in their homes
- ▶ enhanced Métis community support in the form of cultural programming and activities offered through the centres
- ▶ minimized the cultural and social isolation and loneliness that so many seniors experience
- ▶ increased awareness of Ontario Métis culture and people, and their unique history, needs, and aspirations

Key components

- ▶ Métis seniors and other clients are involved in the development and delivery of programs and services to ensure that their health and broader well-being needs are met
- ▶ culturally appropriate and safe care
- ▶ committed leadership combined with the ability to build effective teams
- ▶ appropriate training for all staff and volunteers involved in care and service delivery
- ▶ adopting a “determinants of health” and holistic approach to developing and delivering programs and services that are grounded in Métis community and culture, and built around identified client needs
- ▶ reaching out to Métis seniors who, because of significant cultural, social, and geographical barriers, may not otherwise have access to the care and supports they need to live healthy, independent lives

Bringing chronic disease self-management to rural and remote regions

Rocher-Percé, Quebec

The need

Our population is estimated at around 17,000 people who are scattered along the coastline and throughout the vast territory of Rocher-Percé. Approximately 60% of our clients are seniors. Chronic diseases are a significant problem, with risk factors such as obesity, hypertension, high cholesterol levels, a sedentary lifestyle, alcohol abuse, and smoking.

Accessing treatment is also a problem, especially for people with cardiovascular disease, pulmonary disease, diabetes, and renal disease. We have a small team at the health centre (centre de santé et des services sociaux du Rocher-Percé) with limited capacity and resources—specialized resources are far away. Clients travel to Montreal and Quebec City. Even Rimouski, which is the closest place, is a five-hour drive away.

Our clients were overloading the hospital emergency room, which is a very costly experience. And we know from our clients and the hospital directors that programs were not operating efficiently. For example, there were separate clinics to treat each chronic disease. Not only was it an ineffective approach for the clients because they had multiple chronic diseases, it was also an inefficient use of staff resources. In most cases there would be two or three different nurses working on the same client, but they weren't communicating among themselves. So, the nurse looking after someone with diabetes didn't know that her client was also being followed by another nurse for another condition. Sometimes the client became mixed up with appointments and with care regimens.

The new practice

It started with a Pfizer company representative who met with our director and told us that Pfizer had a funding program in partnership with the Government of Quebec for new and innovative chronic disease programs. He suggested that we put in a proposal. So we developed a program not only to treat our clientele, but also to transform an outdated, "siloed," and reactive service delivery model. We based it on the internationally recognized Chronic Care Model (www.improvingchroniccare.org).

We focused on bringing services closer to clients in their communities through a partnership and team-based model. We are teaching our clients to understand their health and to take responsibility and control (with our help to get them started).

We created a three-month intensive program that takes a holistic look at the client. Rather than having different treatment plans for each chronic condition, our interdisciplinary team (dietitian, registered nurse, and kinesiologist) develops a treatment plan together to effectively address all of the client's conditions. The team receives a referral from the doctor, and then there is follow-up communication about every third week when the team reports on information, such as blood pressure and diabetes status, and makes medication adjustments.

The program includes a focus on a healthy lifestyle (exercise, good nutrition) and we educate our clients (in groups) so they better understand their health situation. The program involves seeing our clients twice a week at a clinic or at a local gym in their community—so it's like a mobile clinic. After the three months, we remain available to our clients but we see them less often so that we can start up a new group.

It's a first for a rural and remote region to have this kind of program. This kind of intensive follow-up is typically only available in specialized health centres, which are far away and difficult for our clients to access.

Let me give you an example of just how intensive the program is. We don't only teach clients what to do; we make them do it in front of us so that we see everything that touches their healthy lifestyle—the exercise, the nutrition, and the medication management. Also we teach them about their disease—for example, how diabetes works in the body and what it does to the different organs. Clients come with a list of their daily eating habits and they bring in their food products so we can read the labels together. We're trying to make them proactive in their treatment so they understand why a particular food is, or isn't, a good choice. The dietitian talks about what they should and shouldn't eat, and we give them written information to take away. At the end of our three-month intensive follow-up, the dietitian travels with the client to the grocery store to discuss any questions about food products.

Making a difference

Since we see clients twice a week for three months, it's long enough for them to include this new healthy lifestyle into their everyday life, and it's having an impact on their health. For example, a 66-year-old man who had a very low heart ejection fraction (a measure of heart function) was supposed to have an operation to implant a pacemaker and defibrillator, but he heard about our program and was interested in trying it first. During his three months with our program, his ejection fraction went from 13% to 48%, which is close to normal. He continues to be in good health and has not had an operation to date.

In another case, a man who visited the emergency room approximately twice a week was referred to us. It's been about a year and he hasn't been to the emergency room since he's been under the care of our team.

We've also seen reduced use of medication, reduced levels of hypertension, reduced cholesterol levels, better-controlled diabetes, weight loss, and a change of lifestyle, including less smoking.

Physicians view the program positively because they no longer need to see their patients every month. They may see them every three months if they're really sick, otherwise once a year.

The program also makes very good use of resources. Initially, it was funded only for two years (ending in January 2013), but we continue to operate because the health centre liked our results and decided to integrate all of the different chronic disease programs into one. As a result, we were able to reallocate money. We're also able to spend more time with clients because we don't have separate staff for each program.

There's a lot of interest in our program. The Government of Quebec is interested in spreading it across the province. And the Government of Canada, specifically the First Nations and Inuit Home and Community Care program, is also interested because they believe it is applicable to rural and remote First Nations and Inuit communities.

Information was provided by Tim Sutton, a kinesiologist and clinical team leader in chronic disease management at the Rocher-Percé health centre (Centre de santé et de services sociaux du Rocher-Percé).

What changed

- ▶ improved access to care
- ▶ improved health outcomes for clients
- ▶ improved efficiency and effectiveness of care delivery
- ▶ the ability to manage multiple chronic conditions
- ▶ improved satisfaction among health care providers

Key components

- ▶ partnerships—with Pfizer, the Government of Quebec, and local gyms
- ▶ interdisciplinary team-based care
- ▶ a best-practice model that empowers clients to manage their chronic diseases
- ▶ intensive follow-up with clients

Adapting the Non-Insured Health Benefits program to meet the needs of First Nations elders

First Nations and Inuit Health Branch, Health Canada-Atlantic region

The need

Elders have expressed a number of ongoing issues about programs and services of the First Nations and Inuit Health Branch (FNIHB)–Atlantic region. As part of a new *Strategic Action Plan for Atlantic First Nations Elder Care*, the FNIHB–Atlantic region is working to improve existing programs and services.

FNIHB–Atlantic has a co-management (i.e. shared decision-making) committee with the Atlantic First Nations Chiefs, called the Mi'kmaq Maliseet Atlantic Health Board. In 2007, the health board established priorities that included elder care. The focus of the strategic plan includes identifying and supporting local options to keep First Nations elders in the community for as long as possible, as well as addressing cultural competency, quality of care, and access to family for those who are admitted to long-term care facilities off-reserve.

The new practice

A first priority was to look at the Non-Insured Health Benefits (NIHB) program. Policies and requirements associated with the program are established mainly at the national level and cannot be easily changed. The program was reviewed from the perspective of whether the region had any flexibility to make changes for the benefit of elders' health and well-being.

A “policy lens” tool was created called the Elder Care Assessment Tool. The process began with identifying what aspects of the program are within the region's discretion to design or modify. Based on elders' issues with the NIHB program, and what they need for their health and well-being, areas for improvement were identified and considered against potential options the region may have to make recommendations.

In a pilot test, the policy tool was applied to the medical transportation component of the NIHB program. One of several issues that elders had identified was the requirement for pre-approval to cover the travel costs of “non-medical” escorts—usually a family member or friend—to travel with them to appointments. Prior to the review, all First Nations people required pre-approval for every single appointment. For elders with complex health needs and multiple doctors, or whose first language is not English, this could mean a lot of paperwork.

As a result of applying the elder care assessment tool, it was learned that while a regional branch of FNIHB could not remove the pre-approval requirement, there was some flexibility to change the procedure for people with chronic health problems or translation needs. Now, they only need to seek pre-approval once a year to have a non-medical escort accompany them to all their appointments. Also, there was a change to the request form so that it was clearer, with easy-to-answer questions, enabling staff to quickly determine whether someone is eligible.

Another area that was explored for improvements was elders' access to prescribed medications. Some medications are covered automatically, but others need to be approved for coverage by the NIHB Drug Exception Centre in Ottawa. The pharmacist needs to call to initiate the review, and then the Drug Exception Centre will send paperwork to the health professional who prescribed the medication. Sometimes there is a breakdown in the process—for example, pharmacists don't call the Drug Exception Centre to ask for a review, or prescribers don't fill out the paperwork. The result is that the elder is denied coverage for the medication, and they must pay for it themselves or have their band pay with money from another program.

FNIHB–Atlantic looked at the medications that were rejected for payment to identify the top medications being requested, and learned that most were approved once they were reviewed at the Drug Exception Centre. In those instances where the pharmacist didn't call, the regional pharmacist in the FNIHB office contacted the pharmacies and reminded them about the process. The regional pharmacist also sent the results of this work to a pharmacy working group at NIHB headquarters in Ottawa, to support policy change for commonly requested medications. The regional pharmacist also created formularies that identified appropriate substitutions for common medications, so that if someone is prescribed a drug that requires a call to the Drug Exception Centre, pharmacists can choose an alternate that is automatically covered by NIHB.

Making a difference

Once it became evident that the Elder Care Assessment Tool had the potential to make a real difference in the lives of First Nations elders, the regional office became very enthusiastic and motivated to promote the success. It was because of this tool that was possible to identify that FNIHB–Atlantic did in fact have flexibility to adjust the procedure for medical transportation, and to think creatively about what else could be done to increase flexibility while at the same time adhering to national policies.

A lot of work remains, and the Elder Care Assessment Tool is still in its infancy, but already FNIH–Atlantic staff and the First Nations partners are developing a strong sense of shared commitment to and responsibility for elders' health.

There are still aspects of programs that cannot be changed easily like national policies and requirements, but conversations with First Nations partners are slowly evolving for the better. More time is now spent in discussions with the health board and other First Nations partners on what FNIHB–Atlantic can change, and on finding creative ways to be more flexible for the benefit of elders' health and well-being.

As a result of this policy tool and other evaluation and quality improvement initiatives taking place within FNIHB nationally, changes to the way the FNIHB–Atlantic region works and changes to policies and programs are beginning to be implemented.

Following the successful pilot test of the Elder Care Assessment Tool, the regional office has committed to completing at least one program review per year. A review of the Aboriginal Diabetes Initiative is underway and is expected to be completed this year. The joint working group of the regional office and First Nations leadership that created the *Strategic Action Plan for Atlantic First Nations Elder Care* will determine which program should be up next.

What changed

- ▶ simplified process and paperwork for non-medical escorts
- ▶ fewer medications declined for coverage

Key components

- ▶ partnership and joint working group with First Nations
- ▶ new Elder Care Assessment Tool used to review policies and procedures
- ▶ flexibility for regional office to make changes to procedures while still working within overall national policies

Community health aides help with nursing shortages and cultural safety

Nunatsiavut

The need

We were having difficulty recruiting and retaining nurses. We were also concerned about the continuity of care for the residents of Nunatsiavut, especially the seniors receiving services through the Home and Community Care program.

The new practice

The Community Health Aide model borrows from Labrador in the past and from Alaska in the present, where community health aides deliver primary health care in remote communities. A new position was created out of necessity, allowing Nunatsiavut to deliver culturally safe, cost-effective care. Where there were two nurses, we now have one nurse and one aide, a skill mix that provides continuity of care.

When the Grenfell Mission first came to Labrador, the doctors and nurses hired local women “aides” to assist in all areas of care. The tradition continued and, in 1996, when the Labrador Inuit Association assumed responsibility for nursing in what is now Nunatsiavut, the community health aides came over as well.

The community health aide has an expanded role in both public health and home and community care. The aides are from the community and bring the language and cultural knowledge that is essential for safe practice.

In the Home and Community Care program, the community health aides function as the nurses’ “right hands” because they fill so many roles, such as being supporters, cultural advisors, and planners. They manage the home support workers, go with the nurse to client visits as needed, order equipment and supplies, schedule appointments, sterilize equipment, complete month-end reports, and anything else that doesn’t require a nurse to do. The nurse is then able to concentrate on direct client care. The aides also do independent home visiting to support the programs, both when a nurse is in town and when the position is vacant.

Just as important, the aides are the cultural advisors to new nurses. They are so trusted in the community that any new nurse is immediately accepted if accompanied by the aide. The aides know everything about the people in the community, including where to find them on any particular day to ensure they come to appointments. Sometimes a new nurse will come in and want to set up a clinic on a certain day, and the community health aide will be the one to tell her it’s the wrong week because it’s duck-hunting season, or that there is a community event going on at that time. You can’t underestimate the value of this relationship.

We have had periods without a nurse in a community, and the community health aide has been our eyes and ears. She would call and say, “This person is deteriorating. This person needs to be reassessed. You need to send a nurse in.” And then when the nurse went in, her work was much more focused because everything had been pre-planned by the aide. The appointments had been made. Everything was set up.

From an elder care perspective, the aides can spend more time with elders than the nurses do; also, they have those personal connections and speak the language. Often elders are alone in their communities because their families have moved away. Community health aides are advocates for elders and they’ll support them with a range of issues including elder abuse, which is a big problem, especially financial abuse. We have also given the community health aides tours of the regional health and long-term care centres in Happy Valley-Goose Bay so that they can describe them to elders and their families and help them become comfortable with the transition.

Making a difference

There is no question about value. We have a challenge recruiting and retaining nurses, and this aide position has allowed us to manage with fewer nurses. For example, in our largest community, instead of having three nurses and one aide, we have two nurses and two aides. We've even been able to maintain programming in a community with no nurse. And the community health aides are a very stable workforce. They live in the community, are committed to the community, and they love their jobs, so there is no turnover. If someone ever does leave, there are people waiting for these jobs.

It's hard to quantify or even to put into words the value they bring—essentially, we would not be able to deliver care without them and clients would not be as willing to receive care. What has enabled the success of the community health aide role is the fact that we are self-governing, so we can be flexible and innovative and develop roles that meet our communities' needs.

This model would work well in other communities. It's hard to understand why it hasn't spread to other parts of the country, particularly since it's also well known in Alaska. I think there's almost a strange fear that by allowing this kind of practice we're encouraging people to be community health aides instead of going into the health professions, but that's not what it's about at all. There is an incredibly valuable role for these people at the community level that no one else can fill like they do, and it just enhances service delivery.

What changed

- ▶ improved well-being of elders, including the ability to remain in their homes in their communities
- ▶ improved recruitment and retention in the Home and Community Care program
- ▶ the ability to deliver the home and community care and public health programs and services needed by the communities

Key components

- ▶ creating the community health aide role, training aides as necessary, being innovative with their roles, and reducing nursing positions for optimal service delivery—enabled by self-governance and a non-unionized environment
- ▶ building on what was already working well in public health
- ▶ hiring Inuit people from the community who have a vested interest in the health and well-being of others in their community

Integrating culture into care

Continuing Care and Independent Living Program, Tlicho Community Service Agency, Northwest Territories

The need

Culture is a critical part of the effectiveness of all health and social service programs. As part of the transition to self-government in 2005, a Tlicho Cosmology Project was developed to help initiate discussion about what culture means for the Tlicho people and to apply this knowledge to modern organizations and programs.

Culture includes stories, legends, rituals, celebrations and practices, taboos, songs, drum dances, child-rearing practices, hunting practices, roles and responsibilities, expectations of leaders, forms of punishment, teaching methods, and how to relate to outsiders—every aspect of how to live one's life.

Cosmology was successfully integrated into a variety of program areas and there was interest in trialing it within the Home and Continuing Care program to enhance its cultural component. There was also a need for new staff roles and training to put cosmology into practice and to expand staff skills and enhance programming.

The new practice

Continuing Care and Independent Living is a program of the Tlicho Community Services Agency (TCSA), which provides the management, administration, and delivery of three program areas—education, health care, and social services—in the four Tlicho communities.

The TCSA is the only authority that combines the functions of a health authority and an education council in the Northwest Territories. So, you can see that we take a holistic approach to the delivery of our programs.

The Continuing Care and Independent Living program includes the following services: continuing care, home care, a day program and a recreational activity program for elders, independent assisted living, medical social work, adult foster homes, and Meals on Wheels. A new position called Manager of Continuing Care and Independent Living was created, and I was hired to fill this role. I am a social worker by training and I am Tlicho, from the community. The new role integrates social work, clinical practice, and a cultural component into a medical model of care. I work with coordinators in all of the program areas to apply cosmology to the programming.

Here are some examples of our work: We did some fundraising through a partnership with the territorial government, the community government, the Friendship Centre, and a local gas station for an elders' five-day spiritual gathering that required traditional food. We bought fish, muskrats, and beavertail. We hired a young adult and provided him with \$200 to buy ammunition to hunt a caribou. He brought it back for the elders to inspect, clean, and cook, and to teach other community members about traditional food preparation and about the ceremonies associated with feasts. Traditional food is very important to elders—not only because the food is of high quality, high in protein, and really fresh, tender, and healthy, but also because of the cooking and cleaning activities that are required.

The TCSA worked with Health Canada to develop and approve a Traditional Food and Diet Policy that basically says that elders have the expertise to determine when an animal is safe to eat. It was quite an effort to get Health Canada on board. We also established the position of Elder's Day Coordinator to oversee elders spending time on the land and in traditional activities such as snaring rabbits, berry picking, and caribou hunting. The coordinator also arranges to bring youth and elders together for games and drumming. The elders really participate by clapping and moving their feet—it's very enjoyable for them and keeps them moving and busy.

Another key area has been the hiring and training of local Tlicho staff. All staff in long-term care and the Continuing Care and Independent Living program are Tlicho, which means elders can communicate with staff. We provide additional training that allows personal support workers to give injections. They become residential care aide workers. They've been tremendously valuable as a back-up to the nurses because we don't have a 24-hour nursing service—it's allowed elders to remain in their community. Without this new staff role, one gentleman who was receiving palliative care would have had to go to a long-term care facility outside of the community.

Last year we started an eight-month program to train students as personal support workers in the community. A trainer from one of the colleges came to the community, and she's living right here in the school. The program is supported by the Tlicho government. Hiring local people has positive impacts on staff retention.

The Tlicho government strongly believes in increasing the knowledge and skills of front-line staff in all health, social, and education program areas so that all services will improve health. So the government funds the Tlicho Community Action Research Team (CART, <http://tlichocart.com/about/>). This is a collaborative project with university-based researchers who conduct “research-to-action” projects to find solutions to health problems and then translate this information into teaching materials for providers. The materials integrate the Tlicho values and beliefs. For example, we have a problem with diabetes in the community and CART developed an Aboriginal Diabetes Initiative. It's based on a First Nations-owned program in Quebec, and we are now training staff on this program.

Making a difference

We held a community consultation to receive feedback on these initiatives, and the results were very positive. Elders enjoy the community activities; they keep them healthy, happy, and more independent. Hiring and training local people has had very positive impacts on staff retention. Our capacity to fill gaps in care has improved, and our waiting list for long-term care has shortened to only one or two people because we are able to keep people in their homes longer. The cultural component is now embedded in our programs and services.

We are always trying out new ideas, and two important changes are fast approaching. First, our old Seniors Home is being replaced by a larger facility. The second change will take longer, but it will be very important to how we deliver long-term care. The Tlicho government has notified the Government of the NWT (GNWT) and the federal Minister of Aboriginal Affairs that it wants to negotiate changes to the Intergovernmental Services Agreement (ISA), which lays out the arrangements by which the TCSA delivers GNWT education, health, and social programs in our communities.

What changed

- ▶ elders are able to remain in their communities and in their homes longer
- ▶ gaps in care are filled and long-term care wait times have been reduced
- ▶ elders are participating in traditional activities, which benefits their well-being

Key components

- ▶ self-government allows for flexible development of programs to meet community needs
- ▶ committed First Nations leadership provides guidance
- ▶ the Cosmology Project provides a holistic framework that guides the development of programs and services
- ▶ the collaborative CART project brings best practice research and programs into the community and then integrates them with the traditions and values of the Tlicho people
- ▶ support from leadership to train personal support workers to provide injections
- ▶ hiring and training local staff to improve retention

Youth caring for elders, and preventing elder abuse

Carcross/Tagish First Nation Health and Wellness Department, Yukon

The need

Our major concern was the need to build family and community capacity to care for elders, in order to more effectively meet elders' needs and relieve some of the workload burden on the home care program. Families just weren't stepping up to take care of elders. There were also concerns about elder abuse.

We also needed to improve collaboration between the home care program and families, and among the different types of workers in the home care program.

We wanted to address these needs in keeping with the philosophy of the Carcross/Tagish First Nation government, which is to value and care for seniors by drawing on community assets and traditional ways of being.

The new practice

We've taken a few different approaches to bring elders' needs to the forefront, and we've come up with "out of the box" solutions. Self-government has meant that we have the flexibility to meet our community's needs in the way we think will work best.

About two years ago, we implemented a Transitional Employment Program for youth in order to break the generational cycle of dependence on social assistance. The program was based on a model in the United States called ROCA (<http://rocainc.org/>). It is an evidence-based model that seeks out and helps the most difficult and challenging youth who are unable or unwilling to work or go to school. Because of our need to build capacity in caring for elders, we decided to put elders' needs first when identifying work opportunities for youth.

Youth are assigned to an outreach worker and together they develop a case plan to identify goals and aspirations for education and experience. Some examples of the work that youth do for elders include collecting, cutting, and stacking wood to heat their homes; making sure that snow is removed from their driveways; maintaining their yards; checking their houses for safety issues and doing repairs; putting up handrails; and helping elders with tanning hides.

In exchange, the youth are paid well (\$15 an hour) and receive a job reference to help them get on track. They've learned that they have to show up to work on time and that they cannot show up drunk or hung over. And they've learned that it's not called "social assistance" but "temporary assistance"—it's not a way of life but it is there to help people who are temporarily in difficult situations.

We also knew that elders were suffering abuse at the hands of their family members—primarily financial abuse by an adult child or grandchild. They were spending their temporary financial assistance on alcohol and drugs, then staying with their grandparent(s) and expecting them to feed and shelter them.

We use a couple of different strategies. We contact family members to let them know what we are seeing and if necessary we speak to the perpetrators directly. We're not going to just sweep things under the carpet and pretend they're not happening. It's not going to be tolerated and we'll bring it to the forefront if we have to.

In more extreme situations, if the abuse doesn't stop, rather than giving the family member their temporary financial assistance cheque (which comes from the First Nation government), the elder is provided with money for the family member's room and board. We put the rest of the cheque into the form of a purchase order (PO) at the store to ensure that the money is spent on food. If necessary, we even take it a step further and divide the purchase order in half, so that only half of the PO is spent in the first two weeks of the month and then the other half in the last two weeks. Otherwise, if all of the food was purchased at once, the family member could sell the food for cash. We will put the PO in an outreach worker's name if we suspect the client is selling the PO and will also visit the elder to see what kind of food they need for the household. It seems fairly drastic, and we only do this when absolutely necessary, but we've managed to cover all possibilities to protect the elders and ensure that they have food and that their housing needs are covered.

We've also strengthened the Outreach Program to enhance elders' ability to live well in their homes as long as possible. The staff work collaboratively with families to help them better

understand and fulfill their responsibilities to their elders. They also go out to visit with elders in their homes to hear about their concerns and needs. We purchased a couple of vehicles to take elders to their medical appointments, and outreach workers go along as advocates and make sure the information is being understood correctly.

In the last year, we also started organizing a weekly tea that brings together elders and non-indigenous seniors in the Carcross community. It's been a tremendous experience; people who've been neighbours for years but have never socialized are now becoming friends. Traditional activities such as berry picking are also being organized.

We also have interagency meetings once a month where our Health and Wellness Department meets with other agencies to make sure we collaborate better. We've also built the capacity of home care workers with training activities, and we pay staff well in order to support retention.

Making a difference

The Transitional Employment Program has made a big difference in helping elders remain in their homes. They have wood to heat their homes and their homes are safer. The elders are also happier and less frustrated because they can get out in winter, now that their driveways are cleared sooner. The youth are making progress in terms of becoming responsible, and they are able to apply for jobs outside of the First Nations community because they have a job reference.

Although it is relatively new, the PO strategy appears to be working. The outreach workers see that there is food in the homes and the elders are happier.

Overall, we've been able to encourage more responsibility (especially on the part of families) for elders and their care. Family members appreciate the shared responsibility and feel less stress because they are relieved to know there is a team of people involved in the well-being of their elders. This gives them the motivation to be involved because it's not so overwhelming.

Information provided by Nina Bolton, Director, and Roberta Shepherd, Outreach Program Manager, Carcross/Tagish First Nation Health and Wellness Department.

What changed

- ▶ elders are better taken care of, with food and housing needs looked after
- ▶ elders feel happier and less isolated, with family support and new friendships
- ▶ everyone is working as a team to support elders—families, outreach workers, home care workers, mental health workers, and other community agencies

Key components

- ▶ self-government and great support from the First Nations government for the elders and for the outreach and home care workers
- ▶ everyone is in agreement that elders' needs are a priority
- ▶ teamwork and lots of communication

Appendix

List of practices discussed by participants

This list provides the majority of practices discussed at the Health Council's sessions and during the key informant interviews with senior government officials and First Nations, Inuit, and Métis organizations. Wherever possible, we have provided links to websites.

National

- ▶ Online education for community-based health care providers means they can receive culturally appropriate elder care training without leaving their communities – Saint Elizabeth @YourSide Colleague First Nation Elder Care Course. National. <http://www.saintelizabeth.com/FNIM/Home.aspx>
 - ▶ The federal First Nations and Inuit Home and Community Care program seeded innovative initiatives and helps seniors remain in their communities. National. <http://hc-sc.gc.ca/fniiah-spnia/services/home-domicile/index-eng.php>
 - ▶ The Aboriginal Affairs and Northern Development Canada Assisted Living program helps meet the health care needs of older Aboriginal people. National. <http://www.aadnc-aandc.gc.ca/eng/1100100035250/1100100035251>
 - ▶ Inuit Tapiriit Kanatami, the national Inuit organization in Canada, addresses issues of concern regarding the health and well-being of elders. National. <https://www.itk.ca/>
 - ▶ The National Association of Aboriginal Friendship Centres held a Fostering Biimaadziwin ("the good life") National Research Conference on Urban Aboriginal Peoples that focused on elder care, providing a knowledge exchange that will improve Aboriginal seniors' health. National. <http://www.naho.ca/blog/2011/02/04/fostering-biimaadziwin-national-research-conference-on-urban-aboriginal-peoples/>
 - ▶ New Horizons for Seniors is a proposal-driven program in which projects are led or inspired by seniors. This initiative helps develop community-based programs and incorporates traditional activities. National. <http://www.hrsdc.gc.ca/eng/seniors/funding/index.shtml>
 - ▶ The Canadian Home Care Association produced a document on promising practices in Aboriginal home care and works with the First Nations and Inuit Home and Community Care program (FNIHCC) to improve home care. National. <http://www.cdnhomecare.ca/content.php?sec=0>
 - ▶ HelpAge Canada is the country's only organization dedicated exclusively to helping older people in Canada and the developing world. It has played a key role in helping to develop seniors societies in the North. National. <http://helpagecanada.ca/>
- ### British Columbia
- ▶ The First Nations Health Authority (FNHA) is moving forward with transformative change with a focus on wellness and through partnerships with the federal and provincial governments and regional health authorities. British Columbia. <http://www.fnhc.ca/>
 - ▶ Carrier Sekani Family Services uses telehealth to enhance access to primary care and continuity of care in remote First Nations communities in north-central British Columbia. <http://www.csfs.org/>
 - ▶ In Bella Coola there is one home care program for everyone, whether they live on- or off-reserve, to ensure equal access to care. British Columbia. http://www.vch.ca/locations_and_services/find_health_services/residential_care/coast_garibaldi/bella_coola_general_hospital/
 - ▶ In the Bella Bella region, seniors in remote communities have access to a range of integrated services through travelling teams, portable technology, and telehealth. British Columbia. <http://www.rccbc.ca/Bella-Bella/hospital-and-healthcare-centre-information>
 - ▶ The Saanich First Nations' Adult Care Society addresses gaps in care for elders and disabled people in First Nations communities on Vancouver Island. British Columbia. <http://www.yellowpages.ca/bus/British-Columbia/Brentwood-Bay/Saanich-First-Nations-Adult-Care-Society/2513713.html>
 - ▶ The British Columbia Association of Aboriginal Friendship Centres provides important urban services for Aboriginal seniors and others. British Columbia. <http://www.bcaafc.com/>
 - ▶ The government of British Columbia partnered with the United Way to improve non-medical home support services to First Nations communities. British Columbia. <http://www.betterathome.ca/>
 - ▶ The Aboriginal Health Team project at Interior Health supports integrated care, navigators, and community development. British Columbia. <http://www.interiorhealth.ca/Pages/default.aspx>
 - ▶ The Home and Community Health Program run by the North Peace Tribal Council provides home and community health care on-reserve to prevent clients from falling through gaps. British Columbia. <http://www.nptc.ca/index.php?q=home-community-care>
 - ▶ The First Nations ReAct tool was developed in partnership between home care and mental health services. It supports the recognition and awareness of elder abuse. British Columbia, Saskatchewan. http://www.vchreact.ca/aboriginal_manual.htm
 - ▶ Q'wemtsin Health Society developed a home and community care program to help seniors maintain their independence. British Columbia. <http://www.qwemtsin.org/>
 - ▶ Métis Nation BC works in partnership with other organizations to meet the needs of elders. British Columbia. <http://www.mnbc.ca/>
- ### Alberta
- ▶ Providing integrated services to elders on-reserve, Siksika Health Services allows seniors to remain comfortably and safely in their homes for longer. Alberta. <http://www.siksikahealth.com/index.html>
 - ▶ The Royal Alexandra Hospital's Aboriginal care coordinators and case management approach improve coordinated care in a hospital environment for First Nations and Métis people – Alberta Health Services. Alberta. <http://www.albertahealthservices.ca/facilities.asp?pid=facility&rid=6598>
 - ▶ Alexander First Nation built a facility for seniors, and through a memorandum of understanding with Capital Health provides beds for seniors who are not part of the community. Alberta. <http://www.alexanderfn.com/>

- ▶ The Aboriginal Diabetes Wellness program at the Royal Alexandra Hospital improves care for seniors and others. Alberta. <http://www.albertahealthservices.ca/facilities.asp?pid=facility&rid=6598>
- ▶ The Alberta Region of Health Canada's First Nations and Inuit Health Branch successfully piloted InterRAI in six communities according to the principles of ownership, control, access, and possession (OCAP), and a toolkit is now available nationwide for all First Nations. Alberta. <http://hc-sc.gc.ca/ahc-asc/branch-dirgen/rapb-dgrp/reg/al-eng.php>
- ▶ The Métis Elder Abuse Awareness Program raises awareness about elder abuse and about who the Métis people are. Alberta. <http://metiselder.wordpress.com/>

Saskatchewan

- ▶ Shared caregiving in the community improves care for the elderly, reduces the burden on families, and improves the coordination of culturally safe care – Peter Ballantyne Cree Nation. Saskatchewan. <http://www.peterballantyne.ca/index.html>
- ▶ The Aboriginal Home Care Program in the Regina Qu'Appelle Health Region is improving culturally safe home care services for First Nations and Métis people. Saskatchewan. http://www.rqhealth.ca/programs/comm_hlth_services/homecare/homecare.shtml
- ▶ The Saskatchewan First Nations Aboriginal Diabetes Initiative Action Plan reduces the incidence and effects of type 2 diabetes in First Nations people – First Nations and Inuit Health Branch, Saskatchewan region. <http://www.hc-sc.gc.ca/contact/fniab-spnia/fnih-spni/rd-dr-eng.php>
- ▶ The Collaborative Practice Model pilot program supported chronic disease prevention and management through collaboration among the First Nations and Inuit Health Branch (SK Region), the Kidney Foundation of Canada (Saskatchewan), the Regina Qu'Appelle Health Region, and three First Nations communities (Cowessess First Nation, Gordon First Nation, and Muskowekwan First Nation). Saskatchewan. <http://www.kidney.ca/saskatchewan>
- ▶ The Discharge Planning Toolkit of the Federation of Saskatchewan Indian Nations supports continuity in care from hospital to community. Saskatchewan. <http://www.fsin.com/>
- ▶ The Standing Buffalo long-term care facility in Fort Qu'Appelle provides long-term care on-reserve for First Nations elders. Saskatchewan. <http://www.rqhealth.ca/programs/aboriginal/communities.shtml>
- ▶ The Lac La Ronge Indian Band has elder care facilities, including long-term care, in three of their communities on-reserve. Saskatchewan. <http://llrib.org/>
- ▶ White Bear First Nations has a multi-use elder care facility including home and community care on-reserve, and an elder facility adapted to enable children's programming. Saskatchewan. <http://whitebearfirstnation.ca/>
- ▶ Onion Lake Cree Nation has an elder care facility, home and community care, and traditional and community supports on-reserve. Saskatchewan. <http://www.onionlake.ca/>
- ▶ Battlefords Tribal Council Indian Health Services coordinates health services between First Nations and the local health region. It also provides chronic disease management, home support, and health and social programs. Saskatchewan. <http://battlefordtribalcouncil.ca/en/pages/111>
- ▶ The Meadow Lake Tribal Council Health and Social Development Authority includes an Elders Advisory Council and provides home and community care, traditional supports, and community supports in a remote northern region. Saskatchewan. http://www.ehealth-north.sk.ca/tribal_council.aspx?m=4&dir=4&tc=19
- ▶ Saskatoon Health Region's Aboriginal Health Strategy 2010–2015 addresses the needs of the elderly. Saskatchewan. http://www.saskatoonhealthregion.ca/about_us/aboriginal_health_strategy.htm
- ▶ The Prince Albert Grand Council Health and Social Development Office works in partnership with the Prince Albert Parkland Health District on elder care including home care. Saskatchewan. <http://www.ehealth-north.sk.ca/contactus.aspx?m=7>

Manitoba

- ▶ The Manitoba Métis Federation is recognized for its programs, services, and reports that improve the health and well-being of Métis people, particularly its research on aging in place. Manitoba. <http://www.mmf.mb.ca/>
- ▶ The Southeast Personal Care Home supports culturally safe care and connections with family and community. Manitoba. <http://www.serdc.mb.ca/programs-and-services/sepersonalcarehome>
- ▶ The Aboriginal Senior Resources Centre provides advocacy and support with housing, assisted living, home care, long-term care, and elder abuse. Manitoba. http://asrcwpg.ca/seniors_resources.htm
- ▶ Fisher River Cree Nation and the Manitoba First Nations Personal Care Home Networking Group involves collaboration across governments and communities to improve culturally safe long-term care, including the development of culturally appropriate licensing standards for six personal care homes in First Nations communities. Manitoba. <http://www.fisherriver.com/>
- ▶ Aboriginal home support workers in the Southern Region Health Authority provide culturally safe care and advocacy for clients and support for health providers. Manitoba. <http://www.srha.gov.jm/>
- ▶ Peguis First Nation's Health Centre supports a home care program and delivers senior care through an interdisciplinary team approach; Peguis First Nation also participates in the Lakehead University palliative care project. Manitoba. http://pubweb.lakeheadu.ca/~eolfn/?page_id=137
- ▶ The Keewatin Tribal Council Health Department provides a comprehensive home and community care program to support seniors and their families. Manitoba. <http://www.ktc.ca/home/departments/health-services/home--community-care-program>

Central Canada

- ▶ Tungasuvvingat Inuit Family Health Team Medical Centre and Family Resource and Health Promotion Centre bring an integrated primary health care team to Inuit who are living in Ottawa to access medical care. Ontario. <http://www.tungasuvvingatinuit.ca/eng/diabetes.htm>
- ▶ Building bridges between First Nation health care providers and the mainstream health care system improves quality of care and trust – Mamaweswen, the North Shore Tribal Council. Ontario. <http://www.mamaweswen.ca/health.htm>
- ▶ Métis Nation of Ontario Community Centres serve as cultural and service hubs that link Métis citizens to each other and to services and supports in their local areas. Ontario. <http://www.metisnation.org/>
- ▶ Telehealth improves care, reduces isolation for Elders, and allows seniors to remain in their communities – Keewatinook Okimakanak Telemedicine. Ontario. <http://telemedicine.knet.ca/>
- ▶ Supporting Aboriginal Seniors at Home (SASH) provides culturally safe care to address health disparities between Aboriginal and non-Aboriginal seniors – Southwest Ontario Aboriginal Health Access Centre. Ontario. <http://www.soahac.on.ca/>
- ▶ The Traditional Healing, Medicines, Foods and Supports program and Aging at Home Elder Care Continuum improve the health and well-being of seniors in remote and isolated communities – Sioux Lookout Meno Ya Win Health Centre. Ontario. <http://www.slmhc.on.ca/traditional-healing>
- ▶ Alzheimer Society London & Middlesex and the Oneida Nation of the Thames developed the First Link First Nations Program, which provides culturally safe information and support to people with dementia and their families and caregivers. Ontario. <http://www.alzheimerlondon.ca/node/11>
- ▶ Wikwemikong Health Centre on Manitoulin Island works in partnership with the Noojmowin Teg Health Centre and the Victoria Order of Nurses to provide seniors' home care and a long-term care facility that incorporates traditional teaching. Ontario. http://www.wikwemikong.ca/index.php?option=com_content&view=article&id=55&Itemid=85
- ▶ Geriatric telemedicine at St. Joseph's hospital in northwestern Ontario is a nurse-led program that provides assessment and support to clients and their families, including health promotion for chronic disease and cognitive decline and discharge support for those living in remote communities. Ontario. <http://www.sjcg.net/services/complex-physical-rehab/specialized-seniors/geriatric.aspx>
- ▶ Oneida Nation of the Thames home and community care, long-term care, and aging-at-home programs offer a full range of programming and reduce the isolation of seniors by promoting social interaction and activities. Ontario. <http://oneida.on.ca/health-services/home-and-community-care/>
- ▶ The Chiefs of Ontario Home and Community Care Liaison Officer works with a representative of Health Canada to support home and community care programs throughout Ontario. Ontario. <http://chiefs-of-ontario.org/node/430>
- ▶ Akwesasne Health provides home care, home support, and long-term care to improve quality of life and help seniors stay in their communities. Ontario. <http://www.akwesasne.ca/Health.html>
- ▶ Ottawa Health Services Network Inc. is a not-for-profit organization that coordinates specialist and tertiary health care for residents of the Baffin region while respecting the Inuit vision of wellness. Ontario, Nunavut. <http://www.ohsni.com/>
- ▶ The Tyendiaga Home and Community Care Program and the Community Wellbeing Centre run by the Mohawks of the Bay of Quinte supports integrated care, a single point of access, a continuum of home care, and links between hospital and communities to support discharge planning. Ontario. <http://www.mbq-tmt.org/administration-and-services/community-wellbeing/home--community-care>
- ▶ Lakehead University is developing a model for culturally appropriate and safe palliative care services, allowing First Nations people to die in their communities. Ontario. <http://cerah.lakeheadu.ca/>
- ▶ Kahnawake Home and Community Care Services provides a continuum of integrated care in communities for First Nations seniors and others and ensures elders' needs are met through an efficient care delivery model. Quebec. <http://www.kscs.ca/taxonomy/term/5/all>
- ▶ Bringing chronic disease self-management to rural and remote regions through an interprofessional team improves access to care, improves health outcomes, and reduces cost – Rocher-Percé. Quebec. <http://interestsante.ca/participation-au-4e-rendez-vous-de-la-gestion-des-maladies-chroniques.php>
- ▶ The Kanesatake Home and Community Care Program delivers programming to improve quality of life and help seniors remain in their communities. Quebec. <http://kanesatakehealthcenter.ca/khccp>

Atlantic region

- ▶ An Atlantic First Nations Elder Care Assessment Tool helps programs better meet the needs of Atlantic First Nations Elders, based on Elders' perspectives – First Nations and Inuit Health Branch, Atlantic region. <http://www.apcfn.ca/en/health/resources/ElderCareStrategicActionPlan.pdf>
- ▶ The Strategic Plan for Atlantic First Nations Elder Care outlines directions in policy development, advocacy, program and service design and delivery, healthy aging, and aging in place. Atlantic region. <http://www.apcfn.ca/en/health/resources/ElderCareStrategicActionPlan.pdf>
- ▶ The Nova Scotia Aboriginal Home Care Steering Committee completed detailed analyses and reports on home care, long-term care, and discharge planning. They recently launched a communications strategy to improve provincial continuing care programs. Nova Scotia. <http://novascotia.ca/dhw/>
- ▶ The Nova Scotia Aboriginal Continuing Care Policy Forum is an ongoing, effective mechanism that addresses multi-jurisdictional continuing care issues. Nova Scotia. <http://novascotia.ca/dhw/ccs/aboriginal-continuing-care.asp>
- ▶ Aboriginal patient navigators at the tertiary care centre in St. John's support system navigation and coordination for First Nations and Inuit. Atlantic region. <http://www.sjnfc.com/index.php/programs/aboriginal-patient-navigator-program>

Inuit regions

- ▶ The Pond Inlet Elder Education and Awareness Program addresses the isolation, health knowledge levels, and self-management skills of Inuit Elders in a rural and remote community. Nunavut. http://www.nunavutnurses.ca/english/living/communities/pond_inlet.shtml
- ▶ The Nunavut Senior's Society is in development with the support of HelpAge Canada. The society will address elder abuse and reduce isolation. Nunavut. <http://helpagecanada.ca/index.php/nunavut-senior-s-society>
- ▶ The Home and Community Care Program delivers culturally safe care and supports discharge planning to all communities with assistance from Elders, interpreters, doctors, nurses, and other professionals, which is supporting reduced hospitalizations. Nunavut. <http://hss.gov.nu.ca/en/Your%20Health%20Home%20and%20Community%20Care.aspx>
- ▶ Caregiver consultations helped to shape a new territorial policy that provides financial compensation to informal caregivers. Nunavut. http://caregivertoolkit.ca/?page_id=242
- ▶ The Nunavik Regional Board of Health and Social Services participated in a global elder abuse awareness campaign. Nunavik. http://www.rrsss17.gouv.qc.ca/index.php?option=com_content&view=article&id=220&Itemid=138&lang=en
- ▶ Community health aides help with nursing shortages and cultural safety, thereby improving the well-being of seniors and allowing them to remain in their homes. Nunatsiavut. http://www.nunatsiavut.com/index.php?option=com_content&view=frontpage&Itemid=1&lang=en
- ▶ Patient liaisons in Labrador work closely with the Non-Insured Health Benefits program to support Innu and Inuit in Happy Valley-Goose Bay, Labrador. Nunatsiavut. <http://www.lghealth.ca/index.php?pageid=42>
- ▶ Robotic telemedicine using a lifelike robot named Rosie improves access to care in remote communities. Nunatsiavut. <http://www.hc-sc.gc.ca/ahc-asc/media/video/atlant-telerobot-eng.php>
- ▶ The William Firth Health Centre in Tetlit Zheh (Fort McPherson) includes a home care nurse, activity worker, and home support worker for the community. Northwest Territories. <http://www.tetlitgwichin.ca/abouttetlitgwichin>
- ▶ A partnership between the Inuvialuit Regional Corporation and the Beaufort-Delta Health Authority is supporting a number of innovative initiatives including development of a new position, called community wellness coordinators, who are health professionals with broad health and wellness roles in communities. Northwest Territories. <http://www.practicenorth.ca/index.php?page=beaufort-delta-hss-authority>
- ▶ Stanton Territorial Hospital includes an extended care unit in the hospital, with a holistic and interdisciplinary team approach and an Aboriginal wellness program. Northwest Territories. <http://srhb.org/home/>
- ▶ Territorial/Integrated Services of the Northwest Territories Department of Health and Social Services oversees home care and long-term care services in the territory. Northwest Territories. <http://www.hlthss.gov.nt.ca/english/default.htm>
- ▶ Youth caring for Elders and preventing elder abuse improves employment for youth and brings the community together to care for Elders – Carcross/Tagish First Nation's Health and Wellness Department. Yukon. <http://www.ctfn.ca/>
- ▶ Community liaison discharge planning addresses the complex needs of First Nations, Inuit, and Métis patients who are discharged from hospital to rural and remote communities – Whitehorse General Hospital. Yukon. <http://www.whitehorsehospital.ca/firstnationhealthprogram/>
- ▶ The First Nation of Na-Cho Nyak Dun Health and Social Services Department includes a focus on elder care, such as a wood/fuel program. Yukon. <http://nndfn.com/>
- ▶ The Council of Yukon First Nations conducted community health assessments and an environmental scan to support improved service delivery and health outcomes. Yukon. <http://www.cyfn.ca/>

Territories*

- ▶ A continuing care and independent living program embeds culture into a continuum of care for the elderly – Tlicho Community Service Agency. Northwest Territories. <http://www.practicenorth.ca/index.php?page=tlicho-community-services-agency>
- ▶ Home care and health care services support integrated care and help seniors remain in their communities. Northwest Territories. <http://www.practicenorth.ca/index.php?page=nwt-health-social-services-delivery>
- ▶ The NWT Seniors' Society provides a range of support for seniors to reduce isolation and increase awareness of elder abuse. Northwest Territories. <http://nwtseiorsociety.ca/>
- ▶ The Aklavik Health Centre is a bright new centre that provides not only health care but a welcoming space for elders to meet. Northwest Territories. <http://bdhssa.nt.ca/community-services/aklavik/index.html>

* Practices from Nunavut are found in the section on Inuit regions.

Methodology

In the spring of 2013, the Health Council of Canada held meetings in Vancouver, Winnipeg, Ottawa, Iqaluit, Inuvik, and Happy Valley-Goose Bay to discuss the health care of First Nations, Inuit, and Métis seniors. The meetings brought together health care providers and managers from across Canada to discuss the unique health needs and care delivery challenges; to learn how programs, practices, or policies were helping to address these needs and challenges; and to identify key learnings from these successes. The Health Council also commissioned interviews with senior provincial and territorial government staff as well as regional First Nations, Inuit, and Métis organizations across the country.

Participants for the interviews and the meetings were selected through a scoping process and literature review. Themes discussed throughout this report were shared by participants in the meetings and interviews. The report draws on these data/discussions.

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