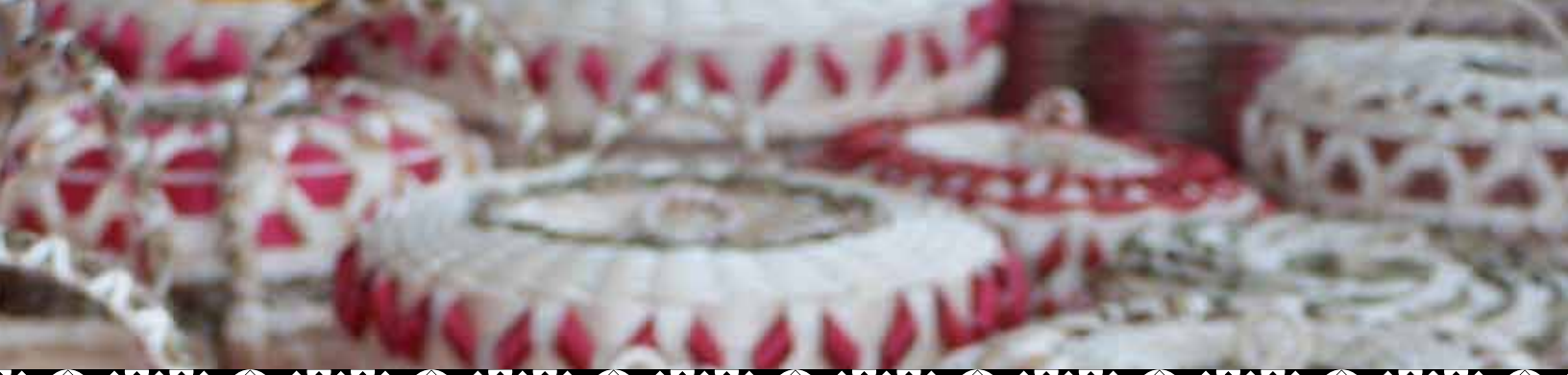
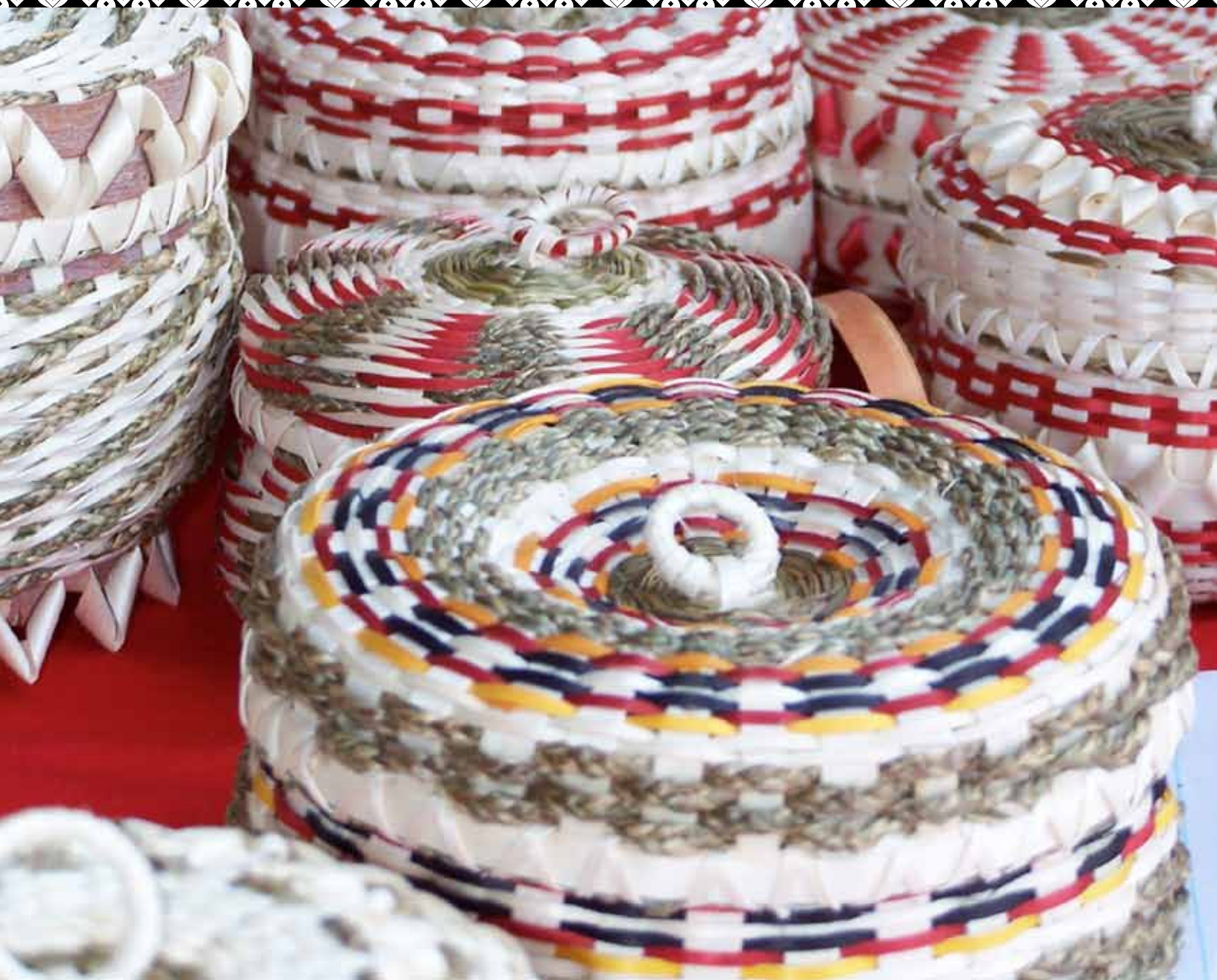


Weaving Partnerships:

A Framework for Aboriginal Home Care in Nova Scotia

2010-2011 resource guide



Weaving Partnerships:
A Framework for Aboriginal Home Care in Nova Scotia

2010-2011 resource guide

A Report of the Nova Scotia Aboriginal Home Care Steering Committee
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Prepared by hampton-and-hampton.ca for the Aboriginal Home Care Steering Committee

Disclaimer: The authors gratefully acknowledge the funding and support of Health Canada's Aboriginal Health Transition Fund and the Nova Scotia Department of Health. This document is not however an official report of the federal or provincial government, nor does it reflect official policy positions by the partner organizations involved in the Aboriginal Home Care Initiative. The contents of this publication may not be reproduced unless written permission is obtained from the copyright holder and acknowledgment is given to the Nova Scotia Department of Health.

Funding provided by the Aboriginal Health Transition Fund and the Nova Scotia Department of Health.
The information and opinions expressed in this document are not necessarily those of Health Canada.

Acknowledgements

The authors wish to thank all the First Nation communities that supported the development of this framework. We especially thank those who participated in the interviews for sharing their time and knowledge about their respective home care programs. The findings from the service profiles offer tremendous insight and were invaluable to the development of this Provincial Home Care Framework for First Nations People Living on-Reserve.

We also wish to thank all of the members of the Steering Committee for their professional and personal commitment to this work. As its co-chairs, Susan Stevens and Loraine Etter must be acknowledged for their extraordinary leadership and for setting the standard for collaboration by being true and tireless champions of solution-finding.

Special thanks to Beth Rajnovich for her project management support in shepherding this work through provincial and federal bureaucracies and Jeff Wilson for his thoughtful and thorough approach to community data collection and relationship building.

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Acronyms

ACCPF	Aboriginal Continuing Care Policy Forum
AHTF	Aboriginal Health Transition Fund
APC	Atlantic Policy Congress of First Nations Chiefs
CCA	Continuing Care Assistant
CFA	Comprehensive Funding Arrangement
CFNA	Canada/First Nation Funding Agreement
CHN	Community Health Nurse
CMM	The Confederacy of Mainland Mi'kmaq
DFNFA	Departmental First Nation Funding Arrangement
DHA	District Health Authority
DINDFNFA	Department of Indian and Northern Development First Nation Funding Arrangement
DoH	Department of Health (Nova Scotia)
E-sdrt	Electronic - service delivery reporting template
FN	First Nation(s)
FNIH	First Nations and Inuit Health
HCC	Home and Community Care
HC FNIH	Health Canada First Nations and Inuit Health
HRM	Halifax Regional Municipality
INAC	Indian & Northern Affairs Canada
LPN	Licensed Practical Nurse
MOU	Memorandum of Understanding
NIHB	Non-Insured Health Benefits
NP	Nurse Practitioner
OT	Occupational Therapy
PT	Physiotherapy
RN	Registered Nurse
SMC	Self-Managed Care
UNSI	Union of Nova Scotia Indians
VON	Victorian Order of Nurses

About this Resource Guide

Dear Reader,

It is with great pleasure that we share the culmination of many months of work that has involved an array of partners and every First Nation community in Nova Scotia. This document serves several purposes. The first is to document the findings and recommendations of the Steering Committee of the Aboriginal Home Care in Nova Scotia Project. These recommendations and the data that support them are the basis of the framework for the organization and delivery of home care services to Aboriginal people living on-Reserve in our province.

As important as this product is to a new chapter for home care and First Nations people in Nova Scotia, the process used to develop it has set the stage for how we continue to strengthen and improve our understanding of what communities need and how best to address those needs. Indeed, as the project steering committee itself transforms into an ongoing forum for collaboration, it is our hope that the relationships developed over the past several years will continue to extend their reach and depth.

The second purpose of this document is to provide everyone involved in home care planning and delivery – in all jurisdictions and in each community – with a common set of definitions so that there is a shared understanding of program scope and purpose. Simply put, we all need to talk the same language to understand each other's needs and capacities.

The third purpose of this document is to serve as a resource guide for all parties with an interest in the design and delivery of home care services for Aboriginal people on-Reserve in Nova Scotia. Having access to current and complete information is vital for everyone's planning and we have tried to anticipate what people need to know in order to continue their good work in this regard.

It is our intention to provide regular updates to this resource guide and would welcome all feedback about how to make it as useful as possible. Over time, we hope that this resource guide becomes a standard reference tool that promotes ease of communication across jurisdictions and cultures.

Welalin,

Loraine Etter
Co-chair (APCFNC)

Susan Stevens
Co-chair (DoH)

Introduction

Disparity in access to home care services by First Nations people living on-Reserve has been raised as a health system concern by the Mi'kmaq-Nova Scotia-Canada Tripartite Health Committee and identified as a priority issue for the Atlantic Policy Congress of First Nations Chiefs (APC), the Union of Nova Scotia Indians (UNSI) and the Confederacy of Mainland Mi'kmaq (CMM). In addition, the Nova Scotia Blueprint for Aboriginal Health and the Continuing Care Strategy identified the need for a collaborative effort between First Nations, federal and provincial government officials to improve access and delivery of home care services for populations living on-Reserve.

The development of Nova Scotia's Continuing Care Strategy led to the increased awareness that Aboriginal people living in the thirteen First Nation communities across the province lack access to a comprehensive range of home care services. The Nova Scotia Aboriginal Home Care Project enables the dialogue about what menu of services is already available, what else is needed and who among our partners is in the best position to provide it.

In the summer of 2007 a group of community, provincial and federal stakeholders came together to address these shared concerns under the auspices of an Aboriginal Health Transition Fund initiative (AHTF). The Steering Committee set out to clarify policies and terms describing home care programs delivered on-Reserve by all jurisdictions; identify areas of gap and overlap in each of the thirteen First Nation communities in Nova Scotia; and create a mechanism for ongoing collaboration in the design and delivery of home care services to Aboriginal people living on-Reserve.

Recognizing how vital it is to achieve continuity of care between hospital and home, this initiative also undertook an evaluation of a Cape Breton based Aboriginal Home Care Discharge Planning pilot project to inform the design of a province-wide approach. In addition, the Nova Scotia Department of Health undertook a national policy review of continuing care programs across Canada to determine how on-Reserve home care delivery is handled in different jurisdictions.

When this initiative was launched, the Continuing Care Branch of the Department of Health was responsible for the provision of home care services across the province. In 2009, the operational responsibility for this program was transferred to the District Health Authorities (DHAs), requiring that health authorities become closely involved in all aspects of the Aboriginal Home Care Project's work.

By any measure, the progress that has been made in advancing the issue of improved access to home care services by Aboriginal people living on-Reserve has been quite remarkable throughout the AHTF initiative. Beyond the objectives of the project itself, the relationships established among members of the Steering Committee enabled greater policy reach into areas that included an expansion of the provincial bed loan program

to First Nation communities, access to respite care services as well as financial consideration being given to on-Reserve residents occupying alternate level of care beds in hospitals.

This initiative weaves a legacy of collaboration among the partners who will work together beyond the life of this project to address the continuing care needs of First Nation communities. With the tabling of this document, the Aboriginal Home Care Steering Committee structure begins its transformation into the Aboriginal Continuing Care Policy Forum.

This framework is the consolidation of several streams of activity, which together inform the design and delivery of Aboriginal Home Care services on-Reserve.

Section 1 is a roll-up of key issues that emerged over the course of the work and recommended approaches to address challenges that were identified. It is important for the reader to understand that service delivery approaches, program challenges, assets and needs differ in each of the thirteen First Nation communities.

Section 2 provides a detailed inventory of home care services provided on-Reserves in Nova Scotia. Service profiles were developed for each of the thirteen First Nation communities in order to understand the specific home care programs being offered locally.

Section 3 presents a summary of programs and terms to facilitate a shared understanding of the different home care services provided by the Nova Scotia Department of Health (Continuing Care Branch), Health Canada, and Indian & Northern Affairs Canada (INAC). It lists what is being offered by each provider and defines the language used by the various organizations in describing what they do.

Section 4 presents the findings of a national policy review of home and continuing care programs as they relate to the provision of services to Aboriginal people living on-Reserve in nine provinces.

Section 5 is a five-year map, detailing when each recommendation of the Steering Committee should be advanced. This action strategy is intended to be a tool to monitor progress over time in the achievement of the full implementation of this framework.

The resulting framework is intended to be a living document. It should serve as a resource guide for stakeholders as they fulfil their particular roles in policy development, service delivery, evaluation and funding. We hope it will also help to promote constructive dialogue and relationship building as First Nation communities, DHAs, the provincial and federal governments continue to work together on their shared agenda.

Section 1: Key Issues and Actions

1.1 The Current Situation

Many people are unaware that home care services have not historically been considered part of the bundle of insured services under the *Canada Health Act*. This gets complicated for residents of First Nation Reserves because they fall into a jurisdictional maze. Nova Scotia has developed a provincial home care program, but access by First Nation people on-Reserves is limited. Health Canada, Indian & Northern Affairs and Veterans Affairs Canada all provide funding for some aspects of home care service delivery on-Reserves in Nova Scotia. No comprehensive, coordinated strategy has yet been developed for the delivery of home care in First Nation communities.

While each First Nation community is unique in its own right, across Nova Scotia and indeed throughout Canada there are clear trends in demographics, health status and service utilization. Put simply, Aboriginal communities are very young, growing quickly and suffer a higher burden of injury and illness than the mainstream Canadian population. Rates of chronic disease are very high with many individuals living with more than one chronic illness over a significant period of their lives.

The top five long-term health conditions facing First Nation adults with and without disabilities are arthritis/rheumatism, chronic back pain, allergies, diabetes and high blood pressure. Complications arising from these illnesses often result in hospitalization and complex home care, frequently contributing to years of disability.

According to Indian & Northern Affairs Canada (2009), the total registered First Nations population in Nova Scotia is 14,239 people. There are 13 governing First Nation Bands overseeing 33 Reserve land communities scattered across Nova Scotia. These Reserves are home to 9,480 First Nation individuals or about 67% of the First Nations population.

Eskasoni, with a population of about 3,300 individuals and Indian Brook, with a population of about 1,200 individuals, are the only two communities with on-Reserve populations of more than 1,000 people. Six of the remaining eleven First Nations have on-Reserve populations of fewer than 500 people.

The small populations of the communities present unique home care service delivery challenges. The on-Reserve census numbers are important as they inform the funding formulas for the Health Canada Home and Community Care Program and the Indian & Northern Affairs Canada Assisted Living Program.

1.2 Issues and Recommendations

The home care services being offered across First Nation communities differ substantially. Nursing services and home support services are offered in all communities. In addition, all communities have access to specialised equipment, medical and personal care supplies, and home oxygen services as covered by Non-Insured Health Benefits (NIHB) as

well as medical transportation to off-Reserve services covered by the Health Canada Transportation Agreement. Every community has access to home maintenance and home repair but the scope of services varies by community pending additional Band support. The availability of other services seems to be partly influenced by community size and district.

In spite of the fact that First Nation communities tend to be rather small, there is a large, multi-jurisdictional and complex labyrinth of policies and services that Aboriginal clients and families are required to navigate in accessing care. A home care model involving multiple levels of government and providers can work when there is good communication about who is bringing what to the table. But if left to chance, important things on the menu will be left out. Many agencies, jurisdictions and professionals provide home-based services but lack the benefit of knowing how they fit into a complete care plan.

To access home care services, all First Nation communities require clients to undergo a formal assessment process. The home care nurse generally conducts the assessment process. A few communities contract the Victorian Order of Nurses (VON) to conduct the assessments. First Nation community members on-Reserve do not pay any fees for home care services nor are there any formal caps on services with the exception of Paqtnkek. In Paqtnkek, service hours are capped at 16 hours per day. If a client requires 24 hour care, the family would provide the remaining hours of care.

None of the programs have age limitations. The majority of programs, however, are designed for adults and seniors in particular. Most communities noted that they do not have the resources to provide services to serve special needs children. None of the communities have formal waitlists for services. Several communities will hire VON if there is demand for services beyond what home care staff or family members are able to provide.

Service providers, especially those in smaller communities, face several challenges. In many cases providers have multiple roles and competing demands for their time. Over half the communities do not have a dedicated home care nurse on staff. In five communities, the community health nurse or, in one community, a nurse practitioner provide home care nursing services in addition to their other nursing portfolios. Even in those communities with a dedicated home care nurse on staff, there is usually no one to backfill during vacations or sick time.

In contributing their ideas to the development of this framework, all thirteen communities indicated concerns about the sustainability of home care, citing funding issues, increasing need and increasing expectations. In all communities, the Band Council subsidizes the home and community care program with other revenue. Relying on Band subsidies to support home care leaves the programs vulnerable to a funding stream which is not guaranteed. Most communities feel pressure to expand service delivery beyond what

they are currently offering in response to growing community home care needs and expectations.

The following section provides more detail by key issue. Please note that 'Registered First Nation individuals' refers to individuals who are registered under the *Indian Act*.

1.2.1 Service Access and Delivery

program mandate/expectations
Home care was originally designed to provide additional support to clients being cared for at home by family members. Many First Nation community members, however, have developed expectations of home care beyond the scope of what programming was intended to provide. These expectations often include 24/7 care for extended periods, the provision of after-hours care and services being made available to off-Reserve community members.

In many communities, the Band Council becomes involved in directing who can access services and for how long. In addition, in some communities the Band provides equipment for clients if not otherwise covered. This contributes to an ad hoc, inconsistent and unsustainable approach to home care delivery and exacerbates provider and client confusion about what is in and out of scope of home support.

While some of the expectations are not possible to fulfill due to issues of resource availability, it must equally be stressed that any care plan has to be developed based on where the client will receive the most appropriate service at the right time, in the right place and by the right provider. While the objective is certainly to keep clients home for as long as possible and return them to home as soon as possible after discharge from hospital – and advances in technology have certainly expanded the reach of home based services – not all services can or should be delivered in a home environment. The use of other facilities throughout the continuum of health care is sometimes necessary.

Recommendation 1: On a go-forward basis, it is vital that the scope of home-based services is clearly explained to all stakeholders, in the context of ensuring the highest quality of care for clients and families in the safest and most appropriate setting. It is equally vital that provincial and federal policy makers/ funders collaborate with First Nation communities and their representative organizations in continuous improvement of home-based care that both responds to the needs and builds on the strengths of each community.

program hours
Program hours range from a few days a week to five days a week and typically do not exceed eight hours per day during 8am – 5pm. Ten communities provide services Monday to Friday. The three smallest communities provide services less than 5 days per week.

In cases where clients need services during off hours, either the services are contracted to VON (which can be costly to the community), the client waits until the following work day or the client goes to a day clinic or the emergency room.

Health professionals outside of the community often have misconceptions about what the home care programs on-Reserves offer. There is a common misconception among health professionals not familiar with First Nations community health programs that Aboriginal people have unlimited health care services available to them on-Reserve.

It should also be noted that communities do not have backfill available for sick time, vacations, or training opportunities. This is especially challenging for communities where there is only one provider.

Recommendation 2: Community service profiles must be updated regularly to ensure that DHAs in general and discharge planners in particular are aware of the hours and scope of local service availability when developing care plans for Aboriginal clients, potentially developing strategies to ensure client access to services after hours to make home care possible. Timely information sharing between local health directors and their DHA will ensure that First Nation home care needs are clearly articulated and reflected in health authority business plans.

provision of care to satellite Reserve Band members

A number of First Nation Bands have satellite populations who require planning consideration for their home care needs. There are 33 Reserves under the leadership of 13 Band Councils (Chief and Council) and these all vary in terms of needs with respect to home care services. Six communities report providing services to satellite Band members, including three of the four smallest governing communities. In one case the population living off the governing Reserve is more than five-times larger than the on-Reserve community.

Recommendation 3: First Nation communities providing home care services to members living off-Reserve consider informing these individuals about their access to provincially funded home care services.

Recommendation 4: The Department of Health and DHAs clarify for First Nation communities what services are already available to Band members living off-Reserve to ensure that potential clients/ families are aware of these services.

Recommendation 5: First Nation communities with Band members living in satellite Reserves provide this information to their respective DHAs so that the needs of these individuals can be reflected in program planning.

access to continuing care services

There appears to be some confusion about which home and community care services delivered by the DHAs are available to First Nation individuals on-Reserve. For example, Adult Day Programs funded through some DHAs are open to First Nation individuals on-Reserve, while in other districts this may not be the case.

Recommendation 6: The Nova Scotia Department of Health and DHAs clarify with First Nation communities what services they are presently able to access and how to do so.

transportation
Off-Reserve transportation is covered by the Health Canada Transportation Agreement. The program either supports medical drivers or provides a mileage stipend to clients. Five communities do not have medical drivers. These communities happen to be among the communities with the smallest on-Reserve populations. Two communities offer on-Reserve transportation to home care clients.

The mileage reimbursement rate of 16 cents/km does not adequately reflect the cost of driving. Communities receiving the mileage reimbursement noted that several community members cannot afford the cost up front. Also, the conditions to receive the reimbursement are difficult to navigate. Two of the communities without medical drivers provide cash advances and subsidize the mileage rate for off-Reserve medical transportation.

Recommendation 7: The communities should suggest that the federal government should revisit the Commuting Assistance rates, upon which the Non-Insured Health Benefits (NIHB) private mileage rates are based. These rates should be increased to reflect actual costs of vehicle operation and maintenance based on the experience of First Nation communities as reported in the AHTF Home Care on-Reserves project.

discharge planning
It is noteworthy that only five First Nation communities reported having formal discharge planning protocols in place with local hospitals and that these communities were the ones participating in a home care discharge planning pilot project in Cape Breton. None of the other First Nation communities on mainland Nova Scotia have established these roles and relationships.

Based on the success of the Cape Breton Home Care Discharge Planning pilot project, a Memorandum of Understanding (MOU) detailing roles and responsibilities at the district and community levels for home care discharge planning will be developed across Nova Scotia. The model is based on the principle that discharge planning should begin at the time of admission to hospital.

Recommendation 8: Province-wide roll-out of the Cape Breton First Nations Home Care Discharge Planning Program should occur as soon as possible, based on the evaluation and recommendations recently tabled by the Aboriginal Home Care Steering Committee and approved by the Nova Scotia Department of Health. This program should be reviewed on a regular cycle.

complex care
Complex cases can drain program funding very quickly, particularly in a community that is very small and with a correspondingly small budget. In one community, the costs of care required to support one client exceeded the entire program budget.

Recommendation 9: By continuing to build on the information provided in the attached community service profiles, DHAs and First Nation communities must continue to collaborate in the identification of complex care clients and ensure, to the greatest extent possible, that their service needs are reflected in health authority business planning.

Recommendation 10: Based upon the experience of First Nation communities as reported in the AHTF Home Care on-Reserves project, the communities should suggest that the federal government should revisit the funding approach to Home and Community Care based on the experience that using a per capita formula means that most communities lack the critical mass to make this formula work.

palliative care

Palliative care consult services are provided in hospitals and in the community by District Health Authorities. The Department of Health is currently leading work to develop standards for palliative care as it is recognized service access and availability varies across health districts. In 2007 the Continuing Care Branch increased the amount of home care services (both nursing and home support) an individual in the chronic home care program can receive during the last three months of life. FN communities indicated they do receive palliative care consult services through the District Health Authorities although in some areas there seems to be a lack of clarity around what services can be provided on-Reserve. In addition FN communities report difficulty providing the increased home care services required at end of life due to funding and resource challenges.

Recommendation 11: The DHAs ensure palliative care consult services available in the community are provided in a culturally appropriate and safe manner to First Nation individuals on-Reserve.

Recommendation 12: Given the federal government does not provide funding for palliative home care services as an essential service and First Nation communities can only provide these services if they have additional revenue, the Department of Health should consider revising the current Palliative Care Home Care Policy to extend these services to Aboriginal people living on-Reserve.

Recommendation 13: The Nova Scotia Department of Health Palliative Care Task Group include First Nation service delivery issues in its planning and deliberations.

self-managed care

The provincial Self-Managed Care program provides funding to individuals who require assistance with the activities of daily living such as personal care and who are willing and able to manage their own care. Self managers take on the role of employer and hire/train/manage their own attendants. The program offers an alternative delivery mechanism for home support services and is designed to foster independence and participation in the community. Self managers typically are adults with significant physical disabilities. Neither Health Canada nor Indian & Northern Affairs Canada provide funding to First Nation communities for a self-managed care program.

Recommendation 14: Given there is no similar federal program, the Department of Health should consider revising its current Self-Managed Care policy to open this program to First Nation individuals living on-Reserve. The Department and DHAs would then need to ensure appropriate program information is shared with First Nation communities regarding program parameters and access.

adult day

The Department of Health has provided interim funding to District Health Authorities to establish adult day programs while work on a provincial adult day policy/program is being completed. Indian & Northern Affairs Canada provides funding for day programs to First Nation communities, however only two communities are providing these services. These programs are for seniors and are social in nature and not health related. Information from other provincial jurisdictions indicates that provincially mandated and funded adult day programs are available to First Nation individuals on-Reserve.

Recommendation 15: As the Department of Health develops policy and standards related to a provincial Adult Day Program, consideration should be given to opening this program to First Nation individuals on-Reserve.

Recommendation 16: The Department of Health should consider providing direction to the DHAs to open interim Adult Day programs to First Nation individuals on-Reserve who meet program eligibility criteria.

community occupational therapy and physiotherapy

The Department of Health has provided interim funding to District Health Authorities to increase outreach of existing community occupational therapy and physical therapy (OT/PT) programs while work on a provincial community OT/PT program is being completed. OT/PT services are considered a supportive service in Health Canada's Home and Community Care program and as such First Nation communities can only offer this service once all essential services are provided and if funding allows. Health Canada does not provide funding for OT/PT services on-Reserve. Nine (9) First Nation communities indicated they are providing some OT/PT services. Information from other provincial jurisdictions indicates that provincially mandated and funded community OT/PT programs are available to First Nation individuals on-Reserve.

Recommendation 17: Given the federal government does not provide funding for rehabilitation services as an essential service and First Nation communities can only provide these services if they have additional revenue, as the Department of Health develops provincial policy and standards for a provincial community OT/PT program, it should consider opening this program to First Nation individuals on-Reserve and ensure that First Nation health directors are aware that community members have access to these services.

Recommendation 18: The Department of Health should consider providing direction to the DHAs to open interim community OT/PT programs to First Nation individuals on-Reserve who meet program eligibility criteria.

home oxygen

First Nation individuals living on-Reserve have access to home oxygen services through Health Canada's Non-Insured Health Benefits program. Individuals off-Reserve have the option to access the Department of Health's Home Oxygen program. Having access to the provincial home oxygen program would allow individuals on-Reserve to access the program that best meets their health needs.

Recommendation 19: The Department of Health should consider revising the current Home Oxygen Policy to open this program to First Nation individuals living on-Reserve. Health Canada through Non-Insured Health Benefits should maintain the current federal Home Oxygen program and in doing so, First Nation individuals would then have the option to access either the provincial or federal Home Oxygen programs, so long as they meet program criteria.

chronic home care (nursing and home support)

Program sustainability issues including funding and human resource challenges limit the services offered on-Reserve through the federally funded programs. These program limitations may result in individuals who otherwise could have been treated at home to seek services through local outpatient clinics or emergency rooms or to go without required services. Being able to access home care services through the provincial home care program delivered by District Health Authorities would allow improved home care on-Reserve and may prevent premature hospitalization or long term care placement.

Recommendation 20: The Department of Health should consider revising the current Home Care Policy to open up chronic home care services to First Nation clients living on-Reserve. District Health Authorities and home care providers need to ensure services are delivered in a culturally appropriate manner. Both Health Canada and Indian & Northern Affairs Canada should maintain the current federally funded Home and Community Care and Assisted Living programs on-Reserve.

acute home care nursing

The provincial home care program provides acute nursing services which are typically short term nursing interventions that historically would have been provided in hospital such as wound care, IV therapy, etc. These services are available to First Nation individuals on-Reserve by exception.

Only two First Nation communities indicated they had accessed these services from the province in the last 5-10 years. Several respondents indicated they had tried to access these services without success, while others indicated they were not aware these services were available to on-Reserve residents.

Recommendation 21: The Department of Health should consider revising the current Home Care Policy to remove the requirement to approve First Nation on-Reserve access to acute nursing care by exception. The Department should then provide clear information to the DHAs and First Nation communities regarding eligibility criteria and the acute care nursing services that can be provided on-Reserve.

long term care

There is an existing and growing requirement for long term care support in First Nation communities in Nova Scotia, with several communities doing their best to fulfill this need on an ad hoc basis. Providing this care exposes communities to safety and liability issues and builds expectations that cannot be sustained.

Recommendation 22: The Aboriginal Continuing Care Policy Forum should determine policy and access issues from the perspective of First Nation communities in Nova Scotia as it relates to long term care, so as to inform a multi-jurisdictional approach that is based on evidence of best practice.

1.2.2 Human Resources

need for trained support

A number of First Nation Health Directors expressed concern that recruiting and keeping qualified home care staff is challenged by a number of factors. These include personnel having to shoulder an often stressful work environment and balancing multiple roles, being limited by uncompetitive pay scales, and finding it difficult to recruit qualified people who are culturally competent to work in an Aboriginal setting.

As client needs become more advanced, program demands increase and subsequently staff members require more training. It is vital to ensure that those providing community-based services are competent to deliver the level of care required. Failure to do so raises significant liability concerns and undermines the credibility and confidence of services overall. Some communities have a policy to hire trained staff only leaving them understaffed because there is no one with training they can hire. Several communities purchase services from VON due to staff shortages which may be more expensive than providing services directly.

Some communities have a policy of paying individuals for providing home care services to their family members. This presents a complex set of issues that are economic, social and political. While some people support this policy because it provides employment in communities where jobs are scarce and matches home support need with a familiar caregiver, others are concerned that an expectation is created that support to family is remunerated as a commercial service. Of greatest concern is that clients who require home care services that ought to be delivered by a trained professional do not get the level of care they need from a paid but untrained family member.

Interviewees indicated that in most cases family members do not have adequate training and there is concern that clients receiving care from family members may not be getting service that is needed or expected. Also, in some cases services may be paid for longer than needed.

Recommendation 23: There is a need for the Continuing Care Assistant (CCA) Program and other training opportunities targeting community members to be made more widely available – removing barriers to access and strengthening the program with curricula customized to address the cultural context of home care delivery in an Aboriginal setting. Recognizing the need for qualified home care staff on-Reserve, the Department of Health should work with First Nation partners, Health Canada and Indian & Northern Affairs Canada to address the issues outlined in the CCA Certification and Training Project proposal developed in 2009.

Recommendation 24: There is an opportunity to develop a mentoring program involving DHA nurses, VON nurses and First

Nation nursing staff that would promote professional and cultural skills development and relationship building within the home care nursing community. First Nation community and DHA champions should be identified and a strategy developed to advance this concept.

Recommendation 25: Regardless of whether a home care service is provided on a paid or volunteer basis, the obligation to the client is to ensure that anyone providing care is qualified to perform necessary tasks. When family members are responsible for delivering services, the Band should ensure that these providers are equipped with the skills they need to perform tasks safely and effectively.

Recommendation 26: The First Nation Band Councils should revisit and consider increasing the rates of compensation for home care workers providing services on-Reserve in order to attract and retain qualified employees and ensure quality service.

Recommendation 27: First Nation health directors should develop a strategy for the retention of home care workers delivering services on-Reserve, including how to provide competitive compensation packages to these workers.

culturally appropriate care

The majority of interviewees noted that service providers in their communities were providing culturally appropriate services. Most communities try to hire First Nation practitioners if feasible. Some communities, especially those relying heavily on VON services, were unsure if culturally appropriate services were being provided. Interviewees noted, however, that they were not aware of any complaints.

Recommendation 28: All health providers should take cultural competency and cultural safety training before working on Reserves.

1.2.3 Policy, Planning and Program Development

It is noteworthy that only one First Nation community reported having a working relationship with the Nova Scotia Department of Health and the minority of communities felt that they had an effective working relationship with their local District Health Authority (although a number of DHAs and First Nation communities have made this relationship-building a priority and are making considerable strides through other AHTF initiatives). Mechanisms, formal and informal, to enable and nurture this relationship building are vital to home care and, indeed, all health-related programming that, by its nature, involves multiple partners.

Recommendation 29: Health Canada, Indian & Northern Affairs Canada, the Department of Health, the District Health Authorities and IWK Health Centre need to ensure meaningful engagement of First Nation communities in new policy/program design and future planning regarding health system development including continuing care services.

Recommendation 30: Venues should be created for DHA and First Nation community representatives to meet, formally and informally, so as to better understand one another's needs, capacities and opportunities for collaboration.

establish/maintain an Aboriginal Continuing Care Policy Forum

Even with the most effective local linkages, broader system-wide policy issues require a forum of multi-jurisdictional partners whose role it is to address gaps where they might exist and to optimize the collaboration of prevailing programs in meeting the needs of First Nation clients on-Reserve.

Recommendation 31: The Aboriginal Continuing Care Policy Forum (ACCPF) should include community, district, provincial and federal representation with terms of reference that facilitates action on multi-jurisdictional issues that will advance continued improvement of services to First Nation people living on-Reserves. Current project partners (and in future, other potential partners such as Veterans Affairs Canada, Canada Mortgage and Housing Corporation, and the Department of Community Services) should commit through the exchange of letters of support to ongoing participation in the Aboriginal Continuing Care Policy Forum as a mechanism to foster and continue to build relationships amongst the partners and as a forum for policy issue resolution. In addition, the Department of Health, Health Canada and INAC should contribute financial resources required to support modest infrastructure for the forum. Support for the forum would include completion of an annual update of the home care framework including the summary of programs & terms, First Nation community service profiles and communications materials to support the discharge planning program. While the Aboriginal Continuing Care Policy Forum is not part of the Mi'kmaq – Nova Scotia Canada – Tripartite Forum, the ACCPF will provide updates on activities and issues as required to the Tripartite Health Committee.

1.3 Terms of Reference: Aboriginal Continuing Care Policy Forum

The Aboriginal Continuing Care Policy Forum includes First Nation community, district, provincial and federal representation and facilitates action on multi-jurisdictional issues that will advance improved quality of care and access to services for First Nations people living on-Reserve.

Purpose/Objectives of the Aboriginal Continuing Care Policy Forum

1. To provide a forum where intergovernmental issues (federal, provincial, district and local) affecting the delivery of the continuum of continuing care services to First Nations people living on-Reserve can be resolved in a collaborative manner.

2. To promote an ongoing shared understanding between the Continuing Care Branch, Department of Health, First Nations and Inuit Health, Health Canada, Indian & Northern Affairs Canada and health care delivery providers regarding current continuing care definitions, service types, scopes of practice and employment, responsibility for service provision, service delivery mechanisms, funding and eligibility for service for First Nations people living on-Reserves in Nova Scotia. This will include ongoing examination of the continuum of services that are part of the federal, provincial and district programs.

3. To develop strategies/recommendations that address gaps and build on community strengths, including the identification of process/service delivery improvements, funding strategies and advocacy for policy amendments where required. Strategies will be based on culturally appropriate models of continuing care services, which address the unique needs of First Nation communities and builds on their strengths and capacities.

4. To contribute content expertise and provide oversight/direction to the annual update of the Summary of Programs and Terms and other resources agreed upon to the support objectives of the forum.

Role of Forum Members

- As representatives of the various stakeholder groups, to provide overall leadership on matters arising from the Forum.
- To facilitate the collection of data necessary to inform ongoing program and policy improvement.
- To serve as a conduit for communication between the stakeholder groups represented by each member and the forum.
- To develop strategies that support the implementation of sustainable, culturally appropriate models of care that are consistent with the objectives of the forum.
- To facilitate the development of policies within the organization each member represents that will support the achievement of forum goals.
- Provide advocacy within relevant stakeholder groups in taking action to enable the implementation of recommendations arising from the Forum.

Decision-making

In that the forum is not a policy making body and is advisory in nature, decisions shall be made and recorded on the basis of consensus.

Agenda Items

Respecting the value of in-person meeting time, in general all items on the agenda will be matters requiring discussion/ debate in order to bring them to resolution. Information items will be shared between meetings by and among forum participants.

Meeting Notes

Meeting notes shall be taken by the forum's secretariat and reviewed for accuracy by Forum membership prior to being finalized. The focus of meeting notes shall be on highlights of discussions that result in action items; the purpose of the meeting notes shall be to serve as a tool of activity monitoring/accountability. Meeting notes will be provided to forum members electronically. Members will be encouraged to share finalized meeting notes within their organizations as part of their own internal communications and management strategies.

Membership

- The Confederacy of Mainland Mi'kmaq
- Union of Nova Scotia Indians
- Atlantic Policy Congress of First Nations Chiefs

- Nova Scotia Department of Health Continuing Care Branch
- Health Canada First Nations & Inuit Health (Atlantic Region)
- Nova Scotia Office of Aboriginal Affairs
- Nova Scotia Department of Health Primary Health Care Branch
- Nova Scotia DHAs & IWK Health Centre
- Indian & Northern Affairs Canada
- Nova Scotia Department of Community Services
- others as agreed upon by consensus of the Forum, as required to advance a mutual agenda

Chairperson
A model of co-chairpersonship, at least one of whom being a representative of a First Nations' stakeholder, is preferred. Co-chairpersons shall be selected by consensus of the forum.

Meeting Frequency
The forum will meet approximately three times a year, based on a pre-determined meeting schedule. Should issues arise requiring forum action between regularly scheduled meetings, the Chair shall call the group together either in person, electronically or by teleconference.

Accountability
The Department of Health will host the forum for the 2010-11 and 2011-12 fiscal years. During this time, decisions will be made regarding future host organizations. Hosting will include setting up meeting dates, arranging meeting rooms, recording and distributing meeting minutes.

Budget
Member organizations agree to cover the travel expenses of their respective representatives. Funding for catering and external support to complete tasks such as the annual update of the Home Care Resource Guide will be shared by Department of Health, Health Canada and Indian & Northern Affairs Canada.

Section 2:
Home Care Community Service Profile

2.1 Data Collection

Fundamental to this project was an understanding and expressed commitment that all data regarding community service profiles is owned by the respective community. The project team is extremely grateful for the assistance and cooperation of community representatives and for the quality of information that was shared.

This framework provides summative data necessary to inform planning and policy development. Readers wishing to obtain the community-specific details supporting this roll-up should contact communities directly for their permission to access this information. Community contact information is provided in Appendix C.

2.1.1 Service Profile Interviews

The service profile interviews were conducted with each First Nation community between November 2008 and February 2009. The interviews targeted home care coordinators and home care service providers. An interview was held with each community.

The number of interviewees per community ranged from one to four. In all cases the home care coordinator or primary home care nurse participated. The level of engagement and detail provided varied by community. The interview questions (Appendix B) were approved by the Steering Committee of the Aboriginal Home Care in Nova Scotia Project.

The service profile interviews focused on the following themes:

1) identifying the burden of need;
2) identifying how communities currently deal with home care support issues;
3) identifying strengths and weaknesses of the programs;
4) identifying gaps in service;
5) identifying what could improve the provision of home care in their communities;
6) identifying what relationships currently exist with hospitals, District Health Authorities and the provincial Department of Health regarding the provision of home care;
7) identifying what mechanisms are in place between local service providers and hospitals regarding home care discharge planning.

2.1.2 Data Collection Process

Michele Landry, Home Care Coordinator with the Union of Nova Scotia Indians (UNSI) and Aboriginal Home Care in Nova Scotia Project Steering Committee member, sent an e-mail to home care coordinators informing them of the project and requesting support. Interviews were arranged with each community.

Interview results for each community were transcribed into a community service profile and sent back to interviewees to confirm accuracy. If changes were made, the revised profiles were sent back for review. For communities that did not reply, a follow up e-mail was sent reminding them to review the service profile write ups. It was assumed that if there were no comments interviewees were satisfied with the findings.

Mid-way through the interview process it was recognized that the interview questions did not solicit adequate information to understand the volume of services being delivered in each community. A subsequent request was sent to communities to get access to the E-sdrt data, which is collected as part of the reporting process for First Nations and Inuit Health (Health Canada). The data request was supported by the First Nation communities' health directors. Eight communities provided E-sdrt data.

2.2 Communities at a Glance

The following table provides an overview of service availability by each First Nation community across Nova Scotia.

Table 1: Service summary

	Acadia	Annapolis Valley	Bear River	Eskasoni	Glooscap	Indian Brook
Population*						
Total	1,066	235	281	3,923	305	2,313
On-Reserve	180	107	103	3,345	95	1,215
Off-Reserve	885	128	178	577	210	1,084
Service delivery						
Integrated funding (FNIH/ INAC)	N	N	Y	Y	N	N
Home care services offered five days a week (business hours)	Y	N	N	Y	N	Y
After hours care (usual scenario)						
• **Provided by nursing staff**	N	N	N	N	N	Y
• **Provided by VON**	Y	Y	Y	N	Y	N
• **Go to ER or outpatients**	N	N	N	Y	N	N
Services available to off-Reserve population	Y	N	Y	N	Y	N
Program subsidized by Band	Y	Y	Y	Y	Y	Y
Service providers						
Home care nurse on staff	N	N	N	Y	N	Y
Nursing services provided by CHN or NP	N	Y	Y	N	Y	N
Nursing services provided by VON (all the time)	Y	N	N	N	N	N
Some CCA trained workers	N	N	N	Y	N	N
Family members compensated for providing home care services (standard practice)	Y	N	N	N	Y	Y
Culturally appropriate services	Y	Y	Y	Y	Y	Y
Band employs service providers	Y	Y	Y	Y	Y	Y

Table 1: Service summary continued

	Membertou	Millbrook	Paqtnkek	Pictou Landing	Potlotek	Wagmatcook	We'koqma'q
Population*							
Total	1,196	1,345	523	589	624	701	901
On-Reserve	767	747	393	447	521	549	816
Off-Reserve	427	598	140	142	103	152	85
Service delivery							
Integrated funding (FNIH/ INAC)	Y	Y	Y	N	N	Y	N
Home care services offered five days a week (business hours)	Y	Y	Y	Y	Y	Y	Y
After hours care (usual scenario)							
• **Provided by nursing staff**	N	N	N	N	N	N	Y
• **Provided by VON**	N	N	Y	Y	N	N	N
• **Go to ER or outpatients**	Y	Y	N	N	Y	Y	N
Services available to off-Reserve population	N	N	Y	N	N	Y	Y
Program subsidized by Band	Y	Y	Y	Y	Y	Y	Y
Service providers							
Home care nurse on staff	Y	Y	N	N	N	Y	Y
Nursing services provided by CHN or NP	N	N	Y	Y	Y	N	N
Nursing services provided by VON (all the time)	N	N	N	N	N	N	N
Some CCA trained workers	Y	Y	Y	Y	Y	Y	Y
Family members compensated for providing home care services (standard practice)	N	Y	N	Y	Y	N	N
Culturally appropriate services	Y	Y	Y	Y	Y	Y	Y
Band employs service providers	Y	Y	Y	Y	Y	Y	Y

Table 1: Service summary continued

	Acadia	Annapolis Valley	Bear River	Eskasoni	Glooscap	Indian Brook
Available services						
Nursing services	Y	Y	Y	Y	Y	Y
Homemaking	Y	Y	Y	Y	Y	Y
In-home respite care	Y	Y	N	Y	Y	Y
Specialized equipment	Y	Y	Y	Y	Y	Y
Medical/personal care supplies	Y	Y	Y	Y	Y	Y
Adult care program	N	N	N	N	N	Y
Meal program	N	Y	Y	Y	N	N
Mental health services	Y	N	Y	N	N	Y
Home based palliative care	Y	Y	Y	Y	Y	Y
Specialized programs for wellness and fitness	Y	Y	N	Y	Y	Y
Non-medical transportation	N	N	Y	N	N	Y
Rehabilitation and therapy services	N	N	Y	Y	N	Y
Personal care	Y	Y	Y	Y	Y	Y
Footcare	N	N	Y	Y	N	Y
Self-managed care	N	N	N	N	N	N
Home oxygen services	Y	Y	Y	Y	Y	Y
Home maintenance	Y	Y	Y	Y	Y	Y
Home repair	Y	Y	Y	Y	Y	Y
off-Reserve medical transportation	Y	Y	Y	Y	Y	Y
Service access and availability						
Formal assessment process	Y	Y	Y	Y	Y	Y
Age limitations	N	N	N	N	N	N
Fees for homecare services	N	N	N	N	N	N
Caps on services	N	N	N	N	N	N
Community accesses acute home care nursing services from province	N	N	N	Y	N	Y
There are waitlists for services on-Reserve	N	N	N	N	N	N

Table 1: Service summary continued

	Membertou	Millbrook	Paqtnkek	Pictou Landing	Potlotek	Wagmatcook	We'koqma'q
Available services							
Nursing services	Y	Y	Y	Y	Y	Y	Y
Homemaking	Y	Y	Y	Y	Y	Y	Y
In-home respite care	Y	Y	Y	Y	Y	Y	Y
Specialized equipment	Y	Y	Y	Y	Y	Y	Y
Medical/personal care supplies	Y	Y	Y	Y	Y	Y	Y
Adult care program	N	Y	N	N	N	N	N
Meal program	Y	N	N	N	N	Y	N
Mental health services	N	Y	N	Y	N	N	N
Home based palliative care	Y	Y	Y	Y	Y	Y	Y
Specialized programs for wellness and fitness	N	Y	N	Y	N	Y	N
Non-medical transportation	N	N	N	N	N	N	N
Rehabilitation and therapy services	Y	Y	Y	Y	Y	Y	N
Personal care	Y	Y	Y	Y	Y	Y	Y
Footcare	N	N	Y	N	N	N	N
Self-managed care	N	N	N	N	N	N	N
Home oxygen services	Y	Y	Y	Y	Y	Y	Y
Home maintenance	Y	Y	Y	Y	Y	Y	Y
Home repair	Y	Y	Y	Y	Y	Y	Y
off-Reserve medical transportation	Y	Y	Y	Y	Y	Y	Y
Service access and availability							
Formal assessment process	Y	Y	Y	Y	Y	Y	Y
Age limitations	N	N	N	N	N	N	N
Fees for homecare services	N	N	N	N	N	N	N
Caps on services	N	N	Y	N	N	N	N
Community accesses acute home care nursing services from province	Y	N	Y	N	N	N	N
There are waitlists for services on-Reserve	N	N	N	N	N	N	N

Table 1: Service summary continued

	Acadia	Annapolis Valley	Bear River	Eskasoni	Glooscap	Indian Brook
Special equipment						
Basic equipment available from Home Care Program	Y	Y	Y	Y	Y	Y
NIHB provides some specialized equipment	Y	Y	Y	Y	Y	Y
Band covers equipment not otherwise provided	Y	Y	N	N	Y	N
Transportation						
off-Reserve medical transportation	Y	Y	Y	Y	Y	Y
Community had medical drivers	N	N	N	Y	N	Y
Band provides cash advances and/or subsidizes milage rate	Y	N	N	n/a	Y	n/a
on-Reserve transportation	N	N	Y	N	N	Y
Relationships						
Relationship with local hospital	N	Y	N	Y	N	Y
Relationship with DHA	Y	Y	Y	Y	Y	N
Relationship with province	N	N	N	N	N	N
Client discharge						
Formal discharge planning protocol	N	N	N	Y	N	N
When a client is discharged from the hospital (standard practice):						
a) The hospital usually contacts the health centre	N	Y	N	Y	N	N
b) the family or client usually contacts the health centre	Y	N	Y	N	Y	Y
If a client is discharged during off hours: (usual scenario)						
a) Home care staff will provide services regardless	N	N	N	N	N	Y
b) VON services are arranged	Y	Y	Y	N	Y	N
c) Client would go to the emergency room	N	N	N	Y	N	N

Table 1: Service summary continued

	Membertou	Millbrook	Paqtnkek	Pictou Landing	Potlotek	Wagmatcook	We'koqma'q
Special equipment							
Basic equipment available from Home Care Program	Y	Y	Y	Y	Y	Y	Y
NIHB provides some specialized equipment	Y	Y	Y	Y	Y	Y	Y
Band covers equipment not otherwise provided	N	N	N	Y	Y	N	N
Transportation							
off-Reserve medical transportation	Y	Y	Y	Y	Y	Y	Y
Community had medical drivers	Y	Y	Y	N	Y	Y	Y
Band provides cash advances and/or subsidizes milage rate	n/a	n/a	n/a	Y	n/a	n/a	N
on-Reserve transportation	N	N	N	N	N	N	N
Relationships							
Relationship with local hospital	Y	N	Y	N	Y	Y	Y
Relationship with DHA	Y	N	Y	Y	Y	Y	Y
Relationship with province	Y	N	N	N	N	N	N
Client discharge							
Formal discharge planning protocol	Y	N	N	N	Y	Y	Y
When a client is discharged from the hospital (standard practice):							
a) The hospital usually contacts the health centre	Y	N	N	N	Y	Y	Y
b) the family or client usually contacts the health centre	N	Y	Y	Y	N	N	N
If a client is discharged during off hours: (usual scenario)							
a) Home care staff will provide services regardless	N	N	Y	N	N	N	N
b) VON services are arranged	N	N	N	Y	Y	N	N
c) Client would go to the emergency room	Y	Y	N	N	N	Y	Y

Table 1: Service summary continued

	Acadia	Annapolis Valley	Bear River	Eskasoni	Glooscap	Indian Brook
Community can support clients who require 24 care	N	N	N	N	N	N
The community is currently providing 24 care to a client(s)	N	Y	N	Y	N	N
Problems and gaps						
Medical Transportation	Y	Y	Y	N	Y	Y
Training	Y	N	Y	Y	Y	Y
Lack of funding	Y	Y	Y	Y	N	Y
More staff needed	N	Y	N	Y	N	N
Long term care	N	Y	N	N	Y	N
Lack of clarity among community members or health officials about what Home Care includes	N	Y	N	Y	Y	N
Service Needs						
Mental health	Y	Y	Y	Y	N	N
OT/PT	N	Y	N	Y	N	N
Adult day program	N	N	N	Y	N	Y
Podiatrist	N	N	N	Y	N	N
Formal discharge protocol with hospitals	Y	Y	Y	N	N	Y
Specialized programs for Elders	N	N	N	N	N	Y

Table 1: Service summary continued

	Membertou	Millbrook	Paqtnkek	Pictou Landing	Potlotek	Wagmatcook	We'koqma'q
Community can support clients who require 24 care	N	N	N	N	N	N	N
The community is currently providing 24 care to a client(s)	N	N	N	N	N	N	N
Problems and gaps							
Medical Transportation	N	N	N	N	N	N	N
Training	Y	Y	Y	Y	Y	Y	Y
Lack of funding	Y	Y	Y	N	Y	Y	Y
More staff needed	N	N	Y	Y	N	N	N
Long term care	Y	Y	N	N	Y	Y	Y
Lack of clarity among community members or health officials about what Home Care includes	N	Y	N	N	Y	N	Y
Service Needs							
Mental health	Y	N	Y	N	Y	N	N
OT/PT	Y	N	N	N	Y	N	Y
Adult day program	N	N	N	N	N	N	N
Podiatrist	N	N	N	N	N	N	Y
Formal discharge protocol with hospitals	N	N	Y	Y	N	Y	Y
Specialized programs for Elders	Y	N	N	N	N	N	N

** Population data:*

- *Registered population as of May, 2009 with the exception of Millbrook and Glooscap where 2009 data is not available. In these cases 2006 data is used.*
- *Total on-Reserve and off-Reserve population do not necessarily add up to total registered population. There are other circumstances such as living on Crown land.*
- *Total on-Reserve population includes registered population living on a governing Reserve or other Reserve.*

Source: Indian & Northern Affairs Canada. First Nations Indian Profile Website. Accessed June 2009.

2.3 Service Utilization

The intent of collecting home care service utilization data is to get a better understanding of program use by service type for each community. Home care service hours are based on Home and Continuing Care E-sdrt summary data recorded by communities as part of First Nations and Inuit Health Home and Community Care reporting requirements. Eight communities representing 79% of the on-Reserve First Nations population in Nova Scotia provided data for the 2007-2008 fiscal year.

2.3.1 Summary E-sdrt data by community reporting

Table 2 presents total home care visits and home care service hours for those communities which provided data. The eight communities represent 79% of the total on-Reserve First Nations population in Nova Scotia. Findings should be interpreted cautiously due to concerns expressed about data quality and accuracy.

Table 2: Summary E-sdrt data by community reporting

	Annapolis Valley		Bear River		Eskasoni		Indian Brook	
on-Reserve population*	107		103		3,345		1,215	
Total home visits (#)	1,344		596		15,578		10,253	
Home visits per person on-Reserve	13		6		5		8	
	hours	%	hours	%	hours	%	hours	%
Assisted Living	1,708	92%	3,554	96%	8,261	42%	35,368	87%
Home management	*1,708*	*92%*	*3,074*	*83%*	*5,871*	*30%*	*29,156*	*72%*
Meal services	-	-	*480*	*13%*	*2,390*	*12%*	*5,405*	*13%*
Other Assisted Living	-	-	-	-	-	-	*807*	*2%*
Nursing services	126	7%	138	4%	3,187	16%	709	2%
Personal care	-	-	-	-	5,627	29%	717	2%
Case management	28	2%	-	-	1,298	7%	170	0%
Prof. therapies	-	-	13	0%	-	-	500	1%
In-home respite	-	-	-	-	1,301	7%	3,104	8%
Total	1,862	100%	3,705	100%	19,673	100%	40,567	100%
Hours per person on-Reserve	17		35		6		33	

*Notes: Percent totals may not add to 100% due to rounding. *Population data source: INAC First Nations Indian Profile Website 2009).*

The average number of home visits per person on-Reserve ranges from a high of thirteen in Annapolis Valley to a low of three in Millbrook. Five home visits is the average number per person based on the seven communities providing data. The average number of service hours received per person range from a high of thirty five hours per person in Bear River to a low of

five hours per person in We'koqma'q. The average number of service hours per person based on the eight communities reporting is 13 hours per person.

While the total on-Reserve population does not access home care services, presenting per person results is useful for cross-Reserve comparisons given that the funding allocation to support the Home and Community Care and Assisted Living programs is based on the on-Reserve population census.

The majority of home care hours support Assisted Living services, notably home management which includes housekeeping, home maintenance and home repairs. Five of the eight communities also offer meal services which account for 6% to 28% of total home care hours depending on the community.

Table 2: Summary E-sdrt data by community reporting (continued)

*** Data for Wagmatcook and We'koqma'q are projected for the year, based on monthly data for 6 months.*

Eskasoni, Millbrook and Wagmatcook have a much higher allocation of hours supporting personal care (29%, 36%, and 31% respectively). Four of the five other communities providing data report no personal care hours. In Indian Brook, 2% of total home care service hours support personal care. The amount of program hours supporting nursing services ranges from 2% to 16%.

2.3.2 Projected Home Care Service Utilization

The data collected from the eight communities was used to project totals for all thirteen on-Reserve home care service hours and number of home visits (Tables 3 and 4). While the data provides some insight into First Nations on-Reserve home care service use in the province, caution should be used regarding the accuracy of the numbers given data quality and reporting concerns with E-sdrt data.

Table 3: Projected home care service hours (fiscal 2007-2008)

	Projected Total Service Hours	Percent of Total Hours	Hours (per person on-Reserve)	Hours (per person 50 years + on-Reserve)
Assisted Living	85,903	73%	9	66
Home management	*72,278*	*62%*	*8*	*55*
Meal services	*12,512*	*11%*	*1*	*10*
Other Assisted Living services	*1,113*	*1%*	*0*	*1*
Nursing services	7,422	6%	1	6
Personal care services	14,731	13%	2	11
Case management	2,916	2%	0	2
Professional therapies	748	1%	0	1
In-home respite	5,580	5%	1	4
Total	**117,300**	**100%**	**13**	**90**

Note: data does include services contracted to VON or if provided by an outside agency.

Table 4: Projected home care visits (fiscal 2007-2008)

	Projected Total Home Visits	Home Visits (per person on-Reserve)	Home Visits (per person 50 years + on-Reserve)
Assisted Living	54,419	6	41

It is projected that federal Home and Community Care programming made over 54,000 home visits and provided 117,300 hours of service during the 2007-2008 fiscal year. To better understand the magnitude of service provision, this translates into an average of 6 home visits per person and 13 hours of service per person living on-Reserve. While home and continuing care services are available to residents on-Reserve of any age, typically programs are accessed by older adults. If we allocate total home visits and program hours to the portion of the on-Reserve population over the age of fifty, it translates into 41 visits and 90 hours per person for this cohort per year.

Sixty-two percent (62%) of home care hours supported home management services which includes housekeeping, followed by personal care services (13%), meal service (11%) nursing services (6%) in home respite (5%), case management (2%) and professional services (1%) and other assisted living services such as day programs and attendant care (1%). The percent allocation of home care hours on-Reserve differs substantially from the percent allocation for the general Nova Scotian population (Table 5). While an interesting comparison, it is important to interpret the findings cautiously given the difference in programs between what is available on-Reserve versus what is available off-Reserve. In addition, the First Nations data in Table 5 contains the projected percent allocation of home care service hours and not actual hours delivered.

Table 5: Percent allocation of home care service hours

	FNIH Home and Community Care	NSDoH Continuing Care
Home management (housekeeping)	62%	13%
Personal care/ nursing services	19%	44%
Meal services	11%	20%
In-home respite	5%	22%

Note: Data provided by the Department of Health is for fiscal year 2008-2009.

In addition to the data presented in this section, eight communities provided the number of clients served in their home and community program each month for fiscal 2007/08. These 8 communities have a total population of 4,715 First Nation individuals living on-Reserve. Three (3) of the communities also provide services to members off-Reserve (total off-Reserve population is 377). Using the highest monthly client number and the on-Reserve populations and where appropriate the off-Reserve populations, a crude utilization rate was calculated. Five (5) communities have a utilization rate of 3% or in other words, of the total population able to access their services 3% were receiving services. One (1) community had a rate of 4% while the remaining two communities had rates of 6% and 11%. The community with the 11% utilization rate was the smallest community in this group.

The provincial home care program has a utilization rate of between 2-3% or in other words approximately 22,000-25,000 individuals access the program each year. It is important to note that the federal Home and Community Care program includes home maintenance, repair and adaptation services and some professional therapies not included in the provincial home care program.

The First Nations data also provides some insight into the amount of service being provided. Based on the data provided from 6 communities, the average number of service hours per client per month ranged from a low of 17 hours/month to a high of 59 hours/month. It is difficult to compare this data with provincial home care data because it includes other services not provided by the provincial home care program. In addition most First Nations programs do not have service limitations and a number of communities indicated they are providing 24/7 care to a very small number of individuals.

Section 3:
Summary of Programs & Terms

Nova Scotia Department of Health, Continuing Care Branch

Health Canada, First Nations and Inuit Health

Indian & Northern Affairs Canada

3.1 About the Summary of Programs and Terms

The Home Care Summary of Programs and Terms document originated out of a need to better understand the different home care programs being offered by the Nova Scotia Department of Health (Continuing Care Branch), Health Canada (First Nations Inuit Health) and Indian & Northern Affairs Canada.

3.2 Summary Check Sheet

The program summary check sheet highlights home and community care programs offered off-Reserve by the Department of Health through the district health authority structure and on-Reserve through Health Canada and/or Indian & Northern Affairs Canada.

Table 6: Programs supported, by organization

Service Summary	Nova Scotia Department of Health	Health Canada	Indian & Northern Affairs Canada
Home making	Yes	Yes	Yes
Personal care (i.e. bathing, footcare, dressing)	Yes	Yes	No
Home nursing support	Yes	Yes	No
Home maintenance (i.e. snow removal, yard work)	No	No	Yes
Home repair and adaptations	No	No	Yes
Home oxygen services	Yes	Yes	No
Meal program	Yes	No*	Yes
Respite care	Yes	Yes*	Yes
Rehabilitation and therapy services (i.e. OT /PT)	No	No*	No
Adult day care	No	No*	Yes
Home based palliative care	Yes	No*	No
Specialized programs for wellness and fitness	No	Yes*	No
Mental health home based services	No	No*	No
Specialized equipment • Hospital beds • General equipment	 Yes No	 No Yes	 No No
Medical/personal care supplies	Yes	Yes	No
Transportation	No	Yes	Yes
Foster care	No	No	Yes
Institutional care	Yes	No	Yes
Self-managed care	Yes	No	No
Caregiver allowance	Yes	No	No

Nova Scotia Department of Health (Continuing Care Branch); Health Canada First Nations and Inuit Health (Home and Community Care Program and Non-Insured Health Benefits Program); Indian & Northern Affairs Canada (Assisted Living Program)

**The essential service elements of the Home and Community Care Program are expected to be developed initially in each First Nation community. The program may expand to include these supportive service elements based on community needs and priorities, existing infrastructure and availability of resources. Health Canada does not provide funding for supportive services, only essential services (see details on pages 44-45).*

3.3 Program Overviews

3.3.1 Nova Scotia Department of Health Continuing Care Branch

The Nova Scotia Department of Health Continuing Care Branch Home Care Program provides services to Nova Scotians of all ages who need help to reach and maintain their optimal level of independence and well being in their homes and communities. The program is designed to complement the help people can receive from others such as family, community, or friends.

The home care program has a number of distinct goals, functions and impacts, including:

- as a substitution function for other more costly services such as hospitals and long term care facilities;
- as a maintenance function, to support clients to remain in their current environment, rather than moving to a new and often more costly venue;
- as a preventative function, investing in client care at additional short-term costs to achieve lower long-term costs.

The home care program provides acute, chronic and palliative types of care. Acute home care is provided over the short term to assist individuals in improving and/or stabilizing a medical or post surgical condition. Chronic home care offers ongoing services to provide the support, respite and care required to safely maintain an individual with a chronic illness or disability in their own home and community. Palliative care is available to individuals, at the end stage of life, who have chosen to spend as much time as possible in their own homes.

A broad range of client services are offered through the home care program. These services may include:

- assessment;
- case management and care coordination;
- home support services that include homemaking (e.g. cleaning, laundry, meal preparation) and personal care (e.g. bathing, dressing, grooming, mobility assistance, feeding, and toileting);
- home nursing services (nursing assessment, health teaching, health monitoring and treatment). Nursing supplies are provided, at no cost to the client, during the nursing visit; and,
- home oxygen services.

In addition, the home care program offers referral and linkage to other Continuing Care and community-based programs such as:

- bed loan program (contracted through the Canadian Red Cross);
- institutional care (long term care in nursing homes, residential care facilities and community-based options);
- self-managed care; and,
- caregiver allowance.

Home care services are paid for through the Department of Health's funding of DHAs and are delivered by contracted provider agencies.

There is no charge to the client for nursing services. There may be a minimal fee charged to the client for home support, self-managed care or home oxygen services. Client fees are based on income and family size and there is a monthly maximum that a client can be charged, depending on his or her income category.

More information about the Home Care Program is available at:

www.gov.ns.ca/health/ccs/homecare.asp

3.3.2 Health Canada First Nations and Inuit Health Home and Community Care Program

The First Nations and Inuit Health Home and Community Care Program will provide basic home and community care services that are:

- comprehensive;
- culturally sensitive;
- accessible;
- effective;
- equitable to that of other Canadians; and,
- responsive to the unique health and social needs of First Nations and Inuit.

The program will be delivered primarily by trained and certified personal care/home health aide workers at the community level supported and supervised by registered nurses.

The Home and Community Care Program will be composed of essential service elements and may be expanded to include supportive service elements provided the essential service elements are met. When communities already have all essential services through alternate sources, the program will not duplicate these services, but will allow communities to augment, through supportive service components, the current services. Essential services include:

- a structured client assessment process;
- care coordination/case management;
- home care nursing services;
- home support services;
- in-home respite care;
- established linkages;
- management and support;
- provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals; and,
- a system of record keeping and data collection.

The Program will coordinate and link with existing programs and services at the community and/or provincial/territorial level.

The essential service elements of the Home and Community Care Program are expected to be developed initially in each First Nation community. The Program may expand to include supportive service elements based on community needs and priorities, existing infrastructure and availability of resources. Health Canada does not fund supportive services elements.

Supportive elements that may be provided within a continuum of home and continuing care might include, but are not limited to:

- facilitation and linkages for rehabilitation and therapy service;
- respite care;
- adult day care;
- meal programs;
- mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness (these services might include traditional counselling and healing services, and medication monitoring);
- support services to maintain independent living, which may include assistance with special transportation needs, grocery shopping, accessing specialized services and interpretative services;

- home-based palliative care;
- social services directly related to continuing care issues; and,
- specialized health promotion, wellness and fitness.

More information about the First Nations Home and Community Care Program is available at:

www.hc-sc.gc.ca/fniah-spnia/services/home-domicile/index-eng.php

3.3.3 Health Canada First Nations and Inuit Health Non-Insured Health Benefits

(The following excerpt is from the First Nations Inuit Health Program Guide)

The Non-Insured Health Benefits (NIHB) Directorate is responsible for the administration of First Nations and Inuit primary health care services that are not otherwise covered by private insurance or the provincial and territorial medical insurance plan.

Benefits provided under the NIHB Program include:

- optometric services (vision care);
- dental services;
- pharmaceutical services (drugs, medical supplies, and equipment)
- out of country and co-insurance fees;
- mental health services (short term crisis intervention), and;
- medical transportation (limited to on-Reserve status clients).

The NIHB Program's policy on coordination of benefits is based on the *1979 Indian Health Policy*, the goal of which was to achieve an increasing level of health in the First Nation and Inuit populations. The provision of health care services to First Nations and Inuit is the joint responsibility of federal, provincial, territorial or municipal governments, First Nations and Inuit communities and the private sector. The program requires that before accessing benefits through NIHB, eligible First Nations or Inuit must first apply for and exhaust all other available benefit coverage.

An NIHB information booklet outlining eligibility and benefits is available for download at www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2003_booklet_livret_info/index-eng.php.

For a list of medical supplies and drugs covered by NIHB see http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php#drug-med.

3.3.4 Indian & Northern Affairs Canada Assisted Living Program

Communities receive Indian & Northern Affairs Canada (INAC) funding for the Assisted Living Program which includes funding for the In-home Care program and Institutional Care Type 1 and Type 2. Program funding is based on a per capita funding formula. A delivery plan is established between the community and INAC outlining what services will be offered. Terms and conditions of the funding agreement states that services being offered must be comparable to provincial standards. Communities decide how to allocate dollars according to community need based on the list of services supported under each program. Individual communities are responsible for program delivery. Program specifics such as service availability, hours, service caps, and who conducts assessments

are determined by the community but need to be in compliance with the funding agreement.

The In-Home Care program provides financial assistance for non-medical personal care services. Services which fall under In-Home Care include:

- meal programs, meal preparation, menu planning;
- day programs;
- attendant care;
- short-term respite care;
- group care;
- light housekeeping, laundry, ironing, mending;
- carrying water or wood;
- home management (light and heavy cleaning);
- minor home maintenance (for example, fixing a door knob or attaching a railing along stairs); and,
- non-medical transportation (this would include transportation for grocery shopping, to and from recreational activities etc).

INAC has limited responsibility for non-medical Types 1 and II levels of care in institutions that are operated according to provincial or territorial laws and standards both on and off-Reserves.

INAC may fund the per diem portion of institutional care. Final recipients in an institution are expected to pay the provincial or territorial government established co-insurance or user fee for care and maintenance and clothing and personal expenses to the extent they are financially able to.

The following may be funded:

- standard accommodation;
- meals, including therapeutic diets;
- food, laundry;
- necessary emergency and routine treatment supplies;
- skilled care with professional supervision as needed and a planned program of social and recreational activities;
- clothing;
- special diets;
- age allowance;
- personal living allowance; and,
- guide dogs in any of the following: foster homes, Types I and II personal care homes on-Reserves, Types I and II care facilities off-Reserves.

More information about the INAC Assisted Living Program is available at:

www.ainc-inac.gc.ca/hb/sp/alp-eng.asp

3.4 Common Definitions

The following tables establish a set of common definitions and describes the programs being offered by each provider and clarifies terms used by the various organizations. The information was compiled with direct input and review from the three respective organizations.

3.4.1 Service summary

Service Summary	Nova Scotia Department of Health – Continuing Care Branch	Health Canada – First Nations and Inuit Health	Indian & Northern Affairs Canada – Assisted Living
Homemaking	Yes, includes cleaning, laundry, meal preparation, etc. These services are offered as part of both the acute and chronic home care streams.	This is usually covered by the Assisted Living program (INAC). A few communities have the FNIHCC Program and Assisted Living - In home care program integrated. Where this exists the FNIHCC program does the assessment of the unmet needs and allocates services like light housekeeping and meal preparation.	Yes, includes light housekeeping, laundry, ironing, and mending. In addition, the Assisted Living Program provides home management which includes light and heavy cleaning.
Personal care (i.e. bathing, footcare, dressing)	Yes, includes bathing, dressing, mobility assistance, feeding, oral care, toileting, and foot care (where it is not available from another source), etc. These services are offered as part of both the acute and chronic home care streams.	Yes, includes non-medical care services such as bathing, skin care, and dressing.	No.
Home nursing support	Yes, includes nursing assessment, health teaching, health monitoring and treatment. These services are offered as part of both the acute and chronic home care streams.	Yes, includes health teaching, health monitoring and treatment, medication administration and management, therapeutic care, foot care and wound management.	No.
Home maintenance (i.e. snow removal, yard work)	No.	No.	Yes, includes snow removal, yard work, and other basic home maintenance.
Home repair and adaptations	No.	No.	Yes, includes minor home maintenance (for example, fixing a door knob or attaching a railing along stairs).

Service Summary	Nova Scotia Department of Health – Continuing Care Branch	Health Canada – First Nations and Inuit Health	Indian & Northern Affairs Canada – Assisted Living
Home oxygen services	Yes, clients who meet medical eligibility and program criteria have access to oxygen concentrators and related supplies. In addition, clients may access up to 10 portable oxygen tanks per month. Approved oxygen vendors deliver, set up, and maintain the equipment.	Yes, covered by Non-Insured Health Benefits.	No.
Meal program	Clients are referred to community programs such as Meals-on-Wheels. However, clients who cannot access a community-based program and require support with meal preparation can receive this service through home support.	A meal program is considered a supplemental program and may be added once all essential programs are provided.	Yes, includes meal programs, meal preparation, and menu planning.
Respite care	Yes, clients can access up to 40 hours of in-home respite per month, and up to 60 days of long term care respite per year.	Yes, in-home respite care is provided for primary caregiver(s).	Yes, short term in home respite care is provided.
Rehabilitation and therapy services (occupational therapy/ physical therapy)	No, however, the Continuing Care Branch is currently providing funding to the District Health Authorities on an interim basis to provide community-based therapy services. Planning is underway to provide therapy services as part of the continuing care menu of services.	Rehabilitation and therapy services are considered a supportive program and may be added once all essential programs are provided.	No.

Service Summary	Nova Scotia Department of Health – Continuing Care Branch	Health Canada – First Nations and Inuit Health	Indian & Northern Affairs Canada – Assisted Living
Adult day care	No, however, the Continuing Care Branch is providing interim funding to the DHAs to provide adult day programs. Planning is underway to develop a provincial adult day program as part of the continuing care menu of services.	Adult day care is considered a supportive program and may be added once all essential programs are provided.	The Assisted Living Program provides attendant care and group care. Attendant care is personal assistance provided to people (typically aged 16 to 64 years) with a physical disability, who have the capacity to manage and direct care workers (ie. home support workers) in their own home. Personal assistance includes: assistance with (or supervision of) dressing and undressing; eating and drinking; transferring; bathing and showering; grooming; and related domestic assistance. Attendants also perform other duties, such as help with meal planning and preparation, laundry, light housekeeping, etc. Group care refers to organized day programs.
Home based palliative care	Yes, palliative care clients can access enhanced services for the last three months of life.	Home based palliative care is considered a supportive program and may be added once all essential programs are provided.	No.
Specialized programs for wellness and fitness	No.	Specialized programs for wellness and fitness are considered a supportive program and may be added once all essential programs are provided.	No.
Mental health home based services	No.	Mental health home based services are considered a supportive program and may be added once all essential programs are provided.	No.

Service Summary	Nova Scotia Department of Health – Continuing Care Branch	Health Canada – First Nations and Inuit Health	Indian & Northern Affairs Canada – Assisted Living
Transportation	No.	Yes, Transportation is provided through Non Insured Health Benefits Transportation Agreement for travel off-Reserve to medical appointments.	Yes, includes non-medical transportation services for such things as grocery/clothing shopping and trips for social activities. It would not include travel for holidays, etc.
Foster care	No.	No.	The Foster Care program provides supervision and care in a family-like setting to people who are unable to live on their own due to physical or psychological limitations, but who do not need constant medical attention. This service represents a viable alternative to institutional care in circumstances where constant medical care is not required on site.
Specialized equipment •*Hospital beds* •*General equipment*	Continuing Care has contracted the Red Cross to operate a hospital bed loan program. Home care clients are responsible for borrowing, rental, purchase or otherwise obtaining other medical equipment required in the home.	Non Insured Health Benefits does not supply hospital beds. Non Insured Health Benefits does provide some specialized equipment.	No.

Service Summary	Nova Scotia Department of Health – Continuing Care Branch	Health Canada – First Nations and Inuit Health	Indian & Northern Affairs Canada – Assisted Living
Medical/personal care supplies	Medical supplies must be on the approved supplies list. For chronic home care clients supplies used during the nursing visit are provided at no direct charge to the client. The client is responsible for supplies required between nursing visits. For acute home care clients, medical supplies required for the treatment of the individual's acute illness or condition are provided for the duration of the client's service at no direct charge to the individual. Medical supplies which are not provided are as follows: • Incontinence supplies that are not on the approved list • Nutritional supplements • Ongoing diabetic supplies • Supplies requiring a prescription • Over the counter medications • Ongoing colostomy supplies	Non-Insured Health Benefits provides medical and personal care supplies to registered FN individuals which can be administered in a home setting or in other ambulatory care settings. The program covers supplies that are not provided in a provincially/territorially covered setting (hospital/institution) or provided through provincially/territorial covered programs or clinics. A prescription from a licensed practitioner is required for any listed drug to be processed as a benefit. Drug products which are not within the scope of the program are as follows: • Anti-obesity drugs; • Household products (regular soaps and shampoos); • Cosmetics; • Alternative therapies, including glucosamine and evening primrose oil; • Megavitamins; • Drugs with investigational status; • Vaccinations for travel indications; • Hair growth stimulants; • Fertility agents and impotence drugs; • Selected over-the-counter products; • Codeine containing cough preparations; • Stadol TM NS and generics (butorphanol tartrate nasal spray); and Darvon® and 642® (propoxyphene); • Fiorinal®, Fiorinal® C ¼, Fiorinal® C ½ and generics (Butalbital containing analgesics with and without codeine); • Dalmane®, Somnol® and generics (flurazepam); • Librium®, Solium®, Medilium® and generics (chlordiazepoxide); • Tranxene® and generics (clorazepate).	No.

Service Summary	Nova Scotia Department of Health – Continuing Care Branch	Health Canada – First Nations and Inuit Health	Indian & Northern Affairs Canada – Assisted Living
Institutional care	Continuing Care provides long term care in nursing homes, residential care facilities and community-based options (of which there are two types - small option homes for 3 or less residents and community residences typically for 1-2 residents).	No.	The Assisted Living Program funds non-medical care for people in designated facilities if at home care is not feasible and institutional care is needed. The following may be funded: standard accommodation; meals, including therapeutic diets; food; laundry; necessary emergency and routine treatment supplies; skilled care with professional supervision as needed and a planned program of social and recreational activities clothing; special diets; age allowance; personal living allowance; guide dogs in any of the following; foster homes; Types I and II personal care homes on-Reserves; Types I and II care facilities off-Reserves.
Self-managed care	Continuing Care provides funding directly to clients to arrange for their own home support services (i.e. non nursing care).	No.	No.

3.4.2 Cross-organizational comparison of home care programming

Is there legislation and/or regulation governing the program?	
Nova Scotia Department of Health Continuing Care Branch	There are two pieces of legislation related to home care in the province: the *Homemakers' Services Act* (1989), and the *Coordinated Home Care Act* (1990). These Acts became outdated with the introduction of the Home Care Nova Scotia program in 1995, which is administered under the Home Care Policy Manual (last revised in 1997 – updated edition expected in early 2010). In December 2005, the *Self-Managed Support Care Act* came into effect.
Health Canada First Nations and Inuit Health	No, the program is not based on legislation but rather is policy-based. FNIH has national standards, guidelines and policies in place which support the program. FNIH Atlantic oversees the specific terms and conditions of the contribution agreements with First Nation communities who deliver the Home and Community Care on-Reserve services.
Indian & Northern Affairs Canada – Assisted Living	The Assisted Living Program is based on national standards and guidelines and is managed nationally by Indian & Northern Affairs Canada. INAC regions oversee specific program delivery and regulation for their region. Nova Scotia falls under the INAC Atlantic Region.

Who is the target population?	
Nova Scotia Department of Health Continuing Care Branch	Home care helps people of all ages who need assistance to maintain their optimal well being and independence at home. Home care serves clients with acute, chronic and palliative needs. Home care encourages and supports the assistance provided by the family and/or community. PROGRAM OBJECTIVES 1. To help people maintain optimal well being and independence at home by: a) determining needs and abilities, developing and coordinating plans of care; b) teaching self-care and coping skills; c) improving, maintaining or delaying loss of functional abilities; d) promoting and supporting family and community responsibility for care; and e) supporting palliative, supportive and acute care provided by family, friends and others. 2. To facilitate appropriate use of health and other community-based services by: a) preventing or delaying the need for admission to long-term care facilities; b) supporting people waiting for long-term care admission; c) preventing the need for hospital admission, making earlier discharge from hospital possible, and reducing the frequency of re-admission; d) helping individuals and families access needed services; e) promoting volunteer participation; f) educating the public and community agencies about home care; g) participating in local service planning and coordination; and h) developing an awareness of and integrating complementary services provided by other organizations and agencies. 3. To make the best use of home care resources by: a) serving people with the greatest need first; b) operating economically and efficiently; and c) communicating relevant information in a timely manner. 4. To meet client needs and optimize client well being and independence within available home care resources while working cooperatively with other community agencies, organizations and individuals.

	Who is the target population? (continued ...)
Health Canada First Nations and Inuit Health	The target population is residents on-Reserve who meet the program eligibility criteria. The program objectives are : - to build the capacity within First Nations and Inuit communities to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services at a pace acceptable to the community; - to assist First Nations and Inuit individuals living with chronic and acute illness in maintaining optimum health, well being and independence in their homes and communities; -to facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan; - to ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible; - to assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients; and, - to build the capacity within First Nations and Inuit communities to deliver home care services through training, evolving technology, information systems to monitor care and services and to develop measurable objectives and indicators.
Indian & Northern Affairs Canada – Assisted Living	The target population is Indians who are ordinarily resident on Reserve that require some type of assistance with daily living. INAC has the authority to provide non-medical types I and II levels of care to individuals ordinarily resident on-Reserve.

What are the eligibility criteria?	
Nova Scotia Department of Health Continuing Care Branch	An individual may be eligible for home care when the Care Coordinator is satisfied that: - The individual has been assessed as requiring a home care service due to an illness or disability which has resulted in an unmet functional need; - The individual's unmet need is such that he/she will be at risk of increase to, or continuation of, illness, injury, institutionalization, or informal support network collapse if the home care services are not provided. This risk is measured through a comprehensive assessment process; - The individual requires home support, nursing and/or personal care services, and home care is the most suitable method of providing the amount, level and type of service required; - The individual is a resident of Nova Scotia and has a Nova Scotia Health Card Number; or the individual is a resident of Nova Scotia and is in the process of applying for a Nova Scotia Health Card Number; or the individual is a resident of Nova Scotia employed by a Federal government department of agency and the services being requested from home care are not the contractual or legal responsibility of the individual's employer; - The individual's physical condition limits his/her ability to reasonably access the necessary care from community-based services such as outpatient departments, clinics of physicians' offices; - The individual's condition and situation is such that he/she can be cared for safely and effectively at home with the services available through home care; - The individual's environment is safe and suitable for the provision of home care services, both for the individual and the caregiver, as determined by the Care Coordinator in consultation with agency care provider staff; - The individual is willing to accept the home care service according to the developed Resource Allocation Plan; - The services required by the individual will not generally exceed the cost of the equivalent level of services in a licensed health care facility. Exceptions may be authorized for short periods.

What are the eligibility criteria? (continued ...)	
... continued ... Nova Scotia Department of Health Continuing Care Branch	***Eligibility Exclusions*** Individuals: - Do not meet the General Eligibility Criteria; - Only require services which are not provided by home care or are the sole responsibility of the individual or of another agency/department; - Require services which are the legal responsibility of the owner or operator of the individual's place of residence (e.g. provision of home support services in a boarding home); - Require services that are the responsibility of the federal government on First Nation Reserves. The provision of home care services to First Nation persons living on-Reserves remains the responsibility of the federal government. Home care provides Chronic Home Care services to Registered Indians living off-Reserves and to non-native, non-registered persons living on-Reserves. Acute Home Care services can also be provided to Registered Indians living on and off Reserves upon approval. This arrangement will remain in place until such time as a letter of understanding has been agreed upon with the federal government, the Band Councils and the provincial government; - Require a level of service such that the care of the individual in the home is assessed to be unsafe and the provision of care by home care contributed to an unacceptable level of risk; - The services exceed the cost of the equivalent level of services in a licensed health care facility.
Health Canada First Nations and Inuit Health	For an individual to be eligible she/he must meet the following criteria: - First Nations or Inuit of any age; and - Who live on a First Nation Reserve, Inuit settlement or First Nation community 'north of 60'; and - Who have undergone a formal assessment of their continuing care service needs and have been assessed to require one or more of the essential services; and - Who have access to services that can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice. This program was developed in 1999 and does not provide services which are already available to First Nation individuals through existing programs. The program was not intended to duplicate existing services but will allow the communities to augment, through the supportive service components, the current services.

... continued ... *What are the eligibility criteria?*	
Indian & Northern Affairs Canada – Assisted Living	For an individual to be eligible she/he must meet the following criteria: - Must be ordinarily resident on-Reserve; - Must be formally assessed by designated social or health professionals as requiring one or more of the designated essential services; - Must be people who do not have the resources to obtain such services themselves and who do not have access to other federal, provincial or territorial sources of support, as confirmed by an assessment covering the following: family composition and age; financial resources available to the household (household as defined by the province). The income test to determine financial resources is often conducted by communities as it has been found to be offensive by the recipient. - In the case of children, must be formally assessed as needing such services, but only in cases where the responsibility for funding and providing such services does not lie with other agencies or programs.

Is there age criteria?	
Nova Scotia Department of Health Continuing Care Branch	The program is available to Nova Scotians of all ages who have assessed unmet care needs. The majority (78%) of home care clients are over the age of 65.
Health Canada First Nations and Inuit Health	No, available to First Nations and Inuit living on-Reserve.
Indian & Northern Affairs Canada – Assisted Living	There is no age criteria. Programs, however, have typically been designed to meet the needs of an aging population.

Do you provide home care services to mental health clients?	
Nova Scotia Department of Health Continuing Care Branch	No specific services are provided to mental health clients, however clients that access mental health services can access home care services if they have a health care need requiring home care.
Health Canada First Nations and Inuit Health	HC-FNIH will provide 10 sessions of counselling for persons in crisis. Additional mental health services are a supplemental program.
Indian & Northern Affairs Canada – Assisted Living	Services are available to anyone who meets the eligibility criteria. There are not specific services targeting mental health clients.

Do you provide home care services to children with special needs?	
Nova Scotia Department of Health Continuing Care Branch	Yes, depending on the care needs of the pediatric client. If the child has health care needs that can be met at home they may be eligible for services through the home care program. However, very few of the clients in the program are children (less than 1% of clients are under the age of 14). Children with special needs more commonly access services through the Department of Community Services. Additionally, the home care program faces a number of challenges in providing services to children as care provider staff often require special training, and given the infrequency of requests for services to the pediatric population, appropriate staff are not always available.
Health Canada First Nations and Inuit Health	HC-FNIH funds FN communities to provide home care services. Services are available to all community members regardless of age who satisfy the eligibility criteria. There is not, however, designated funding or programming specific to children with special needs.
Indian & Northern Affairs Canada – Assisted Living	Yes. (Same criteria apply for program eligibility, as noted previously).

Do you provide home care services to seniors?	
Nova Scotia Department of Health Continuing Care Branch	Yes, seniors make up the majority of clients in the program (78%).
Health Canada First Nations and Inuit Health	Services are available to anyone who meets the eligibility criteria.
Indian & Northern Affairs Canada – Assisted Living	Services are available to anyone who meets the eligibility criteria. Programs, however, have typically been designed to meet the needs of an aging population.

Do you provide home care services to other particular groups?	
Nova Scotia Department of Health Continuing Care Branch	Palliative care home care is available to clients in the last three months of life. In addition to the home care program, clients can access Home Oxygen services, the Bed Loan program and the Self-Managed Care Program which provides funds to clients to arrange for their own care.
Health Canada First Nations and Inuit Health	Services are available to anyone who meets the eligibility criteria.
Indian & Northern Affairs Canada – Assisted Living	Not specifically, the program is available to anyone who meets the eligibility criteria.

Are there user fees/co-payments? If so how are they determined?	
Nova Scotia Department of Health Continuing Care Branch	Clients in the Chronic Home Care program may pay an hourly rate for home care services, up to a maximum monthly fee, for home support, personal care and in-home respite services provided by Continuing Care Assistants. The maximum monthly fee is determined based on the client fee determination process which looks at household income and the number of people in the household. No fees for services are assessed to individuals whose net income falls within or below the designated client income category or who are in receipt of income-tested government benefits (i.e. Guaranteed Income Supplement, Income Assistance, etc.). Currently, the majority of chronic home care clients do not pay any fees. Clients receiving home oxygen may be assessed a monthly fee. No fees are charged for nursing services or personal care services provided by RNs or LPNs. There are no fees for services to clients in the Acute Home Care program.
Health Canada First Nations and Inuit Health	No.
Indian & Northern Affairs Canada – Assisted Living	Access to services is based on an assessment to determine that those who wish to access the services do not have the resources to obtain such services themselves and who do not have access to other federal, provincial or territorial sources of support. Assessments cover family composition and age and financial resources available to the household (household as defined by the province). For the Foster Care Program per diems are provided based on the rate schedule for the reference province or territory. Other eligible non-medical expenses associated with placement may also be paid. For institutional care, INAC will only fund the per diem portion of institutional care. Recipients in an institution are expected to pay the provincial or territorial government established co-insurance or user fee for care and maintenance and clothing and personal expenses to the extent they are financially able to.

Do fee structures differ for different kinds of services?	
Nova Scotia Department of Health Continuing Care Branch	Yes – see above.
Health Canada First Nations and Inuit Health	No.
Indian & Northern Affairs Canada – Assisted Living	They may, depending on provincial rates.

Is there a cap/maximum amount of services a client can receive? If so, what is it?	
Nova Scotia Department of Health Continuing Care Branch	Generally, the costs of home care services will not exceed the cost of services in a long term care facility.
Health Canada First Nations and Inuit Health	The amount of services a client can receive is determined by the community and dependent on resources available.
Indian & Northern Affairs Canada – Assisted Living	The amount of services a client can receive is determined by the community.

Within policy, what hours of the day are services to be available? Do hours vary for different types of services?	
Nova Scotia Department of Health Continuing Care Branch	The program strives to provide all services 24 hours a day, 7 days a week.
Health Canada First Nations and Inuit Health	The hours of service are not consistent among communities as resources provided vary. Where feasible (given resources), it is recommended that communities provide services during daytime hours (9-5) Monday to Friday. Communities make a decision if they can offer extended hours.
Indian & Northern Affairs Canada – Assisted Living	Policy does not state the hours that services are to be available. Program delivery hours will vary by community.

How do clients access the program?	
Nova Scotia Department of Health Continuing Care Branch	Clients apply for home care by calling the toll free Single Entry Access line 1-800-225-7225.
Health Canada First Nations and Inuit Health	By referral from hospital, physicians, self referral or family/ community members. Referrals are to the home and continuing care program in the community.
Indian & Northern Affairs Canada – Assisted Living	By referral, that can come from a number of sources including: final recipient; a friend or relative; health-related programs (for example, Home and Community Care Program); an acute care, rehabilitation or psychiatric hospital; a First Nation social development worker, or other health or social service professional. The referral is made to the coordinator of the Assisted Living Program in the community.

Is there an assessment process? If so, what tools are used?	
Nova Scotia Department of Health Continuing Care Branch	Yes, all clients needing home care services undergo an assessment of function, health, social support and service use. The assessment tool is the InterRAI MDS-HC electronic assessment tool, a standardized assessment tool used in many jurisdictions. The assessment helps determine what care services the client is eligible to receive based on his/her need. Clients requiring home care services for a short period of time only, such as acute nursing care, may not undergo a full assessment.
Health Canada First Nations and Inuit Health	A structured client assessment process that includes on-going reassessment and determines client needs, family supports and service allocation is required to be included in the community program plans. Most communities use the assessment template provided with the program. Some have adapted other agency's assessment tools.
Indian & Northern Affairs Canada – Assisted Living	An initial placement authorization is completed to document the care and rehabilitation program and related costs. The assessment process varies according to INAC region.

Who conducts the assessment?	
Nova Scotia Department of Health Continuing Care Branch	Care coordinators employed by the District Health Authorities conduct the assessment. Care coordination staff are located in communities throughout the province. Assessment services are available in all general tertiary, regional and community hospitals in Nova Scotia.
Health Canada First Nations and Inuit Health	Assessments are performed by an appropriately trained registered nurse. The nurse can either be employed by the community or contracted through other agencies such as VON.
Indian & Northern Affairs Canada – Assisted Living	Assessments are conducted by a designated social or health professional (who is qualified or licensed by the appropriate provincial body) using the care assessment criteria or the relevant provincial or territorial criteria. Individuals conducting assessments are either employed by the community or contracted by the community to undertake the assessments.

How are services allocated?	
Nova Scotia Department of Health Continuing Care Branch	The care coordinator reviews the assessment data to confirm the unmet functional needs. She/he then establishes a service plan, in collaboration with the client and/or family.
Health Canada First Nations and Inuit Health	Services are allocated based on assessed unmet needs and resources available.
Indian & Northern Affairs Canada – Assisted Living	Service allocation is determined by the community.

Is there case management/care coordination? If so, what is the role? (to access, reassess, authorize services)?	
Nova Scotia Department of Health Continuing Care Branch	Care coordination staff are responsible for all case management functions including assessment, service planning, resource allocation, authorization of service and referral to other community-based resources. Care coordination includes ongoing communication between the home care program, the client and or family, informal caregivers and agency care providers regarding the client's needs and the services provided. Current policy indicates that a reassessment of acute home care clients be done weekly, or as needed, or as requested by the physician/care providers and upon completion of services. Reassessment of chronic home care clients should occur at the 2 month point or sooner if requested, and then at least on an annual basis.
Health Canada First Nations and Inuit Health	Assessment to access the program, reassessment and service allocation is tied into the structured client assessment process. Case management/care coordination involves linking with other professionals and agencies to ensure that clients receive quality care.
Indian & Northern Affairs Canada – Assisted Living	Case management is provided by an Assisted Living program coordinator. Depending on the size of the community it is sometimes done by the health nurse or by the social development administrator. Case management includes assessment and reassessment and service allocation.

Is there a waitlist for services? If so, how is it managed?	
Nova Scotia Department of Health Continuing Care Branch	There are waitlists for home support services in some areas of the province. Wait lists for home support exist for various reasons including human resource challenges. If a waitlist is required, home support provider agencies maintain a waitlist based on the home support waitlist guidelines established by the Continuing Care Branch, Department of Health. These guidelines prioritize clients based on risk.
Health Canada First Nations and Inuit Health	Waitlist and service delivery protocols will vary by community.
Indian & Northern Affairs Canada – Assisted Living	Waitlists will vary by community.

How are services funded/paid for?	
Nova Scotia Department of Health Continuing Care Branch	As home care is a provincially funded program, services are paid for through the Department of Health's budget to the contracted agencies that provide services. Provider agencies submit a business plan to the Department of Health annually which is reviewed, and based on new dollars available, is adjusted accordingly. In 2010/11 this process will change with funding going from the Department of Health to the District Health Authorities who will then fund approved home care agencies. Beginning with the 2010/11 business planning cycle, home care agencies will submit their business plans to the respective District Health Authorities.
Health Canada First Nations and Inuit Health	Health Canada funds the First Nations and Inuit Home and Community Care program through contribution agreements with the First Nations Chief and councils.
Indian & Northern Affairs Canada – Assisted Living	Allowable expenses are based on the service standards and rate schedules of the province or territory of residence. Payments are made monthly to the recipient based on a cash flow forecast from the recipient or by reimbursing eligible costs. In terms of the larger program funding, all INAC programs are covered under a single funding arrangement with a First Nation community. Under the Assisted Living Program, each First Nation community will have either one of two arrangement types in place: - Comprehensive Funding Arrangement (CFA) – This is a program budgeted funding arrangement that INAC enters into with First Nations for one year. - Canada/First Nation Funding Agreements (CFNFA) – This is a block-funded agreement that INAC enters into with a First Nation for up to five years. It can include funding from other federal departments. This type of agreement is also called an *Alternative Funding Arrangement* or *Financial Transfer Agreement*. In Atlantic Region, most First Nations use a funding instrument called a Departmental First Nation Funding Arrangement (DFNFA) Department of Indian and Northern Development/First Nation Funding agreements - a type of CFNFA).

How do you coordinate services with primary care and acute care?	
Nova Scotia Department of Health Continuing Care Branch	There are care coordinators in hospitals throughout the provinces that are involved in discharge planning for clients requiring home care following a hospital stay. The client's physician determines the medical suitability and stability for Acute Home Care and recommends admission to the home care program. The physician provides primary acute diagnosis, pertinent medical information, and medical orders. The attending physician is responsible for provision of continuous medical care and coverage, and availability to home care staff for consultation on the acute home care clients as required. Family physicians are consulted regularly by care coordinators for chronic home care clients.
Health Canada First Nations and Inuit Health	A managed care process is an essential service that must be provided. A managed care process incorporates case management, referrals and service linkages to existing services provided both on- and off-Reserve. In addition, communities in their program plans are required to demonstrate established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with such providers as hospitals, physicians, respite and therapeutic services.
Indian & Northern Affairs Canada – Assisted Living	Service coordination will vary by community.

Who provides the care (what type of care providers)?	
Nova Scotia Department of Health Continuing Care Branch	Registered Nurses (RNs) and Licenced Practical Nurses (LPNs) provide nursing services and Continuing Care Assistants (CCAs) (previously home support workers and personal care workers) provide services such as home support, personal care, and respite. RNs and LPNs may provide personal care services if the needs of the client require this level of provider.
Health Canada First Nations and Inuit Health	Services are provided by Registered Nurses, Licensed Practical Nurses and Certified Home Health Aids or Personal Care Workers at the community level. The home health aids and personal care workers must be supervised by registered nurses.
Indian & Northern Affairs Canada – Assisted Living	The First Nation community oversees the care. The actual care is provided by privately incorporated service providers (either on- or off-Reserve).

Who employs the care providers?	
Nova Scotia Department of Health Continuing Care Branch	Registered Nurses and Licensed Practical Nurses are employed largely by the VON, but some are also employed by the District Health Authorities in the Cape Breton area and the Eastern Shore of Halifax Regional Municipality. Continuing Care Assistants that provide home support services are employed by private sector agencies that are approved by the Department of Health.
Health Canada First Nations and Inuit Health	The Band employs the care providers unless some of the care is being contracted out or is being delivered by utilizing linkages such as District Health Authorities.
Indian & Northern Affairs Canada – Assisted Living	The Band employs the providers.

Who schedules home care visits?	
Nova Scotia Department of Health Continuing Care Branch	The care coordinators provide the agency with a service plan for the client that authorizes the services to be provided. Care Coordinators may indicate preferred or required time periods for delivery of particular services, however, it is the responsibility of the provider agency to develop the service delivery schedule.
Health Canada First Nations and Inuit Health	It varies by community; typically the home care coordinator or nurse supervisor does the scheduling.
Indian & Northern Affairs Canada – Assisted Living	The coordinating First Nation personnel.

When compared to the hours that services are to be available according to policy, are there any gaps in the hours that services are provided? If so, what is the gap, and what is the reason for it?	
Nova Scotia Department of Health Continuing Care Branch	Some agencies providing services indicate that they cannot provide 24/7 services, largely due to human resource limitations. Hours of service availability vary by provider agency.
Health Canada First Nations and Inuit Health	Services in Nova Scotia vary by community. It is a service that is available Monday–Friday daytime hours. No community offers 24-hour care, 7 days a week. Protocols for handling services during off hours/holidays will vary by community. Some of the gaps exist because of: a lack of contingency plans for back up; lack of required resources; and a lack of trained staff to deliver the program.
Indian & Northern Affairs Canada – Assisted Living	Hours of service vary by community. There are no specific hours according to policy.

Is there monitoring of the program and/or providers?	
Nova Scotia Department of Health Continuing Care Branch	The Continuing Care Branch, NS Department of Health employs several Monitoring and Evaluation Officers. Part of their role/responsibility involves auditing home care providers using DoH Home Care Service Standards. In addition, there are currently a number of home care indicators that are monitored at a provincial level including: a. number of admissions b. diagnosis c. amounts of service delivery (by type) d. expenditures e. safety events and critical incidents.
Health Canada First Nations and Inuit Health	Yes, all community program plans undergo a collaborative review process. FNIH monitors the providers by asking the Band to collect licenses to practice annually for registered health professionals and to provide a copy of their liability insurance for health staff. Employers may consult with us or the registering body should they have concerns regarding their employees. At the regional level, FNIH requires financial and annual reports. As well, FNIH will monitor services through community visits.
Indian & Northern Affairs Canada – Assisted Living	INAC requires First Nation community recipients to report on several key areas including conflict of interest, financial management, audited financial statements, transparency, disclosure, etc. There are no regional program requirements. The regional INAC office is responsible for oversight of the program delivery aspects in relation to the national policy.

What program evaluation is in place?	
Nova Scotia Department of Health Continuing Care Branch	The Continuing Care Branch employs staff members that are responsible for program evaluation. No comprehensive evaluation of the home care program has been completed recently, but evaluation of particular components is ongoing.
Health Canada First Nations and Inuit Health	All communities must complete reporting requirements as determined by the contribution agreement on an annual basis.
Indian & Northern Affairs Canada – Assisted Living	Sporadic compliance and program reviews are done by the INAC regional staff to ensure that financial and policy requirements are being met.

Do you have a recent evaluation report?	
Nova Scotia Department of Health Continuing Care Branch	No. However, the Continuing Care Strategy released by government in 2006 identified a number of key areas for improvement of the home care program.
Health Canada First Nations and Inuit Health	No. There have been numerous studies which have identified recommendations for improving continuing care services to First Nations and Inuit.
Indian & Northern Affairs Canada – Assisted Living	No.

What accountability structures are in place?	
Nova Scotia Department of Health Continuing Care Branch	Home Care provider agencies are required to provide the Department of Health with monthly reports accounting for the amounts and types of direct service they provide and for costs of indirect time related to service delivery (administrative time). They must also provide the Department with an audited financial statement at year-end.
Health Canada First Nations and Inuit Health	The contribution agreement is a legal agreement with goals, objectives and activities of the FNIH Home and Community Care Program. To receive funding, communities submit a program plan. Any proposed changes to their existing plans must be approved by the Regional Home and Continuing Care officer. Communities report once a year on their Program.
Indian & Northern Affairs Canada – Assisted Living	INAC conducts program reviews with communities which include compliance and financial reviews. Communities are required to provide reports by service area, # of clients, and hours on a monthly or annual basis depending on their funding agreement.

What kind of information systems do you have to track client data?	
Nova Scotia Department of Health Continuing Care Branch	The Continuing Care Branch has an integrated case management system that captures comprehensive data around referrals, assessments, home care plans and long-term care.
Health Canada First Nations and Inuit Health	In program plans, communities are required to demonstrate that they have a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities. All communities use an Electronic Service Delivery Reporting Template (E-sdrt) to report to the region. The Region is provided with aggregate information. Individual client records are maintained in the community. Monitoring, planning and evaluation expertise varies among communities.
Indian & Northern Affairs Canada – Assisted Living	None.

Section 4:
Cross Canada Review

Nova Scotia Department of Health
(Continuing Care Branch)
First Nations Inter-jurisdictional Survey

4.1 Overview

During the period April to July 2009, the Continuing Care Branch of the Nova Scotia Department of Health conducted survey research across Canada on eligibility and access by First Nation individuals to provincially funded home care, long term care and community-based programming. Information was collected from the following eight provincial jurisdictions:

British Columbia	Alberta
Saskatchewan	Manitoba
Ontario	New Brunswick
Prince Edward Island	Newfoundland & Labrador

Data sources included provincial Ministries and Regional or District level service administration structures.

The focus of this effort was to determine the current state of affairs with respect to a number of key issues as they relate to the provision of provincially funded services to First Nation individuals. The areas of interest included:

- The service delivery structure for provincial Continuing Care services in the jurisdiction.
- The extent of First Nation populations in the jurisdiction.
- The approach adopted by the jurisdiction respecting funding of continuing care services to First Nation individuals.
- The role of the federal government in providing or funding services to First Nation individuals.
- The role of provincial authorities in setting policy related to eligibility and access to continuing care programming.
- What, if any, formal approaches have been adopted by the jurisdiction with respect to managing relationships with First Nation communities. Examples might include Memoranda of Understanding, formal funding or service agreements, etc.
- Particular challenges experienced with regard to the delivery of services to First Nation populations in the jurisdiction.

Of most interest was the approach adopted by provincial Ministries of Health with regard to access to services on-Reserve. Some provinces provide First Nation individuals on-Reserve with access to the same home care services as other citizens, some provide access to services only for needs not met through federally funded home care programs, and others see home care services to First Nation individuals on-Reserve as the responsibility of the federal government and do not provide provincially funded services on Reserves.

4.2 Funding Responsibility

4.2.1 Nova Scotia Context

Currently in Nova Scotia, provincial home care services are not provided to Registered Status individuals on-Reserve, except for acute home care services, which are approved by exception. First Nation individuals living off-Reserve are eligible to access the full range of provincially funded home care services. Some other provincially funded community-based services, e.g. the Bed Loan Program, may be available on-Reserve. The full costs of long term care services to Registered Status individuals living on-Reserve are deemed the responsibility of the federal government and are paid through Indian & Northern Affairs Canada.

4.2.2 Other Jurisdictions

There are a number of different approaches used across Canada for the development of home care policy and the delivery of home care programs. In most provinces, including British Columbia, Alberta, Saskatchewan and Manitoba, the province sets home care policy with regards to access and eligibility, while regional health authorities deliver the home care program. In PEI home care is delivered as a provincial program by the Department of Health. Ontario has a mixed approach with the provincial Ministry of Health taking responsibility for developing policies, while Local Health Integration Networks (LHINs) are responsible for planning and funding of health services, such as the Community Care Access Centres which deliver the home care program.

Additionally, there is a mix of approaches across Canada with regard to the provision of home care services to First Nation individuals living on-Reserve. British Columbia, Ontario, and Newfoundland indicated that provincial home care services are available to all citizens of the province including First Nation residents living on-Reserve. Provincial services do not replace but rather complement or supplement services available through a FN community's home care program. In New Brunswick home support services provided through the Department of Social Development are not delivered on-Reserve however, nursing services, limited home support and professional therapies such as occupational therapy provided through the Extra-Mural program of the Department of Health are delivered on-Reserve and funded by the province.

Alberta, Manitoba and Saskatchewan do not provide provincial home care services to First Nation individuals living on-Reserve. Residents in these communities are expected to access federally funded home care programs. Both Alberta and Saskatchewan report that First Nation communities can and do contract with regional health authorities for home care services, however these services are funded by the First Nation community not the province.

With regard to more general community-based care programs, British Columbia indicated that there are no specific on-Reserve programs, but that First Nation individuals on-Reserve can access programs such as adult day that exist throughout the province. Alberta indicated that seniors lodges are available to individuals living on some Reserves. These lodges provide services such as meals, adult day programs and assisted living, but do not provide medical services. In Saskatchewan, First Nation individuals living on-Reserve are able to access community-based programs off-Reserve, but no specific services are provided on-Reserves. Newfoundland, Manitoba and Ontario indicated that First Nation individuals living on-Reserve have the same access to community-based programs as other residents of the province.

All provinces indicated that First Nation individuals living on-Reserve can access long term care services within the province. Many provinces, including Ontario, British Columbia, and Saskatchewan have agreements in place with Indian & Northern Affairs Canada (INAC) where INAC pays part of the costs for long term care and the province assumes some of the costs. In New Brunswick and Newfoundland long term care fees for First Nation individuals living on-Reserve are calculated by the province and financial assistance is provided as it is to other provincial residents.

With regard to access to long term care on First Nation Reserves, British Columbia indicated that there are some long term care facilities located on-Reserve and operated by the individual Bands, but that these facilities must meet licensing and other standards set by the provincial government. Manitoba indicated that INAC has eight facilities in the province specifically designed for First Nation individuals requiring long term care. Two of these facilities are located on-Reserve and are licensed by the province and six are in the process of being licensed. Ontario indicated that there are three facilities on-Reserve receiving provincial funding. There are currently three personal care homes on-Reserve in Saskatchewan. All other provinces indicated that they do not provide any specialized long term care services for First Nation individuals living on-Reserve.

4.3 Summary

The results of the inter-jurisdictional survey show that, nationally, there are differences between jurisdictions in the approach they adopt with respect to the provision of Continuing Care services to registered status First Nation individuals living on-Reserve.

Section 5:
Concluding Remarks & Action Strategy

5.1 Five-Year Plan

The Aboriginal Home Care Steering Committee has developed thirty-one recommendations designed to improve access to and delivery of home care services on-Reserve. The recommendations address the need to engage First Nation communities in a meaningful way at both the local health district level and the provincial and federal levels in the development of strategic health system priorities and new program/policy. As evidenced by the success of this AHTF initiative several recommendations speak to the need for continued relationship building among health system partners.

With a First Nation population struggling under the burden of chronic disease, the need to address gaps in home care service between federal and provincial governments has never been more important. A number of recommendations are aimed at closing funding and policy gaps and ensuring First Nation individuals on-Reserve have access to comparable services as their off-Reserve neighbours.

The final piece of work for the Aboriginal Home Care Steering Committee is the Action Strategy which will serve as a five-year plan for the implementation of all thirty-one recommendations found below. This action strategy will be reviewed regularly by the ACCPF to ensure appropriate movement forward on the recommendations.

Recommendation	Fiscal Year		
	2010 - 2011	2011 - 2012	2012 - 2015
1. On a go-forward basis, it is vital that the scope of home-based services is clearly explained to all stakeholders, in the context of ensuring the highest quality of care for clients and families in the safest and most appropriate setting. It is equally vital that provincial and federal policy makers/funders collaborate with First Nation communities and their representative organizations in continuous improvement of home-based care that both responds to the needs and builds on the strengths of each community.	X		
2. Community service profiles must be updated regularly to ensure that DHAs in general and discharge planners in particular are aware of the hours and scope of local service availability when developing care plans for Aboriginal clients, potentially developing strategies to ensure client access to services after hours to make home care possible. Timely information sharing between local health directors and their DHA will ensure that First Nation home care needs are clearly articulated and reflected in health authority business plans.	X		

Recommendation	Fiscal Year		
	2010 - 2011	2011 - 2012	2012 - 2015
3. First Nation communities providing home care services to members living off-Reserve consider informing these individuals about their access to provincially funded home care services.		X	
4. The Department of Health and DHAs clarify for First Nation communities what services are already available to Band members living off-Reserve to ensure that potential clients/families are aware of these services.	X		
5. First Nation communities with Band members living in satellite Reserves provide this information to their respective DHAs so that the needs of these individuals can be reflected in program planning.	X		
6. The Nova Scotia Department of Health and DHAs clarify with First Nation communities what services they are presently able to access and how to do so.	X		
7. The communities should suggest that the federal government should revisit the Commuting Assistance rates, upon which the Non-Insured Health Benefits (NIHB) private mileage rates are based. These rates should be increased to reflect actual costs of vehicle operation and maintenance based on the experience of First Nation communities as reported in the AHTF Home Care on-Reserves project.	X		
8. Province-wide roll-out of the Cape Breton First Nations Home Care Discharge Planning Program should occur as soon as possible, based on the evaluation and recommendations recently tabled by the Aboriginal Home Care Steering Committee and approved by the Nova Scotia Department of Health. This program should be reviewed on a regular cycle.	X		
9. By continuing to build on the information provided in the attached community service profiles, DHAs and First Nation communities must continue to collaborate in the identification of complex care clients and ensure, to the greatest extent possible, that their service needs are reflected in health authority business planning.		X	
10. Based upon the experience of First Nation communities as reported in the AHTF Home Care on-Reserves project, the communities should suggest that the federal government should revisit the funding approach to Home and Community Care based on the experience that using a per capita formula means that most communities lack the critical mass to make this formula work.	X		
11. The DHAs ensure palliative care consult services available in the community are provided in a culturally appropriate and safe manner to First Nation individuals on-Reserve.	X		

Recommendation	Fiscal Year		
	2010 - 2011	2011 - 2012	2012 - 2015
12. Given the federal government does not provide funding for palliative home care services as an essential service and First Nation communities can only provide these services if they have additional revenue, the Department of Health should consider revising the current Palliative Care Home Care Policy to extend these services to Aboriginal people living on-Reserve.	X		
13. The Nova Scotia Department of Health Palliative Care Task Group include First Nation service delivery issues in its planning and deliberations.	X		
14. Given there is no similar federal program, the Department of Health should consider revising its current Self-Managed Care Policy to open this program to First Nation individuals living on-Reserve. The Department and DHAs would then need to ensure appropriate program information is shared with First Nation communities regarding program parameters and access.		X	
15. As the Department of Health develops policy and standards related to a provincial Adult Day program, consideration should be given to opening this program to First Nation individuals on-Reserve.			X
16. The Department of Health should consider providing direction to the DHAs to open interim Adult Day programs to First Nation individuals on-Reserve who meet program eligibility criteria.		X	
17. Given the federal government does not provide funding for rehabilitation services as an essential service and First Nation communities can only provide these services if they have additional revenue, as the Department of Health develops provincial policy and standards for a provincial community OT/PT program, it should consider opening this program to First Nation individuals on-Reserve and ensure that First Nation health directors are aware that community members have access to these services.			X
18. The Department of Health should consider providing direction to the DHAs to open interim community OT/PT programs to First Nation individuals on-Reserve who meet program eligibility criteria.		X	
19. The Department of Health should consider revising the current Home Oxygen Policy to open this program to First Nation individuals living on-Reserve. Health Canada through Non-Insured Health Benefits should maintain the current federal Home Oxygen program and in doing so, First Nation individuals would then have the option to access either the provincial or federal Home Oxygen programs, so long as they meet program criteria.		X	

Recommendation	Fiscal Year		
	2010 - 2011	2011 - 2012	2012 - 2015
20. The Department of Health should consider revising the current Home Care Policy to open up chronic home care services to First Nation clients living on-Reserve. DHAs and home care providers need to ensure services are delivered in a culturally appropriate manner. Both Health Canada and Indian & Northern Affairs Canada should maintain the current federally funded Home and Community Care and Assisted Living Programs on-Reserve.		X	
21. The Department of Health should consider revising the current Home Care Policy to remove the requirement to approve First Nation on-Reserve access to acute nursing care by exception. The Department should then provide clear information to the DHAs and First Nation communities regarding eligibility criteria and the acute care nursing services that can be provided on-Reserve.	X		
22. The Aboriginal Continuing Care Policy Forum should determine policy and access issues from the perspective of First Nation communities in Nova Scotia as it relates to long term care, so as to inform a multi-jurisdictional approach that is based on evidence of best practice.	X		
23. There is a need for the Continuing Care Assistant (CCA) Program and other training opportunities targeting community members to be made more widely available – removing barriers to access and strengthening the program with curricula customized to address the cultural context of home care delivery in an Aboriginal setting. Recognizing the need for qualified home care staff on-Reserve, the Department of Health should work with First Nation partners, Health Canada and Indian & Northern Affairs Canada to address the issues outlined in the CCA Certification and Training Project proposal developed in 2009.	X		
24. There is an opportunity to develop a mentoring program involving DHA nurses, VON nurses and First Nation nursing staff that would promote professional and cultural skills development and relationship building within the home care nursing community. First Nation community and DHA champions should be identified and a strategy developed to advance this concept.		X	
25. Regardless of whether a home care service is provided on a paid or volunteer basis, the obligation to the client is to ensure that anyone providing care is qualified to perform necessary tasks. When family members are responsible for delivering services, the Band should ensure that these providers are equipped with the skills they need to perform tasks safely and effectively.	X		

Recommendation	Fiscal Year		
	2010 - 2011	2011 - 2012	2012 - 2015
26. The First Nation Band Councils should revisit and consider increasing the rates of compensation for home care workers providing services on-Reserve in order to attract and retain qualified employees and ensure quality service.			X
27. First Nation health directors should develop a strategy for the retention of home care workers delivering services on-Reserve, including how to provide competitive compensation packages to these workers.			X
28. All health providers should take cultural competency and cultural safety training before working on-Reserves.		X	
29. Health Canada, Indian & Northern Affairs Canada, the Department of Health, the DHAs and IWK Health Centre need to ensure meaningful engagement of First Nation communities in new policy/program design and future planning regarding health system development including continuing care services.	X		
30. Venues should be created for DHA and First Nation community representatives to meet, formally and informally, so as to better understand one another's needs, capacities and opportunities for collaboration.	X		
31. The Aboriginal Continuing Care Policy Forum (ACCPF) should include community, district, provincial and federal representation with terms of reference that facilitate action on multi-jurisdictional issues that will advance continued improvement of services to First Nation people living on-Reserves. Current project partners (and in future, other potential partners such as Veterans Affairs Canada, Canada Mortgage and Housing Corporation, and the Department of Community Services) should commit, through the exchange of letters of support, to ongoing participation in the Aboriginal Continuing Care Policy Forum as a mechanism to foster and continue to build relationships amongst the partners and as a forum for policy issue resolution. In addition, the Department of Health, Health Canada and Indian & Northern Affairs Canada should contribute financial resources required to support modest infrastructure for the forum. Support for the forum would include completion of an annual update of the home care framework including the summary of programs & terms, First Nation community service profiles and communications materials to support the discharge planning program. While the Aboriginal Continuing Care Policy Forum is not part of the Mi'kmaq – Nova Scotia – Canada Tripartite Forum, the ACCPF will provide updates on activities and issues as required to the Tripartite Health Committee.	X		

Appendix A: Summary of Recommendations

Please note that 'Registered First Nation individuals' refers to individuals who are registered under the Indian Act.

Recommendation 1: On a go-forward basis, it is vital that the scope of home-based services is clearly explained to all stakeholders, in the context of ensuring the highest quality of care for clients and families in the safest and most appropriate setting. It is equally vital that provincial and federal policy makers/funders collaborate with First Nation communities and their representative organizations in continuous improvement of home-based care that both responds to the needs and builds on the strengths of each community.

Recommendation 2: Community service profiles must be updated regularly to ensure that DHAs in general and discharge planners in particular are aware of the hours and scope of local service availability when developing care plans for Aboriginal clients, potentially developing strategies to ensure client access to services after hours to make home care possible. Timely information sharing between local health directors and their DHA will ensure that First Nation home care needs are clearly articulated and reflected in health authority business plans.

Recommendation 3: First Nation communities providing home care services to members living off-Reserve consider informing these individuals about their access to provincially funded home care services.

Recommendation 4: The Department of Health and DHAs clarify for First Nation communities what services are already available to Band members living off-Reserve to ensure that potential clients/families are aware of these services.

Recommendation 5: First Nation communities with Band members living in satellite Reserves provide this information to their respective DHAs so that the needs of these individuals can be reflected in program planning.

Recommendation 6: The Nova Scotia Department of Health and DHAs clarify with First Nation communities what services they are presently able to access and how to do so.

Recommendation 7: The communities should suggest that the federal government should revisit the Commuting Assistance rates, upon which the Non-Insured Health Benefits (NIHB) private mileage rates are based. These rates should be increased to reflect actual costs of vehicle operation and maintenance based on the experience of First Nation communities as reported in the AHTF Home Care on-Reserves project.

Recommendation 8: Province-wide roll-out of the Cape Breton First Nations Home Care Discharge Planning Program should occur as soon as possible, based on the evaluation and

recommendations recently tabled by the Aboriginal Home Care Steering Committee and approved by the Nova Scotia Department of Health. This program should be reviewed on a regular cycle.

Recommendation 9: By continuing to build on the information provided in the attached community service profiles, DHAs and First Nation communities must continue to collaborate in the identification of complex care clients and ensure, to the greatest extent possible, that their service needs are reflected in health authority business planning.

Recommendation 10: Based upon the experience of First Nation communities as reported in the AHTF Home Care on-Reserves project, the communities should suggest that the federal government should revisit the funding approach to Home and Community Care based on the experience that using a per capita formula means that most communities lack the critical mass to make this formula work.

Recommendation 11: The DHAs ensure palliative care consult services available in the community are provided in a culturally appropriate and safe manner to First Nation individuals on-Reserve.

Recommendation 12: Given the federal government does not provide funding for palliative home care services as an essential service and First Nation communities can only provide these services if they have additional revenue, the Department of Health should consider revising the current Palliative Care Home Care Policy to extend these services to Aboriginal people living on-Reserve.

Recommendation 13: The Nova Scotia Department of Health Palliative Care Task Group include First Nation service delivery issues in its planning and deliberations.

Recommendation 14: Given there is no similar federal program, the Department of Health should consider revising its current Self-Managed Care Policy to open this program to First Nation individuals living on-Reserve. The Department and DHAs would then need to ensure appropriate program information is shared with First Nation communities regarding program parameters and access.

Recommendation 15: As the Department of Health develops policy and standards related to a provincial Adult Day program, consideration should be given to opening this program to First Nation individuals on-Reserve.

Recommendation 16: The Department of Health should consider providing direction to the DHAs to open interim Adult Day programs to First Nation individuals on-Reserve who meet program eligibility criteria.

Recommendation 17: Given the federal government does not provide funding for rehabilitation services as an essential service and First Nation communities can only provide these services if they have additional revenue, as the Department of Health

develops provincial policy and standards for a provincial community OT/PT program, it should consider opening this program to First Nation individuals on-Reserve and ensure that First Nation health directors are aware that community members have access to these services.

Recommendation 18: The Department of Health should consider providing direction to the DHAs to open interim community OT/PT programs to First Nation individuals on-Reserve who meet program eligibility criteria.

Recommendation 19: The Department of Health should consider revising the current Home Oxygen Policy to open this program to First Nation individuals living on-Reserve. Health Canada through Non-Insured Health Benefits should maintain the current federal Home Oxygen program and in doing so, First Nation individuals would then have the option to access either the provincial or federal Home Oxygen programs, so long as they meet program criteria.

Recommendation 20: The Department of Health should consider revising the current Home Care Policy to open up chronic home care services to First Nation clients living on-Reserve. District health authorities and home care providers need to ensure services are delivered in a culturally appropriate manner. Both Health Canada and Indian & Northern Affairs Canada should maintain the current federally funded Home and Community Care and Assisted Living Programs on-Reserve.

Recommendation 21: The Department of Health should consider revising the current Home Care Policy to remove the requirement to approve First Nation on-Reserve access to acute nursing care by exception. The Department should then provide clear information to the DHAs and First Nation communities regarding eligibility criteria and the acute care nursing services that can be provided on-Reserve.

Recommendation 22: The Aboriginal Continuing Care Policy Forum should determine policy and access issues from the perspective of First Nation communities in Nova Scotia as it relates to long term care, so as to inform a multi-jurisdictional approach that is based on evidence of best practice.

Recommendation 23: There is a need for the Continuing Care Assistant (CCA) Program and other training opportunities targeting community members to be made more widely available – removing barriers to access and strengthening the program with curricula customized to address the cultural context of home care delivery in an Aboriginal setting. Recognizing the need for qualified home care staff on-Reserve, the Department of Health should work with First Nation partners, Health Canada and Indian & Northern Affairs Canada to address the issues outlined in the CCA Certification and Training Project proposal developed in 2009.

Recommendation 24: There is an opportunity to develop a mentoring program involving DHA nurses, VON nurses and First Nation nursing staff that would promote professional

and cultural skills development and relationship building within the home care nursing community. First Nation community and DHA champions should be identified and a strategy developed to advance this concept.

Recommendation 25: Regardless of whether a home care service is provided on a paid or volunteer basis, the obligation to the client is to ensure that anyone providing care is qualified to perform necessary tasks. When family members are responsible for delivering services, the Band should ensure that these providers are equipped with the skills they need to perform tasks safely and effectively.

Recommendation 26: The First Nation Band Councils should revisit and consider increasing the rates of compensation for home care workers providing services on-Reserve in order to attract and retain qualified employees and ensure quality service.

Recommendation 27: First Nation health directors should develop a strategy for the retention of home care workers delivering services on-Reserve, including how to provide competitive compensation packages to these workers.

Recommendation 28: All health providers should take cultural competency and cultural safety training before working on-Reserves.

Recommendation 29: Health Canada, Indian & Northern Affairs Canada, the Department of Health, the DHAs and IWK Health Centre need to ensure meaningful engagement of First Nation communities in new policy/program design and future planning regarding health system development including continuing care services.

Recommendation 30: Venues should be created for DHA and First Nation community representatives to meet, formally and informally, so as to better understand one another's needs, capacities and opportunities for collaboration.

Recommendation 31: The Aboriginal Continuing Care Policy Forum (ACCPF) should include community, district, provincial and federal representation with terms of reference that facilitate action on multi-jurisdictional issues that will advance continued improvement of services to First Nation people living on-Reserves. Current project partners (and in future, other potential partners such as Veterans Affairs Canada, Canada Mortgage and Housing Corporation, and the Department of Community Services) should commit, through the exchange of letters, of support to ongoing participation in the Aboriginal Continuing Care Policy Forum as a mechanism to foster and continue to build relationships amongst the partners and as a forum for policy issue resolution. In addition, the Department of Health, Health Canada and Indian & Northern Affairs Canada should contribute financial resources required to support modest infrastructure for the forum. Support for the forum would include completion of an annual update of the home care framework including the summary of programs & terms, First Nation community service profiles and communications materials to support the discharge planning program. While the Aboriginal Continuing Care Policy Forum is not part of the Mi'kmaq – Nova Scotia – Canada Tripartite Forum, the ACCPF will provide updates on activities and issues as required to the Tripartite Health Committee.

Appendix B: Data Collection Instrument

1) What services are offered under the banner of home care in your community?

Type of service	Yes(Y)/ No(N)	Who provides this service?	Which program funds this service?	Approx. how many people per month access this service?	When are services offered (days of week and hours of day)?	What happens during off hours?
Nursing services						
Homemaking						
Personal care (bathing, footcare, dressing)						
Home support services						
Home maintenance (snow removal, yard work)						
Home repair and adaptations						
Home oxygen services						
Meal program						
In-home respite care (respite for primary care giver)						
Rehabilitation and therapy services (occupational/ physical therapy)						
Adult day program						
Home based palliative care						
Specialized programs for wellness and fitness						
Mental health home based services						
Specialized equipment						
Medical/personal care supplies						
Transportation						
Self-managed care						
Foster care						
Residential care						
Other services (please list):						

2) Who provides homecare in your community (title and organization, employer)?

3) What type of training, certification and credentials do home care providers have?

4) What happens when a particular service is required but not offered in your community?

5) What home care services that are not currently provided would patients benefit from, and how many clients would benefit from each of these services?

6) Over the last year (on average) how many people in a typical month accessed the following services:

   - Home support services?
   - Acute nursing care?
   - Chronic nursing care?

7) How do potential clients go about accessing services?

8) Do potential clients undergo an assessment?

9) Who (title and position) conducts the assessment?

10) Are physicians in your community involved with home care?

11) What home care services do clients pay for?

   - What rates do they pay (by service type)?
   - How are the service pay rates determined?

12) Is there a cap on the amount of a service a person can access?

13) What special equipment is available to clients?

   - Who provides the special equipment?
   - How is the equipment paid for?

14) Is transportation provided to clients (please describe)?

   - Who provides the transportation?
   - How is it paid for?

15) Are there any age restrictions regarding access to services?

16) What additional types of services currently not offered would improve the provision of home care?

17) Are there services that should be available according to federal funding/policy but that are not available in the community?

- If yes, why is this?
- If yes, what are they?

18) Are there waitlists for any services?

- If yes, which services?
- Approximately, how many are on the wait list (by service)?
- How long is the average wait list (by service)?
- If yes, how is the waitlist managed (by service)?

19) Does your community access acute home care nursing services from the province?

- If yes, how often?

20) Does your community access acute home care nursing services from the federal government?

- If yes, how often?

21) Is it expected in your community that family members will provide informal home care?

22) Approximately what percentage of those in need of home care services are being supported by family members?

23) Are family members compensated for providing home care services?

- If yes, which services are family members compensated for and how are pay rates determined?

24) What are the strengths and weaknesses of the current situation regarding the delivery of home care services?

25) What gaps exist in the current delivery model?

26) What would improve the provision of home care in your community?

27) Are services offered in a culturally appropriate manner?

- If not, what would strengthen the cultural appropriateness?

28) What relationships currently exist with hospitals, the District Health Authority, provincial government and federal government regarding the provision of home care?

29) What happens when a patient is discharged from the hospital and requires follow-up home care in the community?

30) What happens when a patient is discharged from the hospital during the off hours and requires follow-up home care in the community?

31) Are there circumstances where a patient can't be discharged from hospital because his/her medical needs are greater than can be supported within current local home care service provision? (If yes, please explain).

32) Are their formal mechanisms in place between local service providers and hospitals regarding discharge planning?

- If not, what mechanism/relationships should be established?

33) Do you have any further suggestions on what could improve the delivery of home care services in your community?

Appendix C: Directory of Contacts

Provincial Continuing Care Programs

Referral and Information Line
1-800-225-7225

District Health Authorities

South Shore Health Authority (1)
Wendy McVeigh
District Manager, Continuing Care
South Shore District Health Authority
Unit 2 - 821 King Street
Bridgewater NS B4V 1B7
wmcveigh@ssdha.nshealth.ca
Phone (902) 527-5451
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South West Nova Health Authority (2)
Bob Jenkins
Director, Continuing Care
South West Nova District Health Authority
Nurses' Residence, 2nd Floor
58 Vancouver Street
Yarmouth, NS B5A 2P4
BJenkins@swndha.nshealth.ca
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Fax (902) 742-0686

Annapolis Valley Health Authority (3)
Cindy Baker
Manager, Continuing Care
Annapolis Valley District Health Authority
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Colchester East Hants Health Authority (4)
Barbara Goad
District Manager, Continuing Care
Colchester East Hants District Health Authority
797 Prince Street
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Patricia Harrington
District Manager, Continuing Care
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Amherst, NS B4H 1X7
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Phone (902) 667-6493
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Pictou Health Authority (6)
Jane Jordan
District Manager, Continuing Care
Pictou County Health Authority
Suite 225 Aberdeen Business Centre
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Tish Campbell
Director, Seniors' Health and Services
Pictou County Health Authority
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Phone (902) 752-7600 ext 4880
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Guysborough Antigonish Strait Area Health Authority (7)
Debbie Samson
District Manager, Continuing Care
Guysborough-Antigonish Strait Health Authority
Suite 11, 218 MacSween St.
Port Hawkesbury, NS B9A 2J9
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Cape Breton Health Authority (8)
Lorne MacLeod
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Cape Breton District Health Authority
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Capital Health (9)
Jill Robbins
Director, Continuing Care
Capital District Health Authority
1796 Summer Street
Halifax NS B3H 3A7
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Fax (902) 473-1210

First Nation Communities

Acadia First Nation (District 2)
Stephanie Smith, Health Director
Acting: Melanie Robinson
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Chester Basin, NS B0J 1K0
mrobinson@acadiaBand.com
Phone: (902) 627-1245
Fax: (902) 627-1361

Afton [Paqtnkek] (District 7)
Juliana Julian, Health Director
7 Dillon Road
RR # 1
Afton First Nation, NS B0H 1A0
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Annapolis First Nation (District 3)
Christine MacFarlane, Acting Director
41 Gym Road
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Bear River First Nation (District 2)
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Amanda Kelly
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Kathy White (902) 467-4197
Sarah Swimanner (902) 247-9533
Mary Lou Lockhart (902) 532-7803
Tracey Goucher (902) 467-3844

Chapel Island First Nation [Potlotek] (District 7)
Laurie Touesnard, Health Director
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Bonnie Gagnon
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Mary Beniot
Home Care Coordinator
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Eskasoni First Nation (District 8)
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Glooscap First Nation (District 3)
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Jocelyn Nickerson, CHN
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Lorraine Whitman, Social Adult Care
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Indian Brook First Nation (District 4)
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Terry Knockwood, RN
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Membertou First Nation (District 8)
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Millbrook First Nation (District 4)
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Suzette MacLeod, Nurse

Lavinia Brooks, CHR

Corinna Milliea, Community Support and Family Enrichment worker

Valerie Julian-Meader, Administrative Liaison

Pictou Landing First Nation (District 6)
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Wagamatcook First Nation (District 8)
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Karen Googoo, CCA

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Mary Janet Isadore, Adult Care

Brenda Basque, Adult Care

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Policy

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The Confederacy of Mainland Mi'kmaq
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First Nations and Inuit Health
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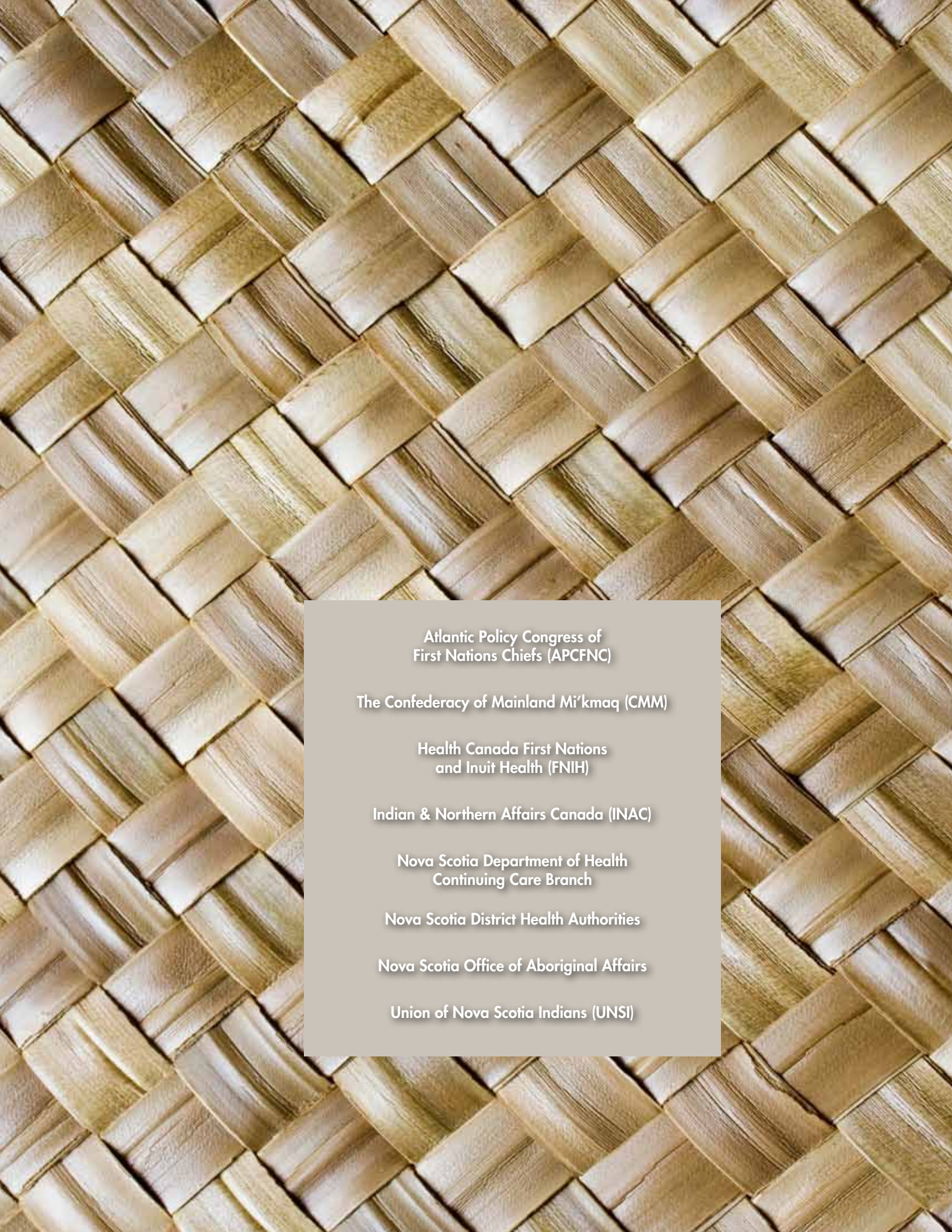

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The Confederacy of Mainland Mi'kmaq (CMM)

Health Canada First Nations
and Inuit Health (FNIH)

Indian & Northern Affairs Canada (INAC)

Nova Scotia Department of Health
Continuing Care Branch

Nova Scotia District Health Authorities

Nova Scotia Office of Aboriginal Affairs

Union of Nova Scotia Indians (UNSI)