Aboriginal Long Term Care in Nova Scotia

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Aboriginal Health Transition Fund
Home Care on-Reserves Project

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A Report of the Nova Scotia Aboriginal Home Care Steering Committee
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contents

1.0 INTRODUCTION 1

2.0 FN COMMUNITY SERVICE PROFILES 1
2.1 Methodology 2
2.2 Current long term care use and potential demand 2
2.3 Experiences and barriers accessing long term care 5
2.4 Key features of a culturally relevant long term care model 7
2.5 Changes needed to current long term care facilities 8

3.0 BEST PRACTICE RESEARCH 9
3.1 Literature review 9
3.2 Long term care need 9
3.3 Challenges and barriers facing First Nation communities 10
3.4 Culturally appropriate long term care 12
3.5 Best practice programs and models of care 14
3.6 Canadian facilities survey results 16

4.0 PROVINCIAL AND FEDERAL PROGRAM OVERVIEW 19
4.1 Nova Scotia Department of Health - Continuing Care Branch 19
4.2 Indian and Northern Affairs Canada 21
4.3 Health Canada First Nations and Inuit Health 22
4.4 Cross organizational program comparison 22

5.0 CROSS CANADA LTC POLICY REVIEW 29
5.1 Nova Scotia context 30
5.2 Other jurisdictions 30
5.3 Summary 31

6.0 POLICY ISSUES AND RECOMMENDATIONS 32

7.0 CONCLUDING REMARKS 38

APPENDIX A – SERVICE PROFILE QUESTIONNAIRE 39

APPENDIX B – LTC FACILITY QUESTIONNAIRE 40

APPENDIX C – FN COMMUNITIES AND LTC FACILITIES 41

APPENDIX D – KEY CONTACTS 42

REFERENCES 43

tables

Table 1: Long term care use and potential demand 4
Table 2: Number of long term care facilities by health district 20
Table 3: Number of DoH licensed/approved long term care beds by health district 21

1.0 Introduction

Long term care (LTC), a key component of continuing care, was raised as an issue of concern over the course of the Aboriginal Health Transition Fund (AHTF) Home Care on-Reserves Project by several steering committee members, First Nations (FN) community home care program coordinators and FN community health directors. Long term care for FN residents living on-Reserve has also been identified as a priority issue by the Mi'kmaq-Nova Scotia-Canada Tripartite Health Committee, the Atlantic Policy Congress of First Nations Chiefs (APC), the Union of Nova Scotia Indians (UNSI) and the Confederacy of Mainland Mi'kmaq (CMM).

Responding to the concern, the AHTF Home Care on-Reserves Project Steering Committee applied for and received additional AHTF funding to examine the provision of long term care for First Nations living on-Reserve in Nova Scotia. With the additional funding, the Steering Committee committed to conducting baseline research and to develop preliminary recommendations which will be used by the Aboriginal Continuing Care Policy Forum to improve long term care services to First Nation populations in Nova Scotia.

This report contains a summary and analysis of the research conducted including:

- service gaps, issues and challenges from the FN communities in Nova Scotia;
- current FN long term care utilization data and potential demand
- best practice research in long term care for FN populations, including a survey of Canadian facilities on-Reserve; and,
- cross-Canada policy review.

Based on this work, eleven recommendations have been developed to improve long term care to FN populations. These recommendations have implications for federal and provincial governments, district health authorities, FN communities and other organizations involved in long term care.

2.0 FN Community Service Profiles

This chapter presents long term care service profile findings from FN communities across Nova Scotia. The profiles were conducted to assess the volume of long term care needs and to identify issues and challenges regarding the provision of long term care to First Nation individuals living on-Reserve in the province.

2.1 METHODOLOGY

Service profile questionnaires were completed between February and March 2010. The questionnaires were sent to community health directors. In several cases, the health directors passed on the questionnaire to the community home care coordinator to complete. Respondents had a choice to complete the questionnaire directly or contact the research coordinator to complete the questionnaire together over the phone.

The level of engagement and detail provided varied by community. In one community, the home care coordinator consulted a group of Elders for input. In several communities, the respondent was relatively new to the position and not actively aware of any pressing long term care issues or details on accessing and using long term care services. In other communities, long term care services are not used and therefore the respondent had little to comment on. The lack of input is also telling with regards to how communities view and understand long term care options for First Nations living on-Reserve. The interview questions (Appendix A) were approved by the AHTF Home Care on-Reserves Steering Committee.

The service profile interviews focused on the following themes:

- Demand for long term care facilities and potential unmet need;
- Issues and challenges around access and use of LTC services;
- Gaps in service;
- What improvements could be made to long term care options for FN individuals;
- What a LTC model that would work for First Nation communities might look like.

This document presents summary findings from the community profiles and includes an analysis of key themes and issues. The community of Paqtnkek did not respond to the community survey, however, LTC utilization data for Paqtnkek that was available through Indian and Northern Affairs Canada (INAC) is represented.

2.2 CURRENT LONG TERM CARE USE AND POTENTIAL DEMAND

There are currently 45 people from First Nation communities living in licensed or approved Department of Health and Department of Community Services long term care facilities. Forty-one (41) people are living in facilities receiving Type 1 care, while 4 are living in facilities receiving Type 2 care[1]. There are no reported First Nation community members living in private/unlicensed facilities that are not approved or licensed by the Province.

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1 There is a distinction between provincial and federal levels of care. Type I and Type II levels of care referenced here are based on the Indian and Northern Affairs Canada (INAC) classification of care.

Communities identified an additional 43 people who they felt would benefit from long term care. Several respondents were careful to note, however, that while a community member may benefit from being in a long term care facility many have chosen not to access residential care options. The distribution of this potential demand for long term care varies by community. Almost half the communities indicated that they do not have any community members at this time that would benefit from long term care. One community noted that their population is young and as a result long term care is not an issue at the moment.

The age of potential long term care residents ranges from 18 to 95 years. With the exception of one community identifying two young adults with disabilities who would benefit from long term care, the vast majority of potential residents identified are elderly. The medical conditions of potential residents include: Alzheimer's disease, dementia, stroke, diabetes, arthritis, Parkinson's disease, multiple sclerosis, Huntington's Chorea, Moon Biedel, Fredrick's Ataxia, blindness, amputations, kidney disease, frailty, wound care, mental illness and acquired brain injury. Table 1 reviews long term care use by community and potential demand. The data is presented alongside community population statistics for the year 2009 from INAC (INAC population numbers count the registered population only). For the communities of Millbrook and Glooscap the latest figures reported by INAC are from the year 2006.

Table 1: Long term care use and potential demand

	Total Population	Total Population on-Reserve	Percent of on-Reserve Population over 50 years	Current LTC Residents		Potential LTC Residents	Age Range of Potential Residents	24 hour care at Home Available
				Type I (INAC)	Type II (INAC)			
Acadia	1,066	180	16%	2	0	0	X	no
Annapolis Valley	235	107	21%	1	0	0	X	yes*
Bear River	281	103	20%	0	0	0	X	no
Eskasoni	3,923	3,345	13%	11	2	14	35-90	yes*
Glooscap	305	95	21%	0	0	0	X	no
Indian Brook	2,313	1,215	17%	5	1	15	40-95	yes**
Membertou	1,196	767	17%	2	0	5	70-90	yes**
Millbrook	1,345	747	16%	3	0	5	70+	yes
Paqtnkek	523	393	13%	4	1	n.a	n.a	n.a
Pictou Landing	589	447	14%	3	0	0	X	no
Potletek	624	521	10%	2	0	3	18-50	yes
Wagmatcook	701	549	11%	1	0	0	X	no
We'koqma'q	901	816	12%	7	0	1	65+	yes
Total	14,002	9,285	14%	41	4	43	18-95	

* Extreme cases only, not general practice.

** Short term end of life palliative care only.

Population data

Sources: Indian Northern Affairs Canada. First Nations Indian Profile Website. Accessed June 2009.; Statistics Canada. 2006 Census. Community Profiles.

Type of care

Source: Indian and Northern Affairs Canada. Assisted Living Program data. November 2009.

2.3 EXPERIENCES AND BARRIERS ACCESSING LONG TERM CARE

Eleven of the thirteen communities have a community member in a long term care facility. An overwhelming message coming from the communities is that long term care is something culturally not accepted and something they try to avoid. Among those communities with members in a long term care facility, most respondents were not familiar with the community members' experiences or the assessment/placement process. In many of these communities, the community members entered the facility a number of years ago and the current health director and home care coordinator are not aware of the circumstances around the placement. One community noted that in the one attempt they made to access long term care the individual died before being placed. This community and another expressed concern about the length of time the placement process took.

Most communities have not had a lot of experience accessing and using long term care facilities. Communities have few members in facilities and do not deal directly with long term care facilities. The arrangements for long term care are looked after by the Confederacy of Mainland Mi'kmaq (CMM). CMM manages the placement and billings for individuals in Type 1 and 2 care. INAC provides funding directly to CMM.

The majority of communities have not accessed long term care respite services recently. Of the four that have, two communities were pleased with the services. One community noted that the provincial long term care respite services are eligible only to those who have applied for long term care and that this is a barrier for those wishing to keep their loved ones at home but need a break for a short period of time. It should be noted that this information is not accurate. Individuals can access residential respite services across the province without having to apply for or being on the waitlist for long term care. This misconception along with the lack of recent experience with long term care may indicate there is a need for up to date, accurate information about provincial long term care programs among FN health staff and community members.

About half of the communities provide 18 to 24 hour care at home. Care is typically provided by a family member or arranged by the family and funded by the community's home care program. Workers or in some cases family members are paid to provide the care. Among those communities offering extended home care, the care is provided as long as it is needed or until the community's home care resources are exhausted. In some cases this level of care is sustained for days, weeks, months and, according to one community, even years. Several communities noted that they offer extended care in extreme cases and that it is not the general practice. Two communities offer 24 hour care at end of life only.

There can be considerable hardship to a family and extended caregivers to those individuals who need 24 hour care (e.g. Alzheimer's disease) while they are waiting for a nursing home placement, and limited information about supports and resources available

to families in this period of transition. At the same time, several health providers in the FN communities expressed concern that programs are unable to safely provide the level of care required. Furthermore, Home and Community Care programs do not have the funding, authority, or resources to support long term care needs. In many cases family members or lay people are hired by the Band to provide long term care services without formal training or accountability for the quality of care provided.

Barriers to First Nation access to long term care can be summed up in the following domains:

Cultural and Linguistic Issues
There was a strong sentiment that it is culturally unacceptable to have a family member placed in a long term care facility even if they would be better off from a health care perspective. One respondent noted that community members would look down on the family. Several communities noted the importance of language and that potential residents, especially seniors suffering from dementia, would not be able to communicate with facility staff or other residents. In addition respondents indicated that families and potential residents do not want to be in a facility surrounded by non-Aboriginal individuals.

Fear of Institutional Care
Potential residents do not want to leave the Reserve because they fear that their families and friends will not visit them and they will be alone, especially if they are placed in a home far away from the community. This fear is by no means unique to Aboriginal individuals, however it may be speculated that the anxiety is more acute due to the lived experience of institutionalization in the Indian Residential School system and the post-traumatic style trauma that many experience throughout their lives. Indeed, a number of respondents noted that many seniors were in Residential Schools and do not want to be in another residential setting or institution.

Lack of Transportation
A lack of transportation is a big issue for many individuals living on-Reserve. Family members may not want their loved one living off Reserve knowing their ability to visit may be limited and as a result their loved one would be lonely and isolated.

Economic Considerations
If a senior moves into a long term care facility, their pension is directed toward covering the costs of the long term care facility. In some cases, the senior's income is being used to help support the larger family in the community and without it the family remaining in the community may experience financial hardship. One respondent noted that potential

clients and their families may also be worried that they will lose his or her house if one or more generations share a dwelling with the person who may move to a nursing home. Also, the family may be receiving money to provide support to their family member at home which would also be lost if this person moved into a long term care facility. As one respondent reported not only does this have an effect on the immediate family it may also have an effect on the broader community economics. “Looking after our own is part of the economy. If you take that away it changes the structure of the economy. This would be lost if you moved community members to long term care facilities off Reserve” (Long Term Care Service Profile Respondent, 2010).

Other Reasons
In a number of the communities, home care and other supports such as financial compensation are available to support family members in caring for a loved one at home. As a result community members are able to get enough support in the home, this coupled with the often long wait times to get into a nursing home discourages people from wanting to enter a long term care facility. There were concerns that there are preconceptions among potential residents that a nursing home is a place where you go to die.

2.4 KEY FEATURES OF A CULTURALLY RELEVANT LONG TERM CARE MODEL

Respondents suggested several attributes of a culturally relevant long term care model. The predominant themes included:

- ensuring adequate Aboriginal staff worked in the facility;
- having staff that could understand and speak the language;
- ensuring that staff understand First Nations culture, values and attitudes;
- ensuring recreation programs included Mi’kmaq crafts, games, music and humor; and,
- making traditions available such as allowing for traditional ceremonies, offering traditional meals, and providing a space for family gatherings.

Other responses highlighted the importance of gathering input from communities and in particular Elders in the design and development of long term care programs and services for FN individuals.[2] These services must take a wholistic approach to health care, have community acceptance and instill a sense of belonging, security and safety for First Nation residents.

2 ‘Elder’ refers to a member of the community who is valued for their experience, wisdom, and as a keeper of knowledge, heritage and traditions. While this is typically associated with age, there is no specific age criterion. Senior has a direct age connotation and typically refers to individuals 65 years and older. Demographically, however, a senior in the Aboriginal community would be closer to 55 years or older due to lower life expectancy (69 years for men and 76 for women) and poor health. (Health Canada, 1998:32 cited in Dumont-Smith, 2002).

Several communities noted that the model that would work for them is in fact not a model for long term care but rather more supports in the community to keep people at home. This approach was recognized to need 24 hour care provided by qualified health care professionals as opposed to relying primarily on family. If long term care was going to be provided in a facility, respondents overwhelmingly stated that it needs to be on-Reserve and ideally located in their community. The general consensus was that a home on-Reserve with First Nation staff would make community members less resistant to nursing home placement.

Some smaller communities recognized that a shared facility serving a cluster of nearby Reserves might work as well, for example, a facility serving the Cape Breton bands located in one of the Unama'ki communities (Eskasoni, Membertou, Potlotek, Wagmatcook, We'koqma'q). It was also suggested such a facility could provide multiple levels of care. If care was going to be provided in a facility shared with non-Aboriginal individuals, the First Nations residents should reside close together in a dedicated wing or section.

2.5 Changes Needed to Current Long Term Care Facilities

About half of respondents were not sure how to answer this question. Among those who provided an answer there was a general sense that existing facilities cannot be changed to make them work for Aboriginal residents. The key factor identified was the need for a long term care facility located on-Reserve. Some respondents noted at the very least a facility must have staff that can understand and speak the language, and have an environment that welcomes and supports Aboriginal residents and families, their unique culture and traditions.

3.0 Best Practice Research

3.1 LITERATURE REVIEW

This chapter presents results from a literature review exploring best practices in long term care serving First Nation clients. More specifically the literature review attempts to identify:

- challenges facing First Nation communities around access, provision and use of long term care facilities;
- long term care needs of First Nations people;
- why long term care for First Nations is different than for the mainstream population;
- key components of culturally appropriate long term care; and,
- best practice models in long term care serving First Nation clients.

The literature review focused on both academic and grey literature. Searches emphasized Canada, United States and Australia.

Little research was found that addresses First Nations long term care issues, models, and needs. Literature discussing broader themes of care for the aged and continuing care provide insights into cultural considerations, challenges, and high level concerns and priorities regarding the provision of long term care. Academics, government agencies and practitioners have identified a crucial need for more research and data gathering on First Nations long term care issues in Canada (Hampton et al., 2010; Hollander, 2008; Joint Working Group on Continuing Care, 2008; Crosata et al., 2007).

3.2 LONG TERM CARE NEED

The Assembly of First Nations Action Plan on Continuing Care (2005) reviews demographic statistics demonstrating a rapidly growing demand for institutional and related continuing care services for First Nation communities over the next several decades. By 2021, the 55- 64 year age group will increase by 236% and the 65+ group by 229%. Population projections predict that there will be 57,000 more First Nations members in Canada aged 65 and older in 2021 than in 2005.

Health data reveals high rates of chronic conditions and disabilities, poorer general health, higher levels of poverty, and inadequate housing among the First Nations and Aboriginal population aged fifty five and above in comparison to the general population (Hampton et al., 2010; AFN, 2005; Ludtke and McDonald, 2005; Benson, 2002; Dixon, 2002; National Resource Center on Native American Aging (NRCNAA), 2002; Ring and Brown, 2002). Limitations on 'activities of daily living' and compromised living conditions suggest that the need for long term care services among First Nation populations is great.

While there is a significant need for long term care, a literature review of continuing care requirements conducted for Health Canada found that long term care facility use remains very low among First Nations people (Hollander, 2008). This finding was confirmed in Nova Scotia by the long term care service profile survey results indicating 45 First Nation clients live in provincial government licensed/approved long term care facilities. Low use of long term care services and facilities appears to be a consistent trend among First Nations and Aboriginal populations world-wide (Kiata, 2005; Ludtke and McDonald, 2005; Benson, 2002; Ring and Brown, 2002). The U.S. Senate Committee on Indian Affairs concluded in response to a hearing examining the long-term care and health care needs of Native American elders that "long term care options for most Native American elders are minimal at best" (2002). While long term care literature tends to focus on the aged, the Assembly of First Nations Action Plan on Continuing Care (2005) identifies children with special needs and clients with mental health challenges as key areas of concern that have been significantly overlooked in terms of long term care requirements.

3.3 CHALLENGES AND BARRIERS FACING FIRST NATION COMMUNITIES

Within Canada, the Joint Working Group (JWG) on Continuing Care with representation from Health Canada, INAC, Inuit Tapiriit Kanatami (ITK), and regional First Nation representatives, leads the majority of research and policy discussion around the improvement of continuing care. The JWG was established recognizing that jurisdictional disagreements around who is responsible for the provision of continuing care has resulted in a "*lack of responsiveness to the needs of First Nation communities, significant gaps in services to these communities, and a lack of long-term planning and development of services. Any attempts to address these issues within the current policy context have had limited success." (JWG, June 2008)*.

The JWG on Continuing Care released *'A Policy Options Analysis Paper'* in August 2008 which identified accessible long term care facilities either on-Reserve or within close proximity as a priority. Critical long term care challenges facing First Nations and Inuit communities identified in the paper include:

- desire of Elders and seniors to remain within their community irrespective of the need for institutional care, coupled with the limited number of facilities within First Nation and Inuit communities;
- long waiting lists for provincial/territorial facilities;
- excessive distance to care facilities;
- low income of most First Nation people limits their ability to access "private pay" out of community facilities; and,
- the lack of a culturally supportive environment in off-Reserve facilities.

Health Canada commissioned a literature review conducted by Hollander (2008) assessing continuing care requirements in First Nations and Inuit communities. Hollander's report concludes that existing facilities on-Reserve face major sustainability issues including lack of sufficient funding and problems with staff recruitment and retention. Training, recruitment and retention of workers for long term care facilities serving First Nation populations is widely recognized as a critical challenge in the United States and New Zealand as well (Kiata et al., 2005; Kauffman, 2002). Redford, in an article discussing developing long term care facilities in Aboriginal communities, notes that the development of a trained, competent, and committed Aboriginal workforce to sustain a full spectrum of services may take years. It entails the recruitment, training, and retention of a workforce comprised of ancillary and professional providers (2002).

Funding continues to be a major barrier within Canada. Jurisdictional issues around funding responsibility jeopardize the provision of long term care services serving First Nation communities (JWG, June 2008). Among facilities on-Reserve, the structure of INAC funding presents a challenge. INAC only funds Type 1 and Type 2 level care. Facilities, however, are pressured to provide higher levels of care so clients can remain in the community. First Nation long term care facilities are also vulnerable to changes in federal funding policies. For example, in Manitoba, INAC changed its policy requiring First Nation personal care homes (PCH) be licensed in accordance with provincial regulations to receive funding. A major challenge of the policy is that most personal care homes were not built to provincial standards. For several facilities to meet long term care building code requirements requires significant capital investment. Furthermore, many communities see the policy change as a restriction of the accessibility of culturally appropriate care (Roscelli, 2005). For example, as learned in the long term care facility interviews conducted as part of the AHTF Home Care on Reserves project, a personal care home in Manitoba under provincial licensing will no longer be able to serve wild meats and local berries.

A 2001 questionnaire conducted by the National Indian Council on Aging and the National Senior Citizens Law Center (NSCLC) to gather information about the current state of long term care in Indian country (United States) identified lack of culturally sensitive care, isolation from family and community, and significant distance between the tribal community and nursing home as the major sources of resident and family dissatisfaction with off-reservation nursing homes. The majority of nursing homes off-Reserve also failed at providing traditional foods, employing tribal members as caregivers, honouring cultural health practices, and recognizing Indian specific needs (Benson, 2002).

The strong family unit and the importance of Elders as teachers, and protectors of culture present a barrier to long term care usage. For long term care to be accepted, it must integrate the family and honour the role that Elders play in the community (Redford, 2002). The burden of long term care in Aboriginal communities traditionally falls on the

family and primarily women. Studies in Canada and the United States suggest that 90% of long term care in First Nations and Aboriginal communities is provided by families (Crosato et al., 2007; Redford, 2002). Caring for family members is an integral part of Aboriginal culture. A study by Crosato and colleagues (2007) to develop a comprehensive understanding of Aboriginal women's experiences and perceptions of providing care to the elderly found that providing care was an expected, traditional role for women within Aboriginal culture. The role of caregiver is embedded in cultural values including passing on traditions, being chosen to care, and supporting the circle of healers. The gap between community values and the realities of caregiving, however, can be immense. Family caregivers are in a difficult position because in many cases the caregiving demands are too much. Caregivers are left with few options, because the alternative, sending a family member away to a long term care facility, is not a culturally accepted option.

Hampton et al. (2010) argue that a major barrier to Aboriginal peoples receiving appropriate end-of-life care is the fact that understandings of care differ between Western biomedicine-oriented models and Aboriginal cultures. The contrasting world views lead to communication difficulties, discrimination, and institutional policies that prevent Aboriginals from expressing their traditional culture.

> *"Medical constructions of death depict death as the enemy and treat the death experience in a technical manner. In contrast, traditional Aboriginal understandings of death depict death as a transition from Mother Earth and recognize family as central to the process, emphasizing spirituality and ceremonies to support the giving of energy and facilitating the transition from corporeal life"* (p.12).

3.4 CULTURALLY APPROPRIATE LONG TERM CARE

The Joint Working Group on Continuing Care commissioned a report to develop and recommend strategies aimed at supporting culturally responsive program planning within the framework for continuing care (2005). The report indicates that providing continuing care in a cultural context for First Nations and Inuit people involves, among other things:

- honouring and encouraging a diversity of beliefs;
- wholistic care;
- access to preferred language;
- access to traditional as well as modern health and healing practices including ceremonies;
- culturally competent staff and organizations; and,
- traditional diet, lifestyles and relationships to the land and community.

Creating culturally appropriate long term care services was a key recommendation of the Indian Health Service (IHS) Roundtable Conference on American Indian and Alaska Native Long Term Care (Kauffman, 2002). To achieve this goal, the recommendation states that facility planners and policy makers acknowledge that culture is an integral component of all services, culture is dynamic and that integrating culture must involve the community.

Henderson, a contributor to the Roundtable Conference on American Indian and Alaska Native Long Term Care, argues that long term care models must be designed to respect and preserve Elders' roles as treasured holders of tribal culture. The role of Elder as tribal culture keeper can be defeated by long term care in two ways: 1) the lack of sufficient, quality long term care, and 2) the use of typical, institutional models of long term care that isolate the elderly from family and community. Henderson suggests that supporting traditional culture within the long term care framework requires the adoption of rituals that symbolize important cultural values into daily operations. Rituals include rites of passage, renewal, intensification, and revitalization (2002: 74). A rite of passage, according to Henderson, is a ceremony or celebration of inclusion that an Elder would partake in when they become a user of long term care services. Rites of renewal include ceremonies held at regular intervals of long term care service which reminds the person that they are cared for in ways that keep them connected to the tribe. A ritual of intensification can be developed to honour Elders' unique and valuable role as holders of tribal culture. A rite of revitalization may be developed for Elders to be re-established as cultural leaders and guardians of tribal culture (77-79).

Research conducted by Hampton et al (2010) in Saskatchewan asked Elders what they would like non-Aboriginal health care providers to know when providing end-of-life care for Aboriginal families. The research results are intended to describe the traditional beliefs and practices of Aboriginal peoples in Canada to guide culturally appropriate end-of-life care delivery. Common themes relevant to long term care emerging from the interviews include:

- Completing the circle: "for Aboriginal people death is a part of life, it's a part of living. And it's as necessary as birth" (p. 9);
- The importance of gathering at the time of death: This differs from the Western perspective, in which visitors to the dying are limited so that the dying person can conserve energy (p. 10);
- Care and comfort: Non-Aboriginal health providers need to recognize that care and comfort of the heart and spirit take precedence at the end of life over medical procedures and protocols (p. 11); and,
- The moments after death: the moments after an Aboriginal person passes from his or her corporeal state are very sacred. Non-Aboriginal health practitioners need to respect this. Elders stated that there are traditional protocols (specific practices) within each First Nation to assist the person to take the next step of their journey in peace (p. 11).

Aboriginal Elders in southern Saskatchewan, in the interviews conducted by Hampton et al. (p. 12) on end-of-life care, suggested ways in which hospital policy and practice could be adapted to facilitate a healing environment for Aboriginal peoples who complete the circle (die) in a hospital setting. The content of several recommendations could enhance the provision of culturally relevant long term care as well. Relevant recommendations included the following:

- Provide family rooms where large groups of extended family and community members can gather to cook, pray, support each other;
- Alter policy to allow for traditional spiritual practices (such as burning sweet grass and smudging);
- Offer cross-cultural education for health care professionals that facilitates dialogue and a deepened understanding between groups;
- Aboriginal peoples respond to care offered from the heart. When skilled health care providers engage at the soul level, it is felt and appreciated. Cross-cultural education can generate a greater understanding among hospital staff of conflicts arising from cultural and communication differences; and,
- Make health care providers aware of culturally appropriate resources and have them inform Aboriginal families and communities about these resources.

Research shows that culturally competent interventions increase Aboriginal participation in health care services (Burhansstipanov, 1999). Proposed guidelines suggested by Hampton et al. (2008) for overcoming barriers to culturally appropriate health care services include: changing the structure of the medical system by integrating cross-cultural policies, staff training to reduce conflict arising from cultural and communication differences, enhancing culturally appropriate resources, and increasing knowledge among ethnic minorities about available services.

3.5 BEST PRACTICE PROGRAMS AND MODELS OF CARE

There is an apparent lack of long term care models catering to First Nations populations. Redford in an article discussing considerations in developing long term care services in the United States recommends an 'Indian models by design' approach. The grassroots approach is founded on the notion that long term care planning needs must be rooted in tribal culture, values and reflects community input instead of following dollars (2002). It is critical that models also integrate the family and protect the dignity and honour of Elders (Henderson, 2002; Redford 2002).

While there is a lack of documentation regarding long term care models targeting First Nation communities, a handful of programs were found, which are described below, exemplifying best practices.

Wikwemikong First Nation

The Wikwemikong First Nation, located on the eastern side of Manitoulin Island, offers seniors' care programs including Home Care and Long Term Care programs that follow a wholistic health approach based on the medicine wheel and guided by 'our grandfather teachings'. Wholistic care includes addressing the physical, mental, social and emotional/spiritual aspects of care. The Wikwemikong grandfather teachings include: respect, humility, compassion, bravery, honesty, trust, wisdom, and unconditional love.

The Wikwemikong seniors' care programs have been identified as best practice models of culturally appropriate care (Corbiere and Pitawanakwat, 2008). It is noteworthy that the Wikwemikong First Nation follows a principle that they will honour the wishes of elders and let them stay in the home as long as possible. In addition to the home care services provided, the community has a local long term care facility, which makes it possible for the aged and infirm to stay in their community even when their care requirements involve institutionalization (Corbiere and Pitawanakwat, 2008).

Key features of the Wikwemikong seniors' care programs include:

- most home care providers and long term care facility workers speak the language (communicating and information sharing with the elderly is optimal if done in their first language);
- Meals on Wheels services and long term care facility meals have incorporated traditional food into the meal plan;
- there is family involvement in the provision of care and social activities;
- the programs provide social activities which often include youth;
- the Health Centre offers rides for the aged and infirm to see traditional healers locally or out of town;
- local physicians and health care providers are aware of and support use of traditional medicine; and,
- the Health Centre has a Traditional Medicine Lodge staffed by an Elder which offers ceremonies as needed (Corbiere and Pitawanakwat, 2008).

Other factors stressed by Corbiere and Pitawanakwat include the importance of respect and communication style when communicating with Elders. For example, service providers should never interrupt an Elder when they are speaking. Also sharing information should never be rushed (2008).

The long term care facility in Wikwemikong is home to both Native and non-Native clients. It is a 60 bed facility staffed mainly by local community members who speak the language. Priority is given to First Nation clients. The facility is located next to the Health Centre.

The Kirkland Lake Aboriginal Elders

The Kirkland Lake Aboriginal Elders Program serving the Kirkland Lake area in Ontario provides social activities for elderly clients (55+) in home care or long term care facilities. The program, which is offered two days a week, arranges transportation, organizes activities, and provides a healthy snack or lunch. On one of the days, the program provides tea and bannock and organizes an activity. On the other day, the program provides a lunch and arranges a guest speaker or outing. The program also celebrates birthdays and community traditions. A key objective of the program is to reduce social isolation among the elderly. For those living in long term care off Reserve, the program provides an opportunity to interact with community members, speak their traditional language, and engage in community traditions and celebrations. The program has fifteen regular clients including two from long term care facilities. The program is funded by Health Canada through the Aboriginal Peoples Alliance of Northern Ontario[3].

3.6 CANADIAN FACILITIES SURVEY RESULTS

The Assembly of First Nations provided our project with a list of long term care homes and personal care homes located on-Reserve. The list included 31 facilities on-Reserve across the country. A letter of introduction and explanation was sent to the respective Bands to confirm that there would be no objection to the project team contacting the facility on their Reserve. For communities where we received approval, long term care facilities were contacted by e-mail, phone, or mail requesting that they complete a questionnaire about their facility. The long term care facility questionnaire (Appendix B) was approved by the AHTF Home Care on-Reserves Steering Committee. At least three attempts were made per facility to reach the administrator or appropriate contact.

We reached 15 long term care facilities. Four (4) facility administrators responded to the questionnaire. One administrator responded directly to the questionnaire in writing, the other three participated in a phone interview with a member of the research team.

According to the Assembly of First Nations, there are a total of 633 First Nation communities across Canada. Thirty-one (31) communities currently have a long term care facility located on-Reserve offering services to seniors and disabled individuals. Long term care facilities include Seniors Lodges, Personal Care Homes and Long Term Care Homes, which provide various levels of care. Licensure of long term care facilities on-Reserves varies from province to province with, for example, all those facilities in Manitoba being licensed by the provincial government.

The existing facilities are not evenly distributed across Canada. Manitoba has 8 facilities, Quebec has 7 facilities, Alberta has 7 facilities, Saskatchewan has 4 facilities, Ontario has 3 facilities, British Columbia has 1 facility and Nova Scotia has 1 facility.

The only long term care residential facility located on-Reserve in Atlantic Canada is in

3 Grossinger, Darlene. 2010. Personal Communication. Program director, Kirkland Lake Aboriginal Elders Program. March 2010.

Waycobah, Nova Scotia. The facility includes two homes and is funded directly by INAC under the Department's Assisted Living program[4]. One is a group home and the other is a semi-independent living facility. They specialize in serving people with developmental disabilities requiring Type I or Type II care. In this unique case INAC funds, on a per diem basis, the cost of residential care for persons ordinarily resident on-Reserve at the time of placement (Collins, 2009).

The funding arrangements of facilities differ significantly as well. Twenty (20) of the on-Reserve facilities are funded (at least in part) by INAC. INAC funding is only for Type 1 and Type 2 care levels. INAC does not support institutional care in Alberta. Funding arrangements for the majority of facilities are a combination of provincial funding, federal funding, band funding, and resident fees.

Facilities overview

The four facilities reviewed range in size from 12 beds to 60 beds and are located in Saskatchewan, Manitoba, and Ontario (2). Three of the four facilities offer Type 1 and Type 2 care only. One facility has the capacity to offer other levels of care, however, they primarily provide personal care. Three of the four facilities are open to First Nation clients and non-Aboriginal clients. All of them, however, target First Nation clients.

The majority of clients at these facilities have chronic care needs. Conditions include: diabetes, dialysis, Alzheimer's, dementia, frailty, physical disability and mental illness. The age of residents ranges from 30 to 98. While the four facilities reviewed target the elderly, they are open to adults 18 years and above. Respondents recognized that the First Nations population compared to the general Canadian population is younger, sicker, and has less support. The staff ratio at the facilities ranges from approximately 0.5 staff members per resident to 1.5 staff members per resident.

Three of the four facilities are regulated by their respective provinces and must meet all provincial licensing, monitoring, and standards. One of the facilities is currently regulated by a community board but is in the process of being provincially licensed. Once licensed, the facility will be required to meet all provincial regulations, standards and policies.

Considerations for long term care facilities on-Reserve

Some respondents felt that there was no difference providing long term care to First Nations groups in comparison to other groups. Other respondents suggested that the attitude, involvement of the family, and strong sense of culture are important differences to consider. One respondent also noted that a major difference to consider is the legacy of Residential Schools and the history of abuse.

Respondents identified a number of key issues and best practices to consider when offering long term care on-Reserve.

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4 The facility is not licensed by the Department of Health, but rather falls under purview of the Department of Community Services.

Facility:

- The facility should be located on-Reserve in a central location, preferably near the health centre or band office.
- The facility should be designed to look and feel like a home and not an institution.
- Private rooms are important especially if there are both Native and non-Native residents.
- Traditional foods should be made available.
- The facility should be designed to support traditional ceremonies such as a smudging and offer a large common room to allow for families and guests to visit comfortably.
- The facility needs to meet all provincial standards and codes. Informants stressed the need for safe water, sewer supply and a backup energy supply. The fact that a significant number of First Nation seniors are addicted to cigarettes is also an issue in facilities that are, by and large, smoke-free.

Staff:

- The facility should hire as many First Nations staff as possible including supervisory positions, nurses and support workers.
- The community needs to offer training programs and education. Training is a key consideration during the development phase so when the facility opens staff from the community already have the proper training and credentials in place.

Operations:

- It is important to have a sound business plan in place and finances in order. The LTC facilities on-Reserve report they are struggling financially.
- For remote communities accessing specialists and professionals can be difficult.

Process:

- The province and First Nations facility require a good working relationship.
- There are often challenges getting non-Native residents to sign residential agreements to live on-Reserve.

Community:

- The community, Chief and Council need to support the long term care facility especially during the project proposal and development phase.
- It is important to ensure that family members and community Elders feel welcome and are encouraged to visit.
- Community members should be engaged wherever possible (staff, board of directors and volunteers).
- Most communities have negative feelings about long term care. It is important to educate the community so they understand what the facility is about and do not feel threatened.

4.0 Provincial and Federal Program Overview

4.1 NOVA SCOTIA DEPARTMENT OF HEALTH - CONTINUING CARE BRANCH

The Nova Scotia Department of Health Continuing Care Branch long term care program provides long term care services to Nova Scotians 18 years and older who meet the program eligibility criteria. Five percent (5%) of the resident population in long term care is under 65 years. There is one nursing home unit for children under aged 18 years, which falls under the mandate of the Department of Health. This 20 bed unit includes 19 regular beds and 1 respite bed and is located at Evergreen Home for Special Care in Kentville. There are other long term care facilities under the Department of Community Services (DCS), which are not included here. INAC funds individuals in DCS facilities as well.

Long term care includes Community Based Options (CBO) care, Residential Care Facilities (RCF) care, Nursing Home Level 1 (NH1) care and Nursing Home Level 2 (NH2) care. Community Based Options and Residential Care Facilities provide accommodation, supervision and non-nursing personal care. Nursing homes provide accommodation, supervision, personal care and nursing care in a residential setting to individuals who require the availability of a registered nurse on-site at all times.

Individuals accessing long term care pay an accommodation charge while government pays the health care costs. The accommodation cost may be subsidized based on the resident's income. Individuals who are provided for by the court or through an award or benefit or are the responsibility of another government agency (Worker's Compensation, Veterans Affairs Canada, INAC) are charged the full per diem rate (both health care and accommodation costs).

Individuals living at home who have been assessed for and are waiting for a placement to a long term care facility can wait until an appropriate bed is available in the facility of their choice. Individuals in hospital who have been assessed for and are waiting for a placement to a long term care facility must accept the first available bed within 100 km from their preferred community. Exceptions can be made to the first available bed process due to compelling circumstances which could include linguistic and/or cultural reasons, end-of-life considerations, etc. Families must bring forward this request to the hospital care coordinator and/or Department of Health placement coordinator for consideration.

There are 78 respite beds located in nursing homes and residential care facilities across the province. Individuals can utilize these beds up to 60 days in a calendar year. The daily charge is $30.90 as of November 2009. Low income applicants can apply for a reduced charge. Access to these beds is through the District Health Authority Continuing Care Single Entry Access point (1-800-225-7225). Eligibility is determined through an assessment completed by a

care coordinator. Individuals do not need to apply for long term care nor be in receipt of home care services to access these beds. First Nation individuals on-Reserve are charged the same rate for use of a respite bed as other Nova Scotians.

There are no provincially approved or licensed nursing homes or community based option homes located on-Reserve in Nova Scotia. There is one provincially-licensed residential care facility on-Reserve, Townsview Estates, located in Millbrook. This facility is owned and operated by a private company, which leases the building/property from the Band. This facility does not give particular focus to providing care to First Nation clients.

Table 2 breaks down the number of provincial long term care facilities by health district. Facility types include nursing home (NH), residential care facility (RCF) and community based options (CBO).

Table 2: Number of long term care facilities by health district

	Facility type				
District	**NH**	**NH & RCF combined**	**RCF**	**CBO**	**Total**
1	7	1	2	1	11
2	8	0	5	0	13
3	7	1	5	0	13
4	6	1	4	4	15
5	6	0	4	0	10
6	4	0	3	0	7
7	6	1	1	0	8
8	16	1	2	7	26
9	17	4	2	19	42
NS - Total*	**77**	**9**	**28**	**31**	**145**

* Excludes 4 hospital sites with nursing home beds (55), in Cape Breton District (DHA 8).
Source: NS Department of Health, Continuing Care Branch; LTC Facilities Directory, July 2010.

There is a total of 145 long term care facilities in the province including 77 nursing homes, 28 residential care facilities, 9 nursing home and residential care facilities combined, and 31 community based options. The 145 facilities make available 7,577 beds. Table 3 presents the number of long term care beds by bed type (regular bed, respite bed) and by health district. A map of the district health authorities in Nova Scotia and the distances between FN communities and local nursing homes is provided in Appendix C.

Table 3: Number of DoH licensed/approved long term care beds by health district

	Number of regular beds				Number of respite beds				Total beds			
District	NH	RCF	CBO	Total	NH	RCF	CBO	Total	NH	RCF	CBO	Total
1	506	52	4	562	9	1	0	10	515	53	4	572
2	506	76	0	582	7	2	0	9	513	78	0	591
3	645	116	0	761	6	3	0	9	651	119	0	770
4	436	128	10	574	3	0	0	3	439	128	10	577
5	281	124	0	405	6	0	0	6	287	124	0	411
6	429	78	0	507	5	0	0	5	434	78	0	512
7	347	48	0	395	5	0	0	5	352	48	0	400
8	1,142	27	21	1,190	13	0	0	13	1,155	27	21	1,203
9	2,302	166	55	2,523	18	0	0	18	2,320	166	55	2,541
NS Tota	**6,594**	**815**	**90**	**7,499**	**72**	**6**	**0**	**78**	**6,666**	**821**	**90**	**7,577**

Source: NS Department of Health Continuing Care Branch, LTC Facilities Directories, July 2010.

More information about the Long Term Program is available at: ww.gov.ns.ca/health/ccs/ltc.asp.

4.2 INDIAN AND NORTHERN AFFAIRS CANADA

Indian and Northern Affairs Canada (INAC) Assisted Living Program includes an institutional care component. The institutional care component funds non-medical care in a facility setting for First Nations people who normally reside on-Reserve that have care needs which can no longer be met at home or in a foster care environment.

The institutional care component includes Type I and Type II levels of care. Type I is institutional care for individuals requiring only limited supervision and assistance with daily living activities. Type II is extended care for individuals requiring some personal care on a 24 hour basis and those under medical or nursing supervision.

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-pay or user fee for care and/or accommodation. Residents are also responsible to pay for any clothing and personal expenses to the extent they are financially able to. If they are not financially able, INAC will provide a comfort allowance, a clothing allowance and a special needs allowance which refers to money allocated to cover expenses required due to a specific non-medical need.

More information about the INAC Assisted Living Program is available at:
www.ainc-inac.gc.ca/hb/sp/alp-eng.asp.

4.3 HEALTH CANADA FIRST NATIONS AND INUIT HEALTH

First Nations and Inuit Health does not fund long term care or provide long term care services. Residents of long term care facilities are still eligible to receive coverage for things like medication, equipment, etc., through Non-Insured Health Benefits (NIHB).

4.4 CROSS ORGANIZATIONAL PROGRAM COMPARISON

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

Who is eligible for long term care (LTC)?	
Nova Scotia Department of Health (Continuing Care Branch)	All Nova Scotia residents with health care needs who are 18 years and older are eligible for LTC. Eligible clients must have a valid NS health care number, an unmet need assessed by a care coordinator and meet residential care level requirements. Evergreen Home for Special Care in Kentville provides a 20 bed unit (including 1 respite bed) for children requiring long term care placement.
INAC	Assisted Living's institutional care component is intended to fund non-medical care in a facility setting for seniors or adults living on-Reserve that have care needs which can no longer be met at home or in a foster care environment. INAC provides for children who are in LTC facilities receiving federal Types 1 and 2 level care through the Assisted Living Program.

What is the policy with regard to First Nation clients living on-Reserve?	
Nova Scotia Department of Health (Continuing Care Branch)	First Nation individuals living on-Reserve in Nova Scotia can access LTC like any other Nova Scotian. First Nations clients living on-Reserve, however, are required to pay the full facility per diem rate. The full facility per diem rate includes both health care and accommodation costs. The rate is approved by the Nova Scotia Department of Health and varies by facility.
INAC	Under the program's authorities funding is to be available only if care is provided in provincially licensed and/or approved facilities either on or off Reserve, and only for federal Type 1 and 2 levels of care and that the facility invoicing does not exceed Types 1 and 2 levels of care. INAC does not provide for Type 3 care.

What is the process to access and be approved for LTC?	
Nova Scotia Department of Health (Continuing Care Branch)	The person or his/her representative must apply for long term care services through the Continuing Care Single Entry Access point (1-800-225-7225). An applicant must undergo a functional assessment to determine the type and level of care required. Health districts 7 and 8 use a panel process to determine the level of care required. In districts 1-6 and 9, a classification officer determines the level of care required. Applicants who cannot afford the standard accommodation charge, must complete a financial application process to determine a reduced charge. Reductions are based on the applicant's net income (line 236) as reported on the previous year's Notice of Assessment. If the individual has a spouse, a different process is used that ensures the spouse remaining in the community retains a minimum amount of income. First Nations clients living on-Reserve with a Band number must pay the full per diem rate and are not eligible for a fee subsidy from the province.
INAC	Facility care is for community members who have lost most of the capacity for self-care and can no longer live safely at home. The placement can be referred by a doctor, health nurse or family. It is then sent to the provincial eligibility review board who then may include community services for the assessment. An initial placement authorization is completed to document the care and rehabilitation program and related costs. The placement is assessed by professionals who are qualified or licensed by the appropriate provincial body. This could be the health nurse in the community or the continuing care staff. Clients must apply through the provincial system. Final recipients in an institution are expected to pay the provincial or territorial government established co-pay or user fee for care and maintenance and clothing and personal expenses to the extent they are financially able to. Determining financial ability is done through an income test.

What care levels do you provide?	
Nova Scotia Department of Health (Continuing Care Branch)	The province provides Residential Care Facility (RCF) care and Nursing Home Level 1 and 2 (NH1 and NH2). ***RCF:*** The care needs of the applicant are consistent with the admission criteria for the category of licensed Residential Care Facility or approved Community Based Option. Generally, care is required by a person: who has decreased physical and/or mental abilities and who primarily requires supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. CBO/RCF residents require less than 1.5 hours of one-on-one care for supervision or assistance with activities of daily living. ***Nursing Home Level 1:*** The care needs of the applicant are consistent with the admission criteria for the category of licensed nursing home. Generally, care is required by a person: with a relatively stabilized (physical or mental) chronic disease or functional disability, whose condition is not likely to change in the near future; and who requires the availability of personal care on a continuing 24 hours basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. ***Nursing Home Level 2:*** Similar to NH1. The distinction between Level 1 or Level 2 depends on the degree and intensity of care and assistance required by the individual. Nursing home level care is generally 2.45 hours of care per resident per day.
INAC	INAC will provide funding for federal Types 1 and 2 levels of care. ***Type 1:*** Residential care for persons requiring primarily supervision and assistance with their daily living activities, and social and recreational services; 0.5 to 1.5 hours therapeutic and personal care or supervision daily. ***Type 2*:** Extended care for persons requiring availability of personal care on a 24-hour basis under medical and nursing supervision; 1.5 to 2.5 hours care or supervision daily.

What are the different types of facilities and what types of care are provided in each?	
Nova Scotia Department of Health (Continuing Care Branch)	***Nursing homes:*** Provide personal and/or skilled nursing care in a residential setting to individuals who require the availability of a registered nurse on-site at all times. These are licensed and inspected by the Department of Health. Nursing Homes operate under the jurisdiction of the DoH and are licensed under the *Homes for Special Care Act* and Regulations. Nursing homes are owned and operated by District Health Authorities, municipalities, not-for-profit and for-profit organizations. Ninety-five percent of nursing home residents are over the age of 65. ***Residential care facilities (RCFs):*** Provide accommodation, supervision and non-nursing personal care that may include help with bathing and dressing, or reminders about daily routines. Personal care and supervision is provided by residential care workers available on site at all times. RCFs operate either under the jurisdiction of the Department of Health or the Department of Community Services. Those under the Department of Health provide care mainly to seniors and are licensed by Departmental staff to ensure they are operating in compliance with the *Homes for Special Care Ac*t and Regulations. RCFs are owned and operated by municipalities, not-for-profit and for-profit organizations. ***Community based-options (CBOs)***: Provide accommodation, supervision and non-nursing personal care that may include help with bathing and dressing, or reminders about daily routines. Personal care and supervision are provided by workers available on site at all times. CBOs provide a similar level of care to residential care facilities but serve a maximum of three people. CBOs operate either under the jurisdiction of the Department of Health or the Department of Community Services. Those under the Department of Health provide care mainly to seniors. CBOs are unlicensed, but are inspected and approved by the Department of Health. Community Based Options are owned and operated by private individuals or organizations. There are two types of CBOs, Community Residences and Small Options Homes. ***Community Residences*** are family homes in which accommodation and minimal supervision is provided for three or less seniors who are not immediate family of the operator. The home assists the resident with self care skills. ***Small Option Homes*** provide support and supervision for three or less seniors in a purchased or rented unit. The home assists the resident with self care skills. Trained staff are available on site at all times.
INAC	First Nation clients access provincially licensed or approved facilities on- or off-Reserve.

How do you pay for LTC for First Nations living on-Reserve?	
Nova Scotia Department of Health (Continuing Care Branch)	The province does not pay for LTC for First Nations living on-Reserve.
INAC	INAC reimburses provincially licensed or approved care facilities for Type I and Type II levels of care for First Nations residents who are registered Indians (with band numbers) who live on-Reserve. Type I per diems range from $80.00 to $376.45. Type II Per diems range from $266.47 to $650.32.

What fees do clients pay?	
Nova Scotia Department of Health (Continuing Care Branch)	Residents are responsible to pay an accommodation charge and the Department of Health is responsible to pay the health care costs. The Department of Health is the payer of last resort for "health care costs" and based on an applicant's income may subsidize the "accommodation costs". There are a number of groups that must pay the full accommodation and health care costs: • Individuals with funds provided for by the court or through an award or benefit. • Clients that are the responsibility of Veterans Affairs Canada; the Workers Compensation Board; or the federal government or First Nation individuals living on-Reserve in Nova Scotia with a Band number. The Standard Accommodation Charge is adjusted every year. The rates effective November 1, 2009 are: • Nursing Homes - $94.75 per day • Residential Care Facilities - $54.50 per day • Community Based Options - $48.00 per day Applicants can request a reduction in the Standard Accommodation Charge. Eligibility for a reduced accommodation charge is determined through an income test. Regardless of an individual's income, no resident will be left with less than the Minimum Retained Income level defined by the Department of Health. Effective November 1, 2009, the Minimum Retained Income (MRI) amount is $2,760/year.
INAC	Because continuing care services are not insured services under the *Canada Health Act*, responsibility for the administration and provision of these services remains that of provincial and territorial governments. First Nations are required to meet the terms of eligibility criteria, availability, and costs set by the province. 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-pay or user fee for care and accommodation. Individuals are also responsible for clothing and personal expenses to the extent they are financially able to. INAC pays the full per diem rate where the recipient is unable to make a personal contribution to their care costs. Persons receiving LTC are entitled to a comfort allowance and clothing allowance. The comfort allowance is $129.50 per month. The clothing allowance is $500.00 per year provided in two equal installments (Spring/Summer = $250 Fall/Winter = $250). Institutional care for nonmedical, Types I and II level of care includes: • Standard accommodation • Meals, including therapeutic diet • Food • Laundry • Necessary emergency and routine supplies • Skilled care with professional supervision as needed • Planned program of social and recreational activities • Clothing • Special diets • Age allowance • Personal living allowance • Respite care (Respite care refers to short term respite care as defined by the reference province or territory for in-home care only. INAC does not cover/provide respite services delivered in long term care facilities). Guide dogs in foster homes, personal care homes on-Reserve, or Types I and II care facilities off Reserve.

Do First Nation clients on-Reserve have access to other programs while in LTC?	
Nova Scotia Department of Health (Continuing Care Branch)	***Specialized Equipment Program:*** Residents of long term care facilities under the DoH mandate may be eligible for specific equipment through the Specialized Equipment Program. The Specialized Equipment Program is administered by the Canadian Red Cross, Nova Scotia Region in accordance with the criteria established in the DoH HELP Specialized Equipment Program Policy and Guidelines. An individual is eligible when the following criteria have been met: • is a regular bed resident of a DoH long term care facility; • requires equipment which is on the Covered Equipment list; • has been assessed by an Occupational Therapist or Physiotherapist as requiring the specified equipment; and, • has the request reviewed and approved by Continuing Care. Clients may pay a monthly fee based on income. ***Home Oxygen:*** 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. Clients may pay a monthly fee based on income. ***Under 65 drug coverage:*** The Department of Health will provide prescription drug coverage as specified in the Nova Scotia Formulary to eligible residents of long term care facilities under its jurisdiction. An individual is eligible to access Pharmacare benefits when the following criteria have been met if the individual: • is a regular bed resident of a long term care facility; • is under the age of 65; • has a valid Nova Scotia Health Card Number (HCN); • does not have access to or coverage under another drug plan, be it from a public or private entity. There is no deductible premium or co-pay. ***Overcost Fund:*** The Department of Health may provide coverage of the cost for the following services or items to eligible residents of long term care facilities under its jurisdiction: • one-on-one attendant care; • tube feeds (special diets and related supplies); • incontinent supplies; • over the counter medications - Residential Care Facilities only; • specialized equipment assessment and follow up visit by an Occupational Therapist or Physiotherapist; • resident specific supplies (atypical circumstances); and/or • specified transportation. There are no user fees for these services. An individual is eligible to have service costs paid out of the Over Cost Fund when the following criteria have been met: • the individual is a regular bed resident of a long term care facility, and • requires a service which is a covered benefit under this policy, and • meets assessment criteria where specified, and • has the request reviewed and approved by Continuing Care prior to delivery of the service. There are no user fees for these services. Retroactive coverage of costs will not be approved.

continued ... Do First Nation clients on-Reserve have access to other programs while in LTC?	
INAC	First Nations people who were Income Assistance recipients prior to leaving the Reserve and coming into care are entitled to a personal needs allowance of $129 per month. First Nations people can continue to access Non-Insured Health Benefits. The Non-Insured Health Benefits Program is Health Canada's national, medically necessary health benefit program that provides coverage for benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counselling and medical transportation for eligible First Nations people and Inuit.

Do you have written policy on funding/access to LTC for First Nation clients?	
Nova Scotia Department of Health (Continuing Care Branch)	Yes, there is a Long Term Care Policy Manual which includes the Service Eligibility, Resident Charge and Facility Placement policies. A copy of the manual can be found online at www.gov.ns.ca/health/ccs/ltc.asp#policies.
INAC	The National Manual provides an overview of the program and recommends that there be a regional manual that interprets the national standards and guidelines within the context of the provincial standards and practices. The Atlantic Region does not yet have a Regional Manual for the Assisted Living Program but has identified this as part of the social program work plan for the next year. The Assisted Living Program National Manual covers the following: Background, Program Components, Funding Arrangements, Reporting and Compliance, and Program Terms and Conditions. A copy of the manual can be found online at http://dsp-psd.pwgsc.gc.ca/Collection/R2-330-2004E.pdf.

5.0 Cross Canada LTC Policy Review

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 long term care, home 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 and Labrador

Data sources included 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 related 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 Nations population in the jurisdiction;
- The approach adopted by the jurisdiction with respect to 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; and,
- Particular challenges experienced with regard to the delivery of services to First Nation populations in the jurisdiction.

Of most interest for this report was the approach adopted by provincial Ministries of Health with regards to access and funding of long term care services for First Nation individuals living on-Reserves.

5.1 NOVA SCOTIA CONTEXT

In Nova Scotia, policy regarding access, eligibility and resident fees is set by the provincial government. Placement in Department of Health licensed or approved long term care facilities is available to all Nova Scotians under identical eligibility and placement criteria, however long term care costs for Registered Status First Nation individuals differ from other residents. The province charges the full per diem rate for a long term care bed to Registered Status FN individuals living on-Reserve. These costs are covered in full or in part by Indian and Northern Affairs Canada (INAC). However, First Nation individuals are charged the same rate as other Nova Scotians for use of a long term care bed on a short term basis for respite. There is no federal funding from Health Canada or INAC available to FN individuals on-Reserve for the costs of residential respite services. There is only one long term care facility under the Department of Health's mandate on a Reserve in Nova Scotia, however this facility has no specific programming aimed at First Nation individuals.

5.2 OTHER JURISDICTIONS

There are a number of different approaches used across Canada for the development of long term care policy and the delivery of long term care services. In most provinces, including British Columbia, Alberta, Saskatchewan, and Manitoba, the province sets policy with regard to access and eligibility, while regional health authorities deliver long term care services. In PEI, long term care is a provincial program with some facilities being government run and others being privately run. Ontario has a mixed approach with the provincial Ministry taking responsibility for developing policy, while Community Care Access Centres deliver and coordinate services and Local Integrated Health Networks (LHINs) are responsible for planning and funding of health services such as long term care homes.

Additionally, there is a mix of approaches across Canada with regard to the provision of long term care services to First Nation individuals living on-Reserve. While all provinces indicated that First Nations had the same access to long term care facilities as other residents, some provinces have long term care facilities on-Reserves, while others do not. In Ontario there are three on-Reserve, provincially-funded long term care homes. In Manitoba, INAC has eight facilities specifically designated for First Nations. New Brunswick, Alberta, PEI, and Newfoundland do not provide facilities on-Reserve. British Columbia and Manitoba indicated that access to services differs based on geographic location as those in rural and remote areas may not have access to long term care homes near the Reserve.

In New Brunswick, Newfoundland and PEI, First Nations on-Reserve are charged the same fees for long term care as other residents. New Brunswick indicated that the province normally provides financial assistance, and PEI indicated that accommodation costs

are based only on income and apply uniformly to all residents. In Alberta, the province assumes the cost of health care and the resident is responsible for room and board costs. In British Columbia, Saskatchewan and Manitoba, INAC covers the costs of long term care for First Nation individuals in some circumstances. In British Columbia, INAC pays the individual's accommodation costs, which vary based on the residents' income, though there is a lack of clarity over whether the province or the federal government should fund First Nation residents under age 65. In Saskatchewan, INAC funds First Nation clients between the ages of 18-65 needing long term care if they lived on-Reserve prior to admission to the long term care facilities. First Nation clients over age 65 are not covered by INAC. In Manitoba, INAC funds First Nation clients assessed as care level 1-3, while those assessed as care level 4 are covered by the province.

5.3 SUMMARY

The results of the interjurisdictional survey show that nationally there are differences between jurisdictions in the approach they adopt with respect to the provision of long term care services to registered status First Nation individuals living on-Reserve.

6.0 Policy Issues and Recommendations

In examining national and international literature on long term care as it relates to Aboriginal people, and reviewing the feedback provided by community health informants regarding local long term care capacities, needs and issues, there appear to be two streams of policy and program development:

a. strategies to extend local capacity (professionals, paraprofessionals, volunteers and family members) for the provision of care to individuals in their own community for as long as is possible – recognizing that this commitment is often of a considerably longer duration than would be experienced in a mainstream context; and,
b. strategies to achieve the best possible experience by First Nation long term care residents and their families when admission to a residential facility is the most appropriate care option.

Anecdotally, First Nation people living on-Reserves express tremendous anxiety about the prospect of leaving their community to live in a long term care facility. While the desire to live in one's own home for as long as possible is also expressed by the mainstream population, there is amplified reluctance to consider long term care placement for Aboriginal people. The most notable reason FN communities in Nova Scotia identified was the profound cultural dislocation associated with leaving their Reserve to live in a mainstream institution[5].

This fear of cultural and social isolation may result in high-risk living conditions for medically compromised individuals who need a far higher level of care than can be provided in their community setting. Local health staff, informal caregivers and extended family can create remarkable support systems that endure for very extended periods of time. Indeed, this is a hallmark of Aboriginal culture, particularly when it comes to the care and support of the elderly. But these extended family care plans can come at a price, measured by the stress and personal limitations experienced by those caregivers (most often women) who take on these responsibilities. Their own physical and mental health may suffer as a result, with consequences for themselves, the ones they care for, and the health care system as well (Hampton et al., 2008; Ludtke and McDonald, 2005).

In developing a long term care strategy for Aboriginal people, it is important to understand that life in an Aboriginal community – family units and social structures – is quite different than in a mainstream setting. Extended family members tend to live in close proximity to

5 While this is an area that requires more research to quantify, feedback to this point by local elders, health care providers and Aboriginal organization representatives on the steering committee has been very consistent.

one another and there is an enduring focus on communal activities. If several generations do not share one roof[6], they will be only a few doors away. And while the broader Canadian family unit has continued to disburse from coast to coast and around the world (making caring for an elderly or infirm relative wholly impractical), Aboriginal families living on-Reserves are tight-knit and interact at least daily.

That is not to say that family support systems are ideal or have been immune to evolution. Indeed, one of the most profound long term impacts of the Indian Residential School policy was the complete loss of an entire generation of Aboriginal people to their kin, community and culture. The result is the breakdown of generational continuity and intergenerational trauma - manifesting itself in grandparents doing their best to raise grand children, at the same time doing their best to support an aging parent, aunt, uncle or cousin. It is only a matter of time before often complex support systems begin to unravel with the caregiver needing care, which may or may not be available.

As the profile of family and community life is different on-Reserve than for non-Aboriginal people, so too is the general profile of a FN individual needing long term care placement. Because FN people are more likely to develop multiple chronic health problems and related disabilities earlier in life than the mainstream population, it is to be expected that FN people requiring long term care services will be younger than the non-Aboriginal cohort (Hollander, 2008; First Nations Regional Health Survey, 2007).

The Aboriginal Home Care Steering Committee has developed the following eleven recommendations designed to improve long term care for FN individuals and their families. Progress toward achieving these changes will be monitored by the Nova Scotia Aboriginal Continuing Care Policy Forum.

Informing FN communities about Long Term Care Policies and Programs

As demonstrated by the responses in the long term care community service profiles in Section 2 of this report, some FN communities have little recent experience with long term care placement. Misinformation and misconceptions may unduly influence individuals and families when deciding whether or not to consider placement. As a result it is critical that the Department of Health and district health authorities provide clear, effective communication regarding long term care policies and programs to FN health staff and community members so that opportunities to benefit from available services are maximized.

Recommendation 1: The Department of Health and district health authorities should collaborate with First Nations community health directors in providing appropriate education and information about long term care services and supports that are available to First Nation residents.

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6 Sixteen percent of Aboriginal seniors living on-Reserve are more likely to be living with extended family members than their non-Aboriginal counterparts (7%). (Dumont- Smith, 2000, p.7)

Different clinical profile means different programming support

Based on the demographic and health context, it is reasonable to expect that the clinical profile of Aboriginal people will be skewed toward such issues as acquired brain injury, a range of dual-diagnosis disorders, complications of Fetal Alcohol Spectrum Disorder and co-morbidities requiring advanced medical care. Whether Aboriginal people have the same or different experience with dementia as the mainstream population is a matter of considerable research interest. It is unclear if the seeming under representation of FN long term care residents with Alzheimer's disease, for example, is due to the fact that Aboriginal people simply don't live long enough in sufficient numbers to develop these conditions (First Nations Regional Health Survey, 2007; Frohlich, et al., 2006; Ring and Brown, 2002).

Recommendation 2: To address the differences in clinical profile and illness experience of the First Nations population, long term care facilities providing care to First Nations residents must ensure they have the appropriate programs and medical supports in place for these residents. First Nations families and Elders must be included in developing approaches to ensuring First Nations residents' health care needs will be met.

Cultural trauma

It is well recognized that the legacy of colonization in general, and Indian Residential School policy in particular has impacted the relationships of FN people with mainstream institutions (Bombay et al, 2009; Haskell & Randall, 2009). While more research is certainly warranted to understand this issue, it would be reasonable to expect that the move from a FN community environment to a mainstream LTC facility could be socially, emotionally and culturally traumatic. There are several considerations and supports that should be in place in long term care facilities to contribute to cultural comfort. These include:

- being cared for by Aboriginal staff;
- having common areas that can accommodate larger family gatherings (expecting that several extended family members will participate in a visit at one time, most likely including young children);
- preparation of culturally appropriate meals;
- space for performing ceremonies, and policies to support them; and
- friendly visiting program from First Nation communities.

Recommendation 3: Long term care facilities providing care to First Nations residents must ensure they provide a culturally safe, secure and appropriate environment for First Nation individuals and their families. Cultural competency and cultural safety should be ensured through collaboration with First Nations families and Elders in the design of appropriate approaches to care and social environments.

Assessment of fees
Federal and provincial assessment processes to determine client fees for long term placement are different, as are the range of services and supports each provides to Aboriginal clients and families. As a result, further study and analysis is required to determine what, if any, policy changes are necessary to better align programs and services.

Recommendation 4: Through the Aboriginal Continuing Care Policy Forum, additional analysis regarding differences between DOH and INAC long term care client fee determination processes should be undertaken with the goal of reducing inequities without disadvantaging First Nation clients.

Recommendation 5: Consistent with INAC's income assessment policy, the Nova Scotia Department of Health should ensure that any financial restitution resulting from an Indian Residential School settlement is exempt when determining client fees for long term care placement.

Centres of Excellence in cultural safety
From the perspective of First Nation communities, it would be ideal for long term care facilities to be located in, or very close to, the home Reserve. When this is not a practical approach, recognizing that the demand for long term care placement by Aboriginal people is relatively small, opportunities should be explored to support a critical mass of residents to support culturally competent care and socially satisfying networks.

Recommendation 6: The Aboriginal Continuing Care Policy Forum should be used as a platform for further exploration and analysis of options for developing culturally appropriate and fiscally sustainable long term care services to First Nation individuals living on-Reserve. This process should involve exploring a variety of possible approaches including, but not limited to, designated households in existing long term care facilities, a small multi-care level facility built on-Reserve providing care for clients across the age continuum and for a broad range of care needs, and a small facility on-Reserve providing service to both the on-Reserve First Nation population and non-Aboriginal population. Providers across the continuum of care, First Nation leaders and Elders must be involved in the discussion and design. Recommended solutions must be First Nations-driven.

Supporting family and community connection
FN communities reported that even a distance of 10 kms to LTC facilities may be a significant barrier to family members, and acknowledging the benefits of maintaining strong connections with one's home community (particularly in a First Nation context), Health Canada's Medical Transportation Program[7] should be revised to support family members to visit First Nation residents in LTC facilities on a regular basis.

7 Details of the Medical Transportation Program are included in Weaving Partnerships: A Framework for Aboriginal Home Care in Nova Scotia 2010-2011 Resource Guide.

Recommendation 7: Health Canada should explore with INAC ways to improve access to financial assistance for residents of Reserves who wish to visit their family member living in a long term care facility off-Reserve.

Caregiver support

Most Aboriginal families have close ties to extended relations, often residing in the same community. While this can, in some ways, make providing support to those who are disabled, sick and aged somewhat easier (because there are many people to share the burden and distances are not great between households), this can also create significant stresses and demands on those individuals who are most regularly relied upon to provide this support. Being caught in the 'sandwich generation' of needing to care for ones children, parents, and often even grandchildren can result in considerable caregiver stress and fatigue.

Recommendation 8: When looking at options for long term care services for First Nations living on-Reserves, the need for caregiver respite provided in a residential care setting should be considered.

Recommendation 9: When looking at options for long term care services for First Nations living on-Reserves, options for family to visit overnight at little or no cost should be considered.

"Elder Abuse"

It is important to understand that using the term "Elder Abuse" in the Aboriginal community is a misnomer. Use of the word Elder has a different connotation for Aboriginal persons than it does in Western cultures. An Elder in the Aboriginal community is not necessarily a senior aged 65 but an individual who has earned respect for their ability to be a teacher/leader of others. Demographically, a senior in the Aboriginal community would be closer to 55 years or older due to lower life expectancy (69 years for men and 76 for women) and poor health. (Health Canada, 1998:32 cited in Dumont-Smith, 2002).

Abuse of older adults has been identified as a serious problem in some First Nation communities (Health Canada, 1997). One community study cites mental or psychological abuse, financial exploitation and physical abuse (in that order) as the most prevalent types of abuse of the elderly (Grier, 1989, in Lane et al 2003, p. 27). Having strained formal and informal caregivers at the community setting, or being alone and at great distance from personal advocates in an institutional setting may increase the risk of abuse.

Recommendation 10: Information and programs identifying the early warning signs of elder abuse and how to respond appropriately should be available to families and care providers who are involved with First Nations patients/clients, as well as through local

seniors' centres with First Nations clients. This should involve collaboration with FN communities, Department of Seniors, and the Department of Health's Adult Protection Program and Protection for Persons in Care Program to ensure that culturally appropriate protocols are developed with and communicated to all stakeholders.

Attracting and training Aboriginal LTC workers

Given the importance of having Aboriginal staff caring for First Nation residents, facilities on-Reserve and/or facilities with designated First Nation households could also be teaching/placement sites, with programs geared to attracting Aboriginal long term care workers. This would serve to address Aboriginal human resource development goals, at the same time creating opportunities for First Nation long term care residents to be cared for by Aboriginal service providers.

Recommendation 11: When looking at options for long term care services for First Nations people living on-Reserve, consideration should be given to establishing teaching/placement sites for Continuing Care Assistants, nurses and related health professionals to increase capacity and skills for providing appropriate care to First Nation clients.

7.0 Concluding Remarks

Aboriginally-specific long term care would appear to be a relatively new policy domain in the international, Canadian and Nova Scotian contexts. In this province, the number of First Nation people in long term care is very small, but the impact of long term care issues for individuals, families and communities can be profound.

There are a number of factors that make planning long term care services in an Aboriginal context different than for non-Native people. First, although the demographic profile for First Nation communities is one of a very young population, there is a growing cohort of older people for whom long term care service capacity does not uniformly exist. Aboriginal culture and tradition highly values the role of elderly community members to be supported within extended family supports. As the health needs of these individuals increase, so too does the burden of providing this care by relatives who often lack the training and resources to do so.

The higher rates of disability and co-morbidities by younger First Nation community members adds an additional long term care complexity, as these individuals require services earlier in life and often over a greater time span. This requires policy considerations that span the continuum of prevention/early intervention to long term chronic disease management and support.

It is noteworthy that most of the First Nation individuals in long term care facilities in Nova Scotia are in facilities administered by the Department of Community Services. This speaks to the need for this provincial government department and its agencies to be represented and engaged in long term care policy development for Aboriginal people. Opportunities should be created to work collaboratively to inform best and promising practices for Aboriginal long term care so that the system is improved in Nova Scotia and across the country.

The decision to seek placement in a long term care facility is rarely easy, for the individual or his/her family. It must be stressed that this decision is particularly challenging for a First Nation family for whom loss of all familiar cultural ties would occur by moving to a mainstream institution. Although most First Nation communities are within a few kilometers of a long term care facility – from a cultural safety perspective, the distance is a world away ... quite literally to a foreign land. While there does not appear to be any documented evidence, anecdotal feedback raises concerns that survivors of Indian Residential Schools who suffer symptoms of Post Traumatic Stress Disorder may be particularly vulnerable to experiencing re-traumatization by institutionalization in their senior years.

This report has started the process of identifying some important issues that need to be addressed at the provincial, federal and community levels as LTC models continue to be developed for Aboriginal people. The Steering Committee for this report suggests that the Aboriginal Continuing Care Policy Forum (ACCPF) serve as a mechanism for further exploration of LTC needs on-Reserve and developing appropriate and sustainable solutions to meet those needs. The ACCPF will serve as a mechanism for continued collaboration, research, planning and policy development aimed at improved healthcare for First Nation people living on-Reserve.

Appendix A – Service Profile Questionnaire

1. Do you have any community members that are currently living in licensed, Department of Health approved, long term care facilities (nursing home, residential care facility or community based option)?
    a. If yes, how many?
    b. What level of care or type of facility are they living in?

2. Do you have any community members that are currently living in a private long term care facility (not licensed or approved by the Department of Health or Department of Community Services)?
    a. If yes, how many?
    b. What level of care or type of facility are they living in?

3. How many additional people do you think would benefit from long term care in your community?
    a. What type of supports do they require?
    b. What is the age range of potential clients?
    c. What medical conditions do they have?

4. Why do you think people who would benefit from a long term care placement have not pursued it?

5. Does the 'Band' provide 18-24 hour care in your community?
    a. If so, who provides the care?
    b. How long does this support typically last (ex. 3 months, 6 months, years)?

6. What kind of experience has your community had with long term care?

7. Do you have any challenges with the assessment/entry process for long term care?

8. Are there any financial issues with regards to funding for long term care placement?

9. What has your community's experience been with LTC respite services?

10. What would you regard as the attributes of a culturally relevant long term care model?

11. What are the key features of a Long Term Care Model that would work for your community?

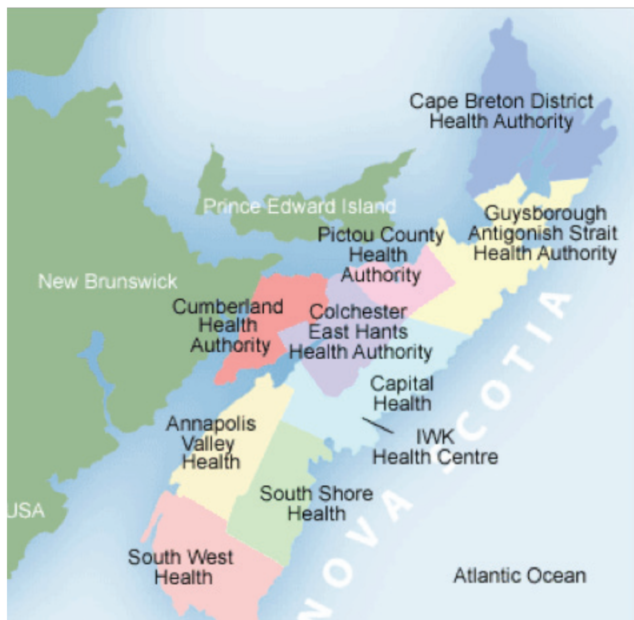
12. What could be changed in existing LTC facilities to make them more suitable for First Nations clients?

13. Is there anything else about long term care for FN clients and families that you would like to tell us?

Appendix B – LTC Facility Questionnaire

1. What type of long term care options and services do you provide?
2. What type of care needs do your residents have?
3. How many individuals does your facility support?
4. What is the staff resident ratio?
5. What is the age range of residents supported by your facility?
6. Does your facility provide services to First Nation clients only? If not, what percentage of residents are First Nation?
7. What issues need to be considered when providing long term care services on-Reserve?
8. What are best practices with regards to:
    a. Building type/design
    b. Staffing
    c. Programming
    d. Location of facility
9. What is different about providing long term care to First Nation residents than to other client groups?
10. How are cultural and spiritual traditions incorporated into long term care provision?
11. How is the local community involved in the long term care facility?
12. Have you had success recruiting First Nation staff to work in your facility? If so, how have you done this?
13. Who funds LTC services on-Reserve (which government agency)?
14. Are services provided on "a fee for services basis"?
15. Does the resident pay for any part of their care/accommodations? How much?
16. Who is responsible for licensing, monitoring, and standards development for long term care facilities on-Reserve?

Appendix C – FN communities and LTC facilities



DHA #	DHA Name
1	South Shore Health
2	South West Health
3	Annapolis Valley Health
4	Colchester East Hants Health Authority
5	Cumberland Health Authority
6	Pictou County Health Authority
7	Guysborough Antigonish Strait Health Authority
8	Cape Breton District Health Authority
9	Capital Health

First Nation Community	Nursing Home	Distance	First Nation Community	Nursing Home	Distance
Acadia	Tidal View Villa St. Joseph Nakile	2.3 km 4 km 25 km	Paqtnkek	RK MacDonald Port Hawkesbury	23 km 31 km
Bear River	Tideview Terrace	17 km	Chapel Island	Richmond St. Anne	10 km 30 km
Annapolis Valley	Evergreen Orchard Hall	11 km 12 km	Eskasoni	Celtic Court RC MacGillivray The Cove	56 km 56 km 56 km
Glooscap	Haliburton Windsor Elms Wolfville	18 km 20 km 20 km	Membertou	Celtic Court RC MacGillivray The Cove	1 km 1 km 1 km
Indian Brook	Magnolia Elk Court Cedarstone	24 km 31 km 43 km	We'koqma'q	Inverary Alderwood Port Hawkesbury	40 km 40 km 42 km
Millbrook	The Mira Wynn Park Cedarstone	4 km 3 km 4 km	Pictou Landing	Glen Haven Shiretown Oddfellows	4km 15km 15km
			Wagmatcook	Alderwood	15 km

Appendix D - Key Contacts

The number to call toll-free in Nova Scotia to connect with Continuing Care services is 1-800-225-7225.

For a directory of Department of Health licensed long term care facilities in Nova Scotia, please visit the following website:

http://www.gov.ns.ca/health/ccs/directories_facilities.asp

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