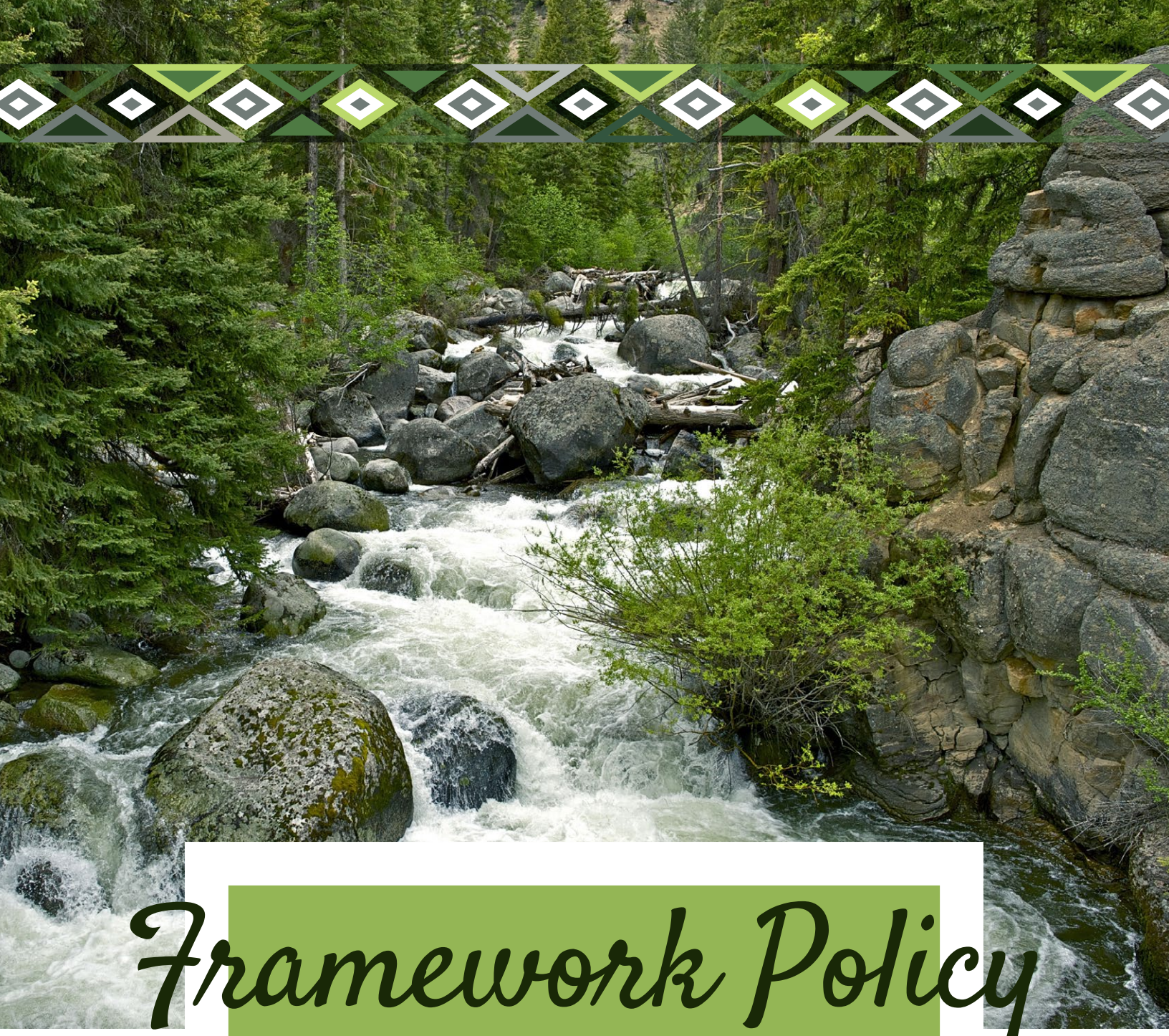

Framework Policy

ON **CONTINUING CARE** FOR PERSONS WITH DECREASING INDEPENDENCE IN QUEBEC FIRST NATIONS

FIRST NATIONS OF QUEBEC AND LABRADOR **HEALTH AND SOCIAL SERVICES COMMISSION**

CSSSPNQL • FNQLHSSC

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An electronic version of this document is available, in French and English, at cssspnql.com/en.

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1. Introduction

Local First Nations governments must cope with the aging of their populations and meet their many needs, including the needs of those who are faced with decreasing independence, while providing them with continuing care in their respective communities. The first steps to developing this policy date back to 2012 with the joint work of six communities: Kahnawake, Kanesatake, Kitigan Zibi, Mashteuiatsh, Timiskaming First Nation and Wendake. In 2015, following a mutual agreement between the communities participating in the project, the Chiefs Assembly of the Assembly of First Nations Quebec-Labrador (AFNQL) passed a resolution to transfer the file to the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).

Framework Policy definition

The Framework Policy is a document that is meant to guide the current and future actions of federal, provincial and First Nations government partners to implement continuing care for persons with decreasing independence residing in First Nations communities.

The Framework Policy will help put formal measures in place and mobilize partners around the concrete actions that will result from them.

The objectives of the Framework Policy are aligned with the objectives of the health and social services governance process,[1] started in 2014, in particular by aiming to give First Nations the possibility of providing continuing care and, in order to do so, define the corresponding priorities develop the appropriate programs. To achieve these objectives, it is necessary to start with resolving the recurring difficulties resulting from conflicts of jurisdiction and the blurring of roles and responsibilities between the federal, provincial and local First Nations governments. These conflicts are at the heart of the fragmentation of services and the difficulty related to the lack of continuity between the care accessed inside and outside the communities. The ultimate goal is to promote access to health and wellness care that is comparable to the care provided to non-Indigenous people.

The development of the health and social services governance model proposes the creation of a First Nations regional health and wellness body that stands to play a fundamental role with communities and governments to ensure the success of this policy. For example, to be able to make sure that health and wellness services are comparable to those offered to non-Indigenous people, it is necessary to have data relating to each community to be able to draw comparisons with data from Quebec. Likewise, all the issues relating to accountability and the roles and responsibilities of the various stakeholders in health and wellness concern all communities, so it would be advantageous for this other collective dimension to be overseen by a First Nations regional body that can support the coordination and negotiation of equitable agreements for each community while taking into account their specificities.

[1] https://gouvernance.cssspnql.com/en

The local health and wellness autonomy targeted in the objectives of the policy, which includes the power to provide culturally respectful continuing care, is contingent on the identification of priorities and services, which requires the integrated planning of health and wellness services, the development of appropriate tools to ensure service quality and capacity-building for the staff and stakeholders involved. In the proposed model for a regional health and wellness body, the main mandate would be to support communities and organizations throughout their integrated health and wellness planning processes, as well as to develop culturally appropriate tools to deliver quality services and support in service evaluation and capacity-building for everyone involved.

2. Purpose, objectives and scope of the Framework Policy

2.1 PURPOSE OF THE FRAMEWORK POLICY

The purpose of the Framework Policy on Continuing Care is to put in place mechanisms to promote a holistic continuum of equitable services for persons with decreasing independence. To do this, a transparent and open process for improving the health and social services system in First Nations communities[2] will be established.

Vision of the Framework Policy

Allow First Nations adults with decreasing independence and their families to benefit from a seamless transition through the continuum of care and services and the most positive experience possible. To achieve this, the contributions and commitments of governments are both essential and central to the challenges of implementation.

(Inspired by the Ministère de la Santé et des Services sociaux *Vers une meilleure intégration des soins et des services pour les personnes ayant une déficience. Cadre de référence pour l'organisation des services en déficience physique, déficience intellectuelle et trouble du spectre de l'autisme* [2017].)

2.2 OBJECTIVES OF THE FRAMEWORK POLICY

The Framework Policy on Continuing Care aims to:

- Stop fragmentation in the provision of services to persons with decreasing independence by implementing a continuum of services adapted to First Nations. Services must also harmonize with traditional approaches and local culture in health and social services.
- Promote access for First Nations adults with decreasing independence to health care comparable to that provided to non-Indigenous people.
- Enable communities to acquire greater autonomy and responsibility in developing a continuing care program that meets their local realities.
- Define and develop priorities and strategies allowing First Nations communities to put in place mechanisms to improve the delivery of health and social services to persons with decreasing independence through their own institutions.
- Make it possible to ensure the provision of continuing care by First Nations communities in Quebec.[3]
- Ensure access, without any discrimination, to all health and social services to First Nations citizens in Quebec.

[2] The Framework Policy does not apply to the Cree, Inuit and Naskapi communities. However, they are free to use the policy as a source of inspiration.

[3] Recommendation #1 - Appendix A: Project for the development of a Framework Policy on Continuing Care for First Nations seniors. Summary report presented by Timiskaming First Nation. 2016.

2.3 THE SCOPE OF THE FRAMEWORK POLICY

The Framework Policy applies to services aimed at meeting the needs of First Nations persons with decreasing independence so that they can benefit from a seamless transition through the continuum of care and services that is consistent with their realities and culture. With that in mind, actions must be taken at both the political and the organizational level. Continuing care must be of high quality, centred on the needs of the individual and fully integrated into the continuum of care and services as well as a network of culturally appropriate programs and organizations.

Continuing care for adults with decreasing independ

3. Persons with decreasing independence targeted by the Framework Policy

This Framework Policy applies only to adults aged 18 years and over with decreasing independence. The services and trajectories used by children and adolescents with special needs are sufficiently different to warrant a specific project to address the continuum of care for this clientele.

Persons with decreasing independence are those whose impairments can limit the performance of their daily activities and their full participation in life in their community. Four categories of people are included in this group: seniors, adults with chronic disease, adults with mental health problems and adults with impairments. Note that these categories are not mutually exclusive (see Appendix B: Definition of clients with decreasing independence).

According to the *Quebec First Nations Regional Health Survey* (RHS) in 2015, the majority of adults aged 35 years and over have to deal with at least two chronic health conditions on a daily basis and nearly half of seniors (65 years and older) have to deal with at least five chronic health conditions on a daily basis.[4] This same survey indicates that 7% of adults (18 to 64 years old) and 46% of seniors (65 years and older) consider that they need home care and services. Among adults who said they needed home care and services, housekeeping and household maintenance were the two most frequently mentioned types of services; this is followed by nursing care, meal preparation or delivery, and help with running errands.[5]

The needs for health and social services are indeed great, and the lack of resources to meet them creates continual pressure on First Nations communities. In the years to come, these pressures will increase considerably, in particular due to the growing prevalence of chronic diseases, the co-morbidities of which can limit the level of independence[6] of those concerned.

Those at the heart of the Framework Policy

[4] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2018). *Quebec First Nations Regional Health Survey – 2015, Health Status and Chronic Health Conditions.* Wendake.

[5] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2018). *Quebec First Nations Regional Health Survey – 2015, Home Care.* Wendake.

[6] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2006). *Assessing Continuing Care Requirements in First Nations and Inuit Communities.* Wendake.

4. Issues

First Nations were consulted on many occasions to identify the issues and commitments surrounding the continuum of care for persons with decreasing independence.[7] These issues and commitments were validated by stakeholders during regional meetings, by the First Nations health directors as well as by the committee of experts and the steering committee of the project to develop a Framework Policy on Continuing Care. The issues are presented in this section, followed by the commitments and measures to address them. These commitments are the responsibility of the federal government (Indigenous Services Canada), the provincial government (Ministère de la Santé et des Services sociaux and the Secrétariat aux affaires autochtones) and First Nations (see Appendix C: Summary table of commitments).

4.1 ACCOUNTABILITY, ROLES AND RESPONSIBILITIES

The implementation of a complete continuum of care poses a major challenge for First Nations, especially given the ambiguity in terms of the roles and responsibilities of the partners involved in the provision of services. "(…) First Nations receive health care and social services from various agencies at a number of levels outside their jurisdiction. Federal programs, initiatives and services coexist with provincial ones and, when resources are available, these are completed by local initiatives implemented by Band councils and other local and community authorities."[8] This leads to the unnecessary duplication of procedures and an overlap in decision-making mechanisms, which alter the effectiveness of many programs and result in poorly integrated and unsuitable services[9] (See Appendix D: Description of health and social services).

COMMITMENTS:

1. Strengthen communication, collaboration and partnerships between local First Nations governments, the Government of Quebec and the federal government.
   - Set up a joint committee for the implementation of continuing care.
   - Establish a mechanism for collaboration between First Nations and partners at both the political and the organizational levels.
   - Make public consultation tools available in a timely manner, in French and in English.
2. Support harmonized and complementary federal, provincial and local programs.
   - Clarify the provincial service offering that applies to First Nations and complements that of federal programs.
   - Create harmonization models adapted to the different realities of First Nations communities and organizations.
   - Clearly identify the program authorities for home and community services.
3. Define the administrative logistics for building out the continuum of care.
   - Clarify the roles, responsibilities and accountability of each partner with regard to service delivery.
   - Promote autonomy in the management of the various service programs.
4. Promote effective and reciprocal accountability.
   - Simplify federal accountability requirements so they better meet the needs of First Nations.
   - Harmonize accountability between programs offered by different funding agencies.

[7] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2006). *Assessing Continuing Care Requirements in First Nations and Inuit Communities*. Wendake. FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2013). *Portrait of First Nations in Quebec Living with Disability or Having Special Needs*. Wendake. Research and situation analysis work led by TFN.

[8] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2007). *2007-2017 Blueprint*. Wendake.

[9] Ibid.

4.2 INFORMATION SHARING

With regard to sharing information about users, communication between First Nations communities and the Quebec health and social services network (RSSS) is not always efficient, which can lead to delays in the provision of services. The trajectories of persons with decreasing independence can be complex and include home care, hospital stays, episodes requiring the support of family caregivers and so forth. It has been noted that the challenge of sharing information on people's needs creates gaps in the continuum of care and services, as well as duplication in the assessment of functional autonomy by professionals in First Nations communities and the RSSS.[10] Support from partners is essential to ensure the sustainability of communication mechanisms and service agreements.

COMMITMENTS:

5. Facilitate information sharing between facilities in the Quebec health and social services network (RSSS) and those in First Nations communities and organizations.
    - Put in place the material, human and financial resources to facilitate the implementation of an integrated services network for adult persons.
    - Enable communities and organizations to access or link to the integrated information systems used by the RSSS.
6. Foster coordination between all stakeholders involved in an individual's continuum of care.
    - Set up a procedure allowing for information about the user to be shared, in accordance with the principles of data privacy and the protection of personal information (e.g., inter-facility requests for services).

4.3 ACCESS TO QUALITY CARE AND SERVICES

First Nations can encounter many obstacles when it comes to receiving services in their community. These obstacles are related to poor streamlining between the various resources, the shortage of health professionals and the lack of social services.

COMMITMENT:

7. Support the development of long-term collaboration and service agreements between the RSSS and First Nations communities and organizations.
    - Establish service agreements with CISSSs and CIUSSSs to foster access to services.
    - Establish service agreements allowing CISSS and CIUSSS professionals to provide services in First Nations communities and organizations.
    - Foster the strengthening of the capacities of health professionals, workers and informal caregivers in palliative and end-of-life care in First Nations communities and organizations.

Certain measures put in place in the RSSS are not accessible to non-agreement First Nations, either because the eligibility criteria limit their access (because of their place of residence) or for reasons of jurisdictional authority. This situation increases the disparities in terms of services between First Nations and the non-Indigenous population in Quebec.

COMMITMENT:

8. Ensure health and social services are equitable.
    - Work with First Nations and the RSSS to develop a strategy for equitable access to services.
    - Provide First Nations with equitable and comparable access to the measures described in the various government action plans applicable to persons with decreasing independence.

[10] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2013). *Portrait of First Nations in Quebec Living with Disability or Having Special Needs*. Wendake.

Palliative and end-of-life care is underdeveloped or non-existent in First Nations communities and organizations since, until very recently, there had been no funding earmarked for it. Develop these types of services requires putting the necessary resources in place, obtaining the collaboration of the RSSS and the strengthening the skills and capacities of First Nations caregivers.

COMMITMENT:

9. Support the culturally appropriate palliative and end-of-life care that is required in First Nations communities and organizations.

- Secure funding that makes it possible to provide palliative and end-of-life care in First Nations communities and organizations.
- Support the adoption of organizational models for palliative and end-of-life care that are adapted to the realities and needs of each community.
- Facilitate access to physicians and other human, material and financial resources aimed at supporting palliative and end-of-life care in First Nations communities and organizations.

The needs for home care and support are growing. However, a gap persists between these needs and the services obtained, despite the considerable efforts of informal caregivers and the contributions of federal programs. Informal caregivers often find themselves faced with challenges related to a lack of financial support, a lack of training to help their loved ones, the juggling of caregiving and personal priorities, and the lack of respite care.

COMMITMENT:

10. Recognize, assist and support caregivers.

- Set up resources and initiatives that meet the need for recognition, support and assistance for informal caregivers.
- Make long-term respite services accessible.
- Make training and tools available to informal caregivers and adapt them to cultural and linguistic needs.

The limitations of federal programs can hinder access to services and care in residential facilities in First Nations communities. In addition, some users refuse to be transferred to the RSSS or decide to stay in their community as long as possible, given the potential negative effects (isolation from their families and loved ones, services that are poorly suited to their values and culture, communication issues (language of use), etc.), even if the services currently being received do not meet their needs and their health and safety are compromised.[11] Various residential and accommodation initiatives must be available to First Nations in order to meet the growing needs of persons with decreasing independence, including intermediate resources, assisted living accommodations, long-term care accommodations, day centres and family-type resources for adults with physical or intellectual impairments or mental health issues.

COMMITMENT:

11. Increase the number of residential resources for all care levels.

- Enable the creation of residential and accommodation initiatives within First Nations communities and organizations.
- Support First Nations in the certification or accreditation process for adult residential facilities.
- Promote accessibility to culturally appropriate care in all settings, including the various residential resources.
- Revise the daily allowance granted to adult care facilities based on user needs, standards and provincial financial allocations.
- Revise the definition of "family" in order to take the realities of First Nations into account.

[11] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2006). *Assessing Continuing Care Requirements in First Nations and Inuit Communities.* Wendake.

Telehealth is one of the measures that must be put in place so that First Nations can access the services to which they are entitled.

COMMITMENT:

12. Promote and support the use of telehealth to help persons with decreasing independence remain in their living environment.

- Set up telehealth services that are adapted to the needs of First Nations.

4.4 DEVELOPMENT AND STRENGTHENING OF SKILLS AND CAPACITIES

Developing the skills of staff is essential for the implementation and delivery of comprehensive and quality continuing care.

In First Nations communities, many challenges persist related to the development of human resources in the health and social services sector. The most important are access to training, skills development, and the recruitment and retention of staff. It should be noted that staff working in First Nations communities and organizations have access to continuing training through the RSSS. However, they do not, or rarely, receive information on when said training is being provided.

The recurring shortage of health and social services personnel is pervasive in First Nations communities and poses a major challenge. Job vacancies and high staff turnover are structural consequences of the lack of sufficiently qualified human resources in the communities. This can certainly have repercussions on the quality of the health care and social services provided to the population.[12]

COMMITMENT:

13. Support the development and strengthening of skills for staff working in First Nations communities and organizations as well as family caregivers.

- Provide training to staff working in First Nations communities and organizations and adapt it to cultural realities as needed.
- Promote the recognition of culturally appropriate training among accreditation agencies.
- Keep staff informed of the training opportunities in French and English available through the RSSS.

4.5 EQUITABLE AND CULTURALLY APPROPRIATE SERVICES

Most First Nations adults with decreasing independence have to go outside their community to obtain services through the RSSS. These services are rarely adapted to their culture and cause First Nations people to deal with various challenges, such as being away from their families and loved ones, a lack of traditional foods, the loss of opportunities to participate in cultural activities and the loss of their role in the community. In addition, the services are usually provided in French or (depending on the resources of each institution) English, languages with which First Nations seniors are not always familiar.

Given the potential negative effects, some users refuse to be transferred to the RSSS or decide to stay in their community as long as possible, even if the services received do not meet their needs and their health and safety are compromised.[13]

[12] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2006). *Assessing Continuing Care Requirements in First Nations and Inuit Communities.* Wendake.

[13] Ibid.

COMMITMENTS:

14. Improve cultural competencies and knowledge among RSSS professionals and staff.

- Deploy cultural safety strategies to improve the delivery of services within the RSSS.
- Set up online training on Indigenous realities.
- Produce a directory of training opportunities on Indigenous realities and cultural safety.

15. Support the integration of cultural practices into the services provided in First Nations communities and organizations and in RSSS facilities.

- Recognize and support the participation of traditional healers in the services provided by First Nations communities and organizations.
- Foster access to spiritual and cultural care in RSSS facilities.
- Use innovative and proven cultural safety practices in the design of health care delivery to First Nations.

16. Promote access to services in English and First Nations languages.

- Determine the mechanisms allowing access to health and social services in First Nations languages.
- Facilitate access to services in English.

5. Guiding principles

Six guiding principles will guide the implementation of the policy.

1. The First Nations in Quebec and Labrador have the right to self-government and self-determination.

   This means that First Nations have the right to manage the services and care within their facilities for themselves.

2. An approach centred on the health, wellness, compassionate care, development, safety, security and rights of persons with decreasing independence must be favoured.

   This assumes that the planning, delivery and evaluation of health care and social services are centred on the needs of the user and their loved ones. Thus, care and services must be based on advantageous partnerships for users, their loved ones, and health and social services professionals. The focus must be on user wellness, health and compassionate care as well as respect for their culture, environment and realities.

3. The provision of continuous, integrated and culturally appropriate services must meet the needs of First Nations.

   This guiding principle assumes respect for and recognition of the diverse cultures and languages of First Nations, and more particularly of their customs, approaches and solutions throughout the continuum of care. It includes flexibility and continued support from all partners to allow for the implementation of community approaches that are most likely to meet the needs of First Nations.

United Nations Declaration on the Rights of Indigenous Peoples

The guiding principles also refer to several provisions of the *United Nations Declaration on the Rights of Indigenous Peoples*, including:

- *Article 19. States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.*
- *Article 23. Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*
- *Article 24-2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.*

4. Capacity-building must take place at all levels while ensuring that First Nations' cultural realities are respected.

   This involves recruiting and retaining competent and stable staff, especially at the local level. It also includes skills development and the transfer of expertise based on mutually beneficial partnerships for First Nations and partners.

5. Accountability and an understanding of the roles and responsibilities of each partner are prerequisites for implementing continuing care.

   The continuum of care requires the accountability of governments to First Nations and of First Nations governments to their populations. The roles and responsibilities of the partners involved in the continuum of care must be clearly established and understood by all.

6. The partners involved in the continuum of care must adhere to the purpose, objectives, principles, themes, commitments and processes of the Framework Policy on Continuing Care.

   This assumes that the partners will commit to implementing the Framework Policy and that they will adopt monitoring indicators to allow them to adjust actions based on results.

6. Partners

In August 2019, the parties formalized their commitment by signing the *Tripartite Memorandum of Understanding as part of the Quebec First Nations health and social services governance process.*[14]

The memorandum of understanding's objectives are as follows:

- Consolidate and define a tripartite collaboration and coordination partnership in order to contribute to the improvement of the health and wellness of First Nations in Quebec.
- Participate in the development of a health and social services governance model that gives more autonomy and control to First Nations in Quebec with regard to federal health and social services programs, in order to improve their living conditions and reduce the gaps compared to those of Quebecers and Canadians.
- Work together so that the problems related to jurisdictional issues are analyzed according to the roles and responsibilities of each party and ensure that changes are made when required to better respond to the realities experienced by First Nations in Quebec.
- In accordance with its responsibilities and in partnership with all parties, the Government of Quebec will identify possible collaborations in the context of the new governance model.

6.1 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

The mission of the Ministère de la Santé et des Services sociaux (MSSS) is to maintain, improve and restore the health and well-being of the Quebec population by ensuring access to a range of integrated and quality health and social services, thus contributing to the social and economic development of Quebec.[15]

With regard to non-agreement communities, the MSSS establishes appropriate referral mechanisms between the establishments of the Quebec network and the bodies responsible for the delivery of health and social services. In so doing, the MSSS strives to improve the continuity of the services received by First Nations in the Quebec network.[16] In the *Government Action Plan for the Social and Cultural Development of the First Nations and Inuit 2017-2022*, the Government of Quebec committed to "consolidate existing services and promote, through the complementarity of the initiatives, the creation of service continuums."[17]

6.2 SECRÉTARIAT AUX AFFAIRES AUTOCHTONES

The Secrétariat aux affaires autochtones (SAA) is the organization with primary responsibility for maintaining ties between Indigenous peoples and the Government of Quebec. It works with First Nations and Inuit organizations to facilitate their access to various government programs and, in some cases, adapt government activities to their needs.[18]

[14] The health and social services governance process is based on these principles. These were ratified by the Chiefs Assembly in February 2014. https://gouvernance.cssspnql.com/en/

[15] https://www.quebec.ca/en/government/ministere/sante-services-sociaux/mission-and-mandates

[16] http://www.msss.gouv.qc.ca/professionnels/soins-et-services/particularites-des-services-aux-communautes-autochtones/

[17] SECRÉTARIAT AUX AFFAIRES AUTOCHTONES, GOVERNMENT OF QUEBEC (2017). *Government Action Plan for the Social and Cultural Development of the First Nations and Inuit 2017-2018.*

[18] https://www.quebec.ca/gouv/ministeres-et-organismes/secretariat-aux-affaires-autochtones

6.3 INDIGENOUS SERVICES CANADA

ISC brings together First Nations and Inuit health services, education services, essential social services, child and family services, and housing and infrastructure services. It works collaboratively with partners to improve access to high quality services for First Nations, Inuit and Métis. ISC's vision is to support and empower Indigenous people to independently deliver services and address the socio-economic conditions in their communities.[19]

6.4 ASSEMBLY OF FIRST NATIONS QUEBEC-LABRADOR

The Assembly of First Nations Quebec-Labrador (AFNQL) is the occasional meeting point for the Chiefs of 43 communities of 10 First Nations in Quebec and Labrador. It deals with many issues such as the defence of First Nations title, ancestral rights and treaty rights; federal and provincial government policies that interfere with First Nations customs and way of life; government legislation and relations with both levels of government; economic development and other social, economic and cultural matters; and all issues affecting self-government, national relations with government and international relations. The AFNQL Secretariat, in collaboration with its regional commissions and organizations, coordinates the files it deems to be priorities as well as the Regional Chief's representative activities, in addition to implementing the decisions made by the Chiefs Assembly.[20]

6.5 FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) is one of the AFNQL's regional commissions. It is a non-profit organization responsible for supporting the efforts of the First Nations in Quebec and Labrador to, among other things, plan and deliver culturally appropriate and preventive health and social services programs. It aims to ensure that First Nations individuals, families and communities are healthy, have equitable access to quality care and services, and exercise their self-determination and cultural autonomy. Its mission is to support the First Nations in Quebec in achieving their objectives in terms of health, wellness, culture and self-determination.

[19] https://www.canada.ca/en/indigenous-services-canada.html

[20] https://apnql.com/en/

7. Implementation of the Framework Policy

7.1 FORMALIZATION OF COMMITMENTS

The implementation of the Framework Policy starts with the formalization of the commitments it contains. ISC, the MSSS and the SAA must undertake the actions required in their respective spheres with regard to the recognition and scope of the policy. The Framework Policy was approved by resolution by the Chiefs of the AFNQL.

A strategy will therefore be developed to ensure that representatives of the First Nations in Quebec and government authorities are aware of the Framework Policy. The Framework Policy will serve as a reference document during talks and negotiations between the relevant partners for the implementation of continuing care. This strategy may take the form of a tripartite agreement or other type of agreement.

7.2 ACTION PLAN OF THE FRAMEWORK POLICY

An action plan will be developed in collaboration with the partners in order to encourage buy-in with regard to the Framework Policy and specify the actions necessary for the implementation of the identified measures. The complexity associated with carrying out these measures stems mainly from the involvement of multiple partners with diverse interests and skills in the area of health and social services. To overcome this challenge, a joint committee will be formed.

OBJECTIVE OF THE JOINT COMMITTEE

Facilitate and maintain partner engagement and consultation to:

1. Identify and use the levers available in each organization to support the implementation of continuing care;
2. Foster the optimal flow of information and the exchange of expertise between partners and within their respective organizations;
3. Support the establishment of mechanisms to help build out the continuum of care;
4. Foster capacity-building among First Nations.

ROLE OF THE JOINT COMMITTEE

1. Develop the elements of the action plan:
   - Identify the actions making it possible to carry out the measures aimed at the implementation of continuing care;
   - Prioritize actions;
   - Determine a precise timetable for each of the actions;
2. Carry out the action plan;
3. Develop a strategy to ensure the monitoring and evaluation of the application of the Framework Policy.

COMPOSITION OF THE JOINT COMMITTEE

The joint committee will be composed of:

- Two representatives of ISC-Regional Operations and the First Nations and Inuit Health Branch;
- Two representatives of the Government of Quebec – MSSS and SAA;
- Two representatives of the FNQLHSSC – Social development and governance;
- Three representatives of First Nations communities;[21]

Other representatives may be invited according to the needs and the subjects discussed.

[21] The existing networks will be consulted according to the subjects discussed. For example: network of long-term facilities, Health and Social Services Directors Network, etc.

7.3 DEVELOPMENT OF MECHANISMS FOR IMPLEMENTING CONTINUING CARE

The appropriate mechanisms to enable actions in the field will be developed, and support that is adapted to identified needs will be offered to the communities involved in implementing the measures of the Framework Policy. These mechanisms will include guides, resources and models to facilitate the delivery of continuing care in First Nations communities and organizations (existing models are presented in Appendix E).

The need for support for the implementation of continuing care in the communities will also be assessed in order to respond appropriately, if applicable.

APPENDIX A

PROJECT FOR THE DEVELOPMENT OF A FRAMEWORK POLICY ON CONTINUING CARE FOR FIRST NATIONS SENIORS. SUMMARY REPORT PRESENTED BY TIMISKAMING FIRST NATION. 2016

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

Summary Report

PROJECT TO DEVELOP A FRAMEWORK POLICY ON CONTINUING CARE FOR FIRST NATIONS ELDERS

Presented by the Timiskaming First Nation

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This document is also available in French and can be downloaded from the FNQLHSSC website: http://www.cssspnql.com/en/fnqlhssc.

The document was produced with financial support from Health Canada's Health Services Integration Fund (HSIF). The mission of the HSIF is to improve and integrate health care services in First Nations and Inuit communities.

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ACKNOWLEDGEMENTS

The Timiskaming First Nation would like to thank the band councils from Kahnawake, Kanesatake, Kitigan Zibi, Mashteuiatsh and Wendake, which joined the Timiskaming First Nation in developing a framework policy on continuing care for elders in First Nations communities and which delegated a representative from their community to serve on the organizing committee for the policy.

The following are the members of the organizing committee who joined Alain Léveillée, Project Leader, and who worked closely together to write an analysis of the continuing care situation:

Mike Horne, Kahnawake
Marie-Josée Martin, Kanesatake
Charlotte Commonda, Kitigan Zibi
Natalie Dauphin and Mylène Tolley, Mashteuiatsh
Micheline Roy, Wendake
Carol McBride, Timiskaming First Nation
Kathleen Jourdain and Véronique Rankin, First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)

Our sincere thanks also go to Serge Awashish from Opitciwan, Agathe Moar from Wemotaci and Tim Dedam-Sorbey from Listuguj, who provided information on the housing needs in their respective communities for our analysis.

Also, many thanks to the Chiefs of Quebec First Nations and the health directors who contributed greatly to the development of the documents.

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Preamble

As part of Health Canada's Health Services Integration Fund, the Timiskaming First Nation presented the project called *Development of a Framework Policy on Continuing Care for Elders in First Nations Communities of Quebec*. The project was approved by Health Canada. It began in June 2012 and ended in March 2016.

The project's two main objectives were the following:

1. Develop a framework policy on continuing care for elders in First Nations communities in Quebec, and
2. In conjunction with the two levels of government, implement regulatory and financial conditions that would permit interested First Nations communities to ensure the continuum of services for elders.

To achieve this, the Timiskaming First Nation worked closely with five other First Nations communities in Quebec (Kahnawake, Kanesatake, Kitigan Zibi, Mashteuiatsh and Wendake) and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). An organizing committee of representatives from the above-named communities and the FNQLHSSC was created to develop this report and a framework policy on continuing care for elders in First Nations communities in Quebec.

The first step in the policy development project was to paint a portrait of the current continuing care situation, here and elsewhere, in indigenous communities and non-indigenous communities, and to draw findings and recommendations from that information that could then be used to develop a framework policy on continuing care.

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Introduction

The distribution of legislative powers in the federal and provincial governments is based on the *Constitution Act of 1867*. According to this law, health and social services fall under provincial jurisdiction. However, the Government of Canada provides ongoing funding to the provinces and territories to help them dispense these programs and services. This transfer of funds from the federal government for health and social programs provides part of the per-person funding (including Indigenous populations) for the health and social services covered by the provinces and territories. Yet most provinces and territories do not offer these services in First Nations communities. Consequently, Health Canada is funding health care programs that are not borne by the province, while Indigenous and Northern Affairs Canada funds social programs in First Nations communities.

The programs that provide funding for the provision of continuing care to Indigenous people living in the communities are mainly Health Canada's First Nations and Inuit Home and Community Care Program (FNIHCC) and INAC's Assisted Living Program.

Despite accessibility to these programs, the continuum of health services in First Nations communities has serious weaknesses. The First Nations communities of Quebec do not have the same leverage to start programs like those run by the province for Quebec elders, such as housing measures for the elderly or new policies on palliative care and the end of life. Unfortunately, the federal budgets allocated to Indigenous communities for health and social services are not adjustable to make the same range of provincial programs, services and initiatives accessible to First Nations communities. The services available in First Nations communities are not generally comparable to those available outside of communities.

Several national and provincial studies on continuing care have been conducted since the 1990s, with input from Indigenous representatives. Yet despite all the documents and specific recommendations to improve the continuum of services and care for elders living in Indigenous communities, few concrete results have emerged.

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The differences in the way the First Nations and the various levels of government interpret the rights and responsibilities regarding the provision of health care have had significant consequences on the First Nations' health and well-being. The lack of clarity in defining these governmental roles and responsibilities in First Nations health care makes it difficult to adopt a continuing care policy that puts Indigenous elders at the forefront. As a result, the Timiskaming First Nation studied the continuing care offered in First Nations communities as the first step in developing a framework policy on continuing care for First Nations elders. This report presents the main findings stemming from their study.

Data sources

Literature review

The examination of various documents written by the First Nations, researchers and federal and provincial departments sheds light on the positions that dovetail with or express the expectations and needs of Quebec First Nations regarding continuing care.

There is a good deal of "grey" literature on continuing care for Indigenous clients. Since the 1990s, numerous reports, assessments, action plans, initiatives, briefs and bulletins have addressed the subject.

Several researchers were also interested in the topic and produced articles and studies that were consulted to further inform the recommendations in this report.

Survey of directors of First Nations residential care facilities

To document the situation in First Nations residential care facilities in Quebec, a questionnaire was sent to their directors. This survey helped establish a general portrait, whose main findings are presented in Appendix 1.

Consultation

Further information for this study of continuing care for elders in First Nations communities was obtained through consultations that gathered input from those involved in the provision of services. An organizing committed was also established to direct the actions and to validate the content of the written documents.

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Organizing committee

This table presents the members of the organizing committee.

Name	Community
Mike Horne	Kahnawake
Marie-Josée Martin	Kanesatake
Charlotte Commonda	Kitigan Zibi
Natalie Dauphin Mylène Tolley	Mashteuiatsh
Micheline Roy	Wendake
Carol McBride	Timiskaming First Nation
Véronique Rankin	FNQLHCCS *(only in the last year)*

Consultations

Presentations to different groups were done throughout the project to gather comments or validate information with the various actors involved by the management of care services for elders in First Nations communities. The following table outlines the presentations.

Date	Meeting	Audience	Content presented
2013			
March 13 to 14, 2013	Meeting of elders' residence directors	Elders' residence directors and FNQLHSSC representatives	Presentation of the HSIF project approved by Health Canada
November 19 to 21, 2013	Network of health directors	Health directors and FNQLHSSC representatives	Presentation of the HSIF project approved by Health Canada
November 27 to 28, 2013	National HSIF meeting	One coordinator per region and Health Canada representatives	Project objectives, successes, challenges and practical examples
2014			

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January 21, 2014	Timiskaming First Nation Band Council	Members of the Band Council and a health director	Presentation of the first draft of the continuing care analysis, including findings and recommendations
March 26, 2014	Meeting of elders' residence directors	Elders' residence directors and FNQLHSSC representatives	Daily rates for continuing care and the integration of home-care and community-based services

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Date	Meeting	Audience	Content presented
2014			
April 30, 2014	Network of health directors	Health directors and FNQLHSSC representatives	Presentation of chapters from the analysis, elements of the framework policy, draft of the content for an agreement protocol and a schedule of tasks
September 10, 2014	Network of health directors	Health directors and FNQLHSSC representatives	Presentation of various chapters to be included in the proposed framework policy on continuing care
November 4, 2014	Timiskaming First Nation Band Council	Members of the Band Council and a health director	Presentation of the content of the proposed framework policy
2015			
January 21 to 22, 2015	Meeting of elders' residence directors	Elders' residence directors and FNQLHSSC representatives	Presentation of the results from the questionnaires completed by residence directors and the resulting findings and recommendations
January 27 to 29, 2015	Assembly of AFNQL Chiefs	Chiefs, health director from the TFN and FNQLHSSC representatives	Presentation of the content for the framework policy on continuing care (including the drafted recommendations)

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February 25, 2015	Forum on First Nations Health	Health directors, Indigenous organization representatives, federal and provincial government representatives	Knowledge-transfer workshop on the HSIF (project presentation, objectives, activities, achievements and impact on the delivery of health services to the First Nations)
Date	**Meeting**	**Audience**	**Content presented**
2015			
March 10 to 12, 2015	Network of health directors	Health directors and FNQLHSSC representatives	Presentation of the final version of the framework policy on continuing care
June 9, 2015	Assembly of Chiefs – AFNQL	Chiefs	Presentation of the process and a request for support by resolution

Transfer of the project to the FNQLHSSC

In June 2015, at the request of the Timiskaming First Nations community, the project was transferred to the FNQLHSSC following a resolution passed by the Assembly of First Nations Quebec-Labrador Chiefs. (See the resolution in Appendix 2.)

Principal findings

INAC's Assisted Living Program

The 2007 study of INAC's ALP highlighted the lack of funds available through the program. INAC's current budgetary allowance for the ALP is based on an old funding formula that allocates an approximate two-percent increase each year. This formula does not take into account the current and future needs of the program's clientele. According to the study, the yearly growth rates did not reach half of what the provinces and territories provide for similar services. The ALP's basic funding was the same in 2015, and the gaps between the funding of continuing care in communities and outside of communities is still great.

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Health Canada's First Nations and Inuit Home and Community Care Program

While Health Canada's First Nations and Inuit Home and Community Care Program (FNIHCC) meets several needs, it does not provide the services and care that meet clients' actual needs. Current funding is insufficient to provide the services needed in palliative care, rehabilitation, respite and mental health. The lack of funding for members of the First Nations who need care in the evening and on the weekends is also a major pitfall.

Integration of federal programs

Health Canada, INAC and the Assembly of First Nations have recognized the importance of creating a "one-stop shop" to manage home care in Indigenous communities. However, despite the discussions over the years on this issue, this measure has not been implemented.

Various authors have written about the importance of integrating health and social services to better meet patient needs, and some have focused on the missing elements in the current health systems that would better meet the needs of Indigenous communities in Canada.

The authors and stakeholders consulted for this report maintain that increased performance in health organizations cannot occur without an integration of health systems, which would better meet the evolving needs and expectations of patients. Integrated care is particularly effective for patients with many health problems.

Continuing care

Long-term care, as practiced in Canada, does not take into account the particular health care needs of indigenous people. The planning and development of long-term care services for Canadians and Quebecers must also consider Indigenous people in the process. Continuing care services must be culturally adapted to Indigenous values and practices and to the organizational situation of the communities. The division of services is a major issue that is overlooked by the different levels of government that set up policies and programs without taking into account the particularities, capacities and obligations of Indigenous communities.

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Orientations from the Government of Quebec

In general, the Government of Quebec offers care and services to Indigenous people who use the institutions in the Quebec network, but it does not offer services in non-treaty communities. There are some exceptions that came about through agreements made with local authorities or the federal government for the provision of care and services in non-treaty communities.

For treaty communities, Quebec assumes the responsibility of the health and social services provided in light of the treaty. Treaty communities are considered distinct social and health regions in Quebec, and the communities in these territories are integrated into the Quebec health network.

There are general financing rules for indigenous health and social services that provide Indigenous people coverage through the *Health Insurance Act* and the *Hospital Insurance Act*. These acts also guarantee equal access to health and social services provided by institutions in the Quebec network. However, since the responsibility for health and social services for Indigenous people living in communities is shared with the federal government, the province "must ensure the existence of appropriate referral mechanisms to be applied when residents of communities not under agreement receive services in the centres operated by institutions of the Québec network and it must facilitate the transfer of expertise and knowledge according to the wishes that may be expressed by the communities." (MSSS, 2007, p. 17) The province can also train staff working in Indigenous non-treaty communities to transfer its knowledge and expertise.

The brief by the FNQLHSSC on Quebec's Bill 10 notably mentions the following:

> Continued efforts must be made on both sides to establish and maintain a true continuum of services available to First Nations. Once established, service corridors and the linking mechanisms that surround them remain very vulnerable to changes in the structures of the Quebec network. (FNQLHSSC, 2014, p. 3)

Although Quebec recognizes its responsibility to continuously provide a complementarity of services in conjunction with non-treaty communities, the First Nations communities have noted factors that limit access to health and social services in the Quebec network, namely the lack of awareness of the services and their complex organization. The barriers

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between Quebec's services and the communities, resulting from a lack of cooperation and a lack of awareness of the cultural differences, reduce the chance of establishing an effective continuum of services for each community. The marginalization of First Nations health issues and the questioning of local health care organizations also restrict collaboration between Indigenous bodies and the Quebec network. This often makes it difficult for the First Nations to develop clinical or organizational projects with the institutions in the Quebec network.

The First Nations' vision

To achieve the vision of a continuum of health care based on a holistic approach, the First Nations presented various governmental authorities with three major recommendations. The key factors needed to improve the continuum of care are:

1. **appropriate funding** based on population growth, health needs and real cost indicators as well as effective measures to manage and compile the expenses;
2. **flexibility** to develop a continuing care program, based on the various needs of First Nations communities, that better integrates culturally adapted care and services; and
3. more efficient and effective **coordination** of First Nations health programs and services that fosters greater participation of the First Nations in developing policies, programs and services that affect them.

Developing a framework policy for continuing care is the preferred method of promoting the establishment of an effective, efficient, sustainable, responsible and culturally adapted system in which a continuum of care can function.

To do this, we must decide, specify and clearly word the health service responsibilities of all parties—the First Nations, the federal government and the provincial government—to eliminate jurisdictional obstacles and explore new arrangements that support an equitable health care system and encourage the First Nations to take control.

Recommendations

The findings from a review of the current literature and consultations have led to recommendations for avenues to develop a framework policy covering continuing care for First Nations elders. Most of the recommendations noted below have already been

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mentioned by the Assembly of First Nations, the Assembly of First Nations Quebec-Labrador and the FNQLHSSC, and have been raised in program assessments done by INAC and Health Canada or by researchers. Many, however, were never implemented.

A framework policy on continuing care for elders in First Nations communities should be in line with the following recommendations:

1. Ensure that Quebec First Nations have control over continuing care in their communities.

2. Encourage the integration, coordination and constancy of services to elders and their families by enabling Quebec's First Nations communities to develop their own action plan for continuing care based on public consultations or other means to hear the target clients' needs and required services firsthand.

3. Improve the coordination and the efficiency of intergovernmental collaboration and partnership by creating a tripartite coordination structure for the project.

4. Address the problems of authority and jurisdiction (federal, provincial) that keep the First Nations communities of Quebec from accessing comparable services available to other Quebec citizens and that impede the integration and continuum of care and services.

5. Ensure the First Nations' active participation in developing programs and policies for continuing care and related issues, including basic and advanced training for workers in an Indigenous environment, caregiver training and support, respite services and attendant services. This participation would allow cultural elements, traditions and the related adapted approaches, as well as the specific needs of the First Nations communities of Quebec, to be taken into consideration.

6. To improve service efficiency, encourage a high degree of coordination between the funders so there is only one overall budget for continuing care services in Quebec's First Nations communities.

7. Create new financial transfers based on a stable allocation of funds that accounts for demographic growth, inflation, an aging population, elders' needs, the overall health of the First Nations, the spirit and intention of the treaties and the principles in the *United*

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Nations Declaration on the Rights of Indigenous Peoples. Fair, sustainable funding is needed to build genuine institutional and governance power among the First Nations. The funding must also consider the current and future needs of the First Nations communities.

Given the current per-person funding and the great disparity in needs, resource allocation must be adapted to the needs of each community and must take into account the situations in small communities and isolated communities in order to ensure fairness to all.

8. Review the funding of services that are not available in the communities, especially those in mental health, palliative care and for the disabled.

9. Encourage INAC and the Canada Mortgage and Housing Corporation to develop other special incentives to create a elders' housing initiative fund that offers more options and support to First Nations communities, such as:

    - Grants for minor home adaptations for elders
    - Grants for major renovations and adaptations in elders' housing
    - Mortgage and grants incentives for communities to build apartments for low-income elder apartments (housing that includes elder-specific adaptations)
    - A program to build and maintain elders' residences (for independent, semi-independent or long-term care clients)

10. Review the current federal housing programs, such as the Residential Rehabilitation Assistance Program or the Home Adaptations for Elders Independence Program, to develop eligibility criteria that are better suited to the elders in First Nations communities. Housing must be made adaptable, appropriate, affordable and safe for Indigenous elders, now and in the future, who want to stay in their homes as long as possible.

11. Develop local continuing care strategies to ensure that family members take part in the support and services for elders.

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12. Allow the elders who so wish to stay in their homes as long as possible and to make sure their safety will not be compromised. Given the importance of family and the role of elders in the communities and to respect the holistic approach of indigenous health, the services and resources must allow clients to stay in their communities, receiving care and services there and participating fully until they die.

13. Support Indigenous elders, families and caregivers by providing defined services that the public is informed about.

14. Create favourable conditions (support, recognition and guidance) and appropriate funding for family members who act as caregivers to those needing continuing care.

15. Consolidate the current network of elders' residences in Indigenous communities. This would require a basic funding source and complementary budgets enabling salaries on par with those given by the province, introductory and advanced training for staff and specific budgets for infrastructure maintenance, equipment and medical supplies.

16. Define the status of elders' residences in communities and ensure funding equal to that of the province based on the institution's status.

17. Introduce diverse residential and housing initiatives in Indigenous communities to meet the growing needs of elders in Quebec's First Nations communities, including intermediary resources, assisted housing, residential and long-term care centres (CHSLD), day centres or group homes for adults with physical or mental problems. Some communities may consider creating centres with mixed clientele and shared common rooms.

    As the First Nations want to see a continuum of services in their communities, levels of care 1, 2, 3, 4 and 5 should all be available and accessible. If these resources cannot be made available in all the First Nations communities, creating regional centres for certain Indigenous communities or centres for both Indigenous and non-Indigenous should be considered.

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18. Establish partnerships with the provincial government (via agreements) to fund spaces in residences located in a community for Indigenous elders living outside the community.

19. Ensure that palliative care and end-of-life care are provided in the First Nations communities in Quebec. These services should be recognized as essential elements in continuing care.

    Palliative and end-of-life care should be covered by federal programs for home care, community-based elders' residences or specialized palliative care units.

20. Increase the offering of home-support services and home-care services to better meet elders' needs (notably, for those who are moderately to severely incapacitated and mainly for elders aged 75 and up) to prevent them from having to move to specialized housing, or to delay this move.

21. Improve access to second-line services (geriatrics, psychogeriatry, intensive functional rehabilitation) and to ensure their complementarity and continuity with home-care and external services.

22. Design a regional indigenous strategy on abuse. This strategy should set out various tools to inform the public of the situation of First Nations elders and the importance of adopting appropriate behaviour towards Indigenous elders. It should be in line with Quebec's strategy, which publicizes the signs and symptoms of elder abuse through diverse media. Appropriate funding from the federal government is required to develop and implement this type of strategy. Individual communities could also develop their own local strategy on elder abuse.

23. Start a First Nations elders' rights program that would make it possible to secure funding for resources and training as well as for creating elders' rights bodies that would counsel and support Indigenous elders, defend their interests and foster the transmission of their culture and traditions.

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24. Facilitate access of First Nations elders to existing discussion groups offered on provincial, regional and local levels, so they can contribute to creating actions in line with their needs, circumstances and cultural specifics in the services offered by the province.

25. Encourage the participation of traditional healers in support services and community activities for elders.

26. Given the complex care elders require and their changing needs, access to ongoing training is vital for building employee expertise.

27. Regarding providing continuing care services, we must:
    - take a client-centred approach
    - support integrated information systems
    - endorse a single-entry or a single-coordination system
    - produce a standardized assessment of needs and the care to be provided (multi-client assessment tool)
    - promote a single-client categorization system
    - promote an ongoing case-management system
    - ensure patient and family participation

28. Support telemedicine and videoconferencing to reduce the need for medical transport and help keep Indigenous elders in their home environments.

<u>The following recommendations were developed with Bill 10 in mind.</u>

29. The provincial minister of health and social services must commit to increasing language protection measures for First Nations, so they can access services similar to those received by the Quebec population in each social and health region.

30. The minister must commit to transferring to the CISSS (Quebec's integrated health and social services centres) all the liaison agent positions for First Nations communities that are now in health and social services agencies with the same resources and powers.

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31. Add an article to the general interpretation provisions of the bill to ensure that the organization of services in the regional service network and the agreements made with the First Nations respect their cultural, linguistic and geographic specificity and favour the exercising of their right to independence.

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Appendix 1 – Summary Report

Abridged profile of the residential care institutions in the First Nations communities of Quebec

Categories	Compilation of responses
Total number of elder residences	7
Year of construction	First residence built in 1989. The others opened in the 1990s.
Number of beds	One elder residence has 24 rooms (27 beds), a second has 22 rooms (25 beds) and a third has 20 rooms (20 beds). The other residences have between 8 and 12 rooms (14 beds). **Total number of beds: 117.**
Occupation rate	In all, 5 residences have over 97% occupation, one has about 58% and another has 50%. Some residences have a waiting list for rooms/beds.
Average age of residents	Most residents are **75 years old or older**.
Financing	INAC Assisted Living Program Five communities have a global funding situation and two have a budget based on a daily allowance and the number of occupied beds. Some residences also have additional budgets for specific needs (additional positions or repairs required following compliance inspections for provincial certification from the ministry of health and social services). **Most residences find the INAC budgets insufficient to run their facility. Three residences have significant deficits that have to be covered mainly by the Band Council.**
Staffing issues	**Hiring and recruitment** - Difficult to hire enough staff to meet the clients' needs. - Employee salaries are not always on par with what the federal or provincial government pays for the same jobs (nurses, auxiliary nurses, aides, etc.).

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	- Difficult to recruit and keep personnel. **Training** - Limited, actually non-existent, training and professional development activities in the residences themselves. - May occasionally attend training programs offered in community health centres (on diabetes, wound care and such) or in the provincial health network (mainly in Health and Social Service Centres [CSSS]). **Replacement personnel** - Difficult to fill spots when staff members are absent for training or other.
Renovations and repairs	The residences are not given an infrastructure budget and must use their operations budget to cover such expenses. They sometimes take from the band council's capital budget for major repairs. **As most residences were built in the 1990s, repairs are now necessary: roof, windows, exterior siding, floors and renovations required by current standards to receive provincial certification for elders' residences.**
Residence management	Overall, the residences are independent (management, services and activities), but they are still connected to local health and social services or the band council. For some residences, the health services and social service organizations manage their administration, finances and human resources.
Services	- Continuous service: 24 hours a day, 7 days a week - **Nursing care** is usually available on site. However, if residents need emergency nursing or medical care when the services are not available in the residence (evenings, nights or weekends), they have to be seen in health centres, CSSSs or neighbouring hospitals. - **Doctors** occasionally see residents (in three of the residences), but usually residents must go to the doctor's office. - Local **pharmacies** prepare the medications and the residences distribute them. The pharmacist is usually in communication with the residence's nursing staff and the doctor associated with the residence or a particular patient. - **For palliative care**, the situation varies greatly. Some communities have this type of care, others don't, and others

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	offer it in a limited capacity. For those that do not have it, palliative care is provided outside the community (in hospitals or in a CHSLD). For some communities that provide this care, CLSCs (local community service centres) might provide assistance when needed. - **Related services**: Cafeteria, laundry and concierge services, bathing assistance, help with daily activities, rooms for activities and family visits (except in one centre).
Health and social services provided by the community	- Psychosocial services are usually provided to residents through the community's health and social services program. - Foot care is typically offered in residences by a specialized nurse or a certified auxiliary nurse, or at the community health centre. - Medical transportation is usually handled by the community health centre.
Equipment	All the residences have mobility and transfer aids (wheelchairs, walkers, hospital or electric beds and hoists), a call system and an alarm system for emergencies. However, not many residences have therapeutic baths, a central bath and individual showers for disabled people. Some residences don't have an oxygen system, a water temperature control system for shower and bath water, draw sheets or a Smart pad system (a call system for confused patients at risk of falling). **Residence managers are not pleased that certain Health Canada programs and services (mainly home care and community-based care, medical and specialized supplies and medical equipment) are not available in elders' residences in Indigenous communities.**
Permits and certification	Two residences do not have an operating permit from the Quebec ministry of health and social services or provincial certification. The federal government asks communities to respect the provincial authority over health and social services, so elders' residences in Indigenous communities must at least have a certificate of compliance. However, since the status of community-based residences is undetermined, the type of certification to obtain is also undetermined.
Insurance	All the residences have liability insurance.
Issues regarding	All community-based elders' residences find the **care levels covered by INAC (1 and 2)** to be insufficient. They would like to have funding

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authorized level of care	for at least 3.5 hours of service per day (as opposed to the 2.5 hours that are provided now). Some services, such as mental health care, palliative care and respite, are not available at all. Several elders have to be transferred to residences outside the community because those in the community do not have the financial resources or enough beds to house and provide services to people undergoing major loss of autonomy.
Security	All the residences have an evacuation plan in case of fire and drills are practiced throughout the year. They have an alarm system, limited entry access during the evening and night, and emergency exits. Aides provide 24-hour surveillance of the residents throughout the year. Some residences have security cameras in all the common rooms.

General client satisfaction

The residents who answered the questionnaire were also asked to assess their satisfaction. According to their answers, they are mostly very satisfied. They sincerely appreciate that their residence is located in their community and that their families can participate in the activities at the residence. In general, the residences are seen as a setting on a human scale, where listening and communication are important and the client's specific needs are taken into consideration. The residents also feel safe.

The main aspects to improve in some residences include foot care (availability and frequency), meal services, lifestyle activities (mainly on the weekends), outdoor equipment (swings, tables, etc.), safety (outdoor lighting, coded door locks, use of a rounds record) and sharing community news with the residents. Overall, the residents are satisfied with the cleanliness of the buildings since most respondents said they liked their room and how it was cleaned. However, some rooms should be remodelled to accommodate wheelchairs.

Regarding the residents' degree of satisfaction with the staff, it should be noted that the clients feel they have the chance to share their opinions about the personnel and that

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they feel respected. They become quickly attached to staff members, and vice versa. They often cited the staff's professionalism, manners, kindness and devotion.

Specific situation for Anglophone communities

Language barriers sometimes force Anglophone elders to go large cities or outside the province to find the services they need. For English residences, communication with the provincial health and social services network may be difficult because the employees don't speak French. It should be noted that mental health services in English are difficult to access outside the communities.

General comments

Currently, there are a very few residences operating in the First Nations of Quebec (seven), and they are only funded for care levels 1 and 2. According to the representatives in this project's partner communities, the residences are under enormous pressure from their communities and from elders to provide higher levels of care (3, 4 and 5). The residents in the elders' homes do not understand and especially do not accept that they have to leave an institution in their community and go live outside the community when their health deteriorates. They want to receive the necessary services in their own community, so they can die in a familiar setting, in the company of their family and friends.

There is also a discrepancy in the funding of residences located in Indigenous communities. Two communities that are not yet in charge of their own social services receive daily funding (daily rate per occupied bed) based on an old funding formula (not annually adjusted). The five other communities that have a elders' residence receive global funding for the Assisted Living Program. This type of funding is indexed every year by about two percent, and there is some budgetary flexibility with the services included in the Assisted Living Program. Note that the INAC program and Health Canada programs do not have specific budgets for construction, renovation, maintenance or material and equipment purchases that are needed for patient care. Band councils must take money from their capital budgets if they want to invest in the residences (construction and maintenance), which has a major impact on all the other local public infrastructure.

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All the directors of community-based elders' residences find that the current INAC budget for their residence is not enough to cover all the needs of the elders living there and all the other operation fees (employee salaries, training and professional development, equipment purchases, building construction and maintenance).

Complementary housing resources may be a solution to meet the demand for elders' housing. The types of housing needs that are mentioned most often are supervised apartments, apartments with support for elders and adults with reduced autonomy, day centres, palliative care units and residential and long-term care centres.

Appendix 2 – Summary Report

AFNQL resolution

Assemblée des Premières Nations Québec–Labrador

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Assembly of First Nations Quebec-Labrador

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RESOLUTION NO. 11/2015

POLICY FRAMEWORK ON CONTINUING CARE OFFERED IN THE FIRST NATIONS COMMUNITIES OF QUEBEC

WHEREAS the community of Timiskaming obtained financing under the Health Services Integration Fund (HSIF) and has been working, since June 2012, on the development of a policy framework on continuing care of elders in the First Nations communities of Quebec;

WHEREAS among other things, the mission of the FNQLHSSC is to improve access to comprehensive and culturally-sensitive health and social services programs designed by First Nations organizations and sanctioned by local authorities, all the while respecting their respective cultures and local autonomy;

WHEREAS the community of Timiskaming wishes to entrust to the FNQLHSSC the mandate to continue efforts and activities to develop said policy;

WHEREAS the policy framework project was developed on the basis of a collaborative process between the communities of Timiskaming, Kitigan Zibi, Kanesatake, Kahnawake, Mashteuiatsh and Wendake;

WHEREAS the Assembly of Chiefs has taken note of the approach proposed by the community of Timiskaming and the FNQLHSSC,

BE IT RESOLVED THAT the Chiefs in Assembly support the continuation of activities related to this project and agree that the mandate be entrusted to the FNQLHSSC until March 31, 2016 and, that the results be presented to the Chiefs before this date, during the winter of 2016, for the purpose of defining future directions.

PROPOSED BY: Chief Claude Jeannotte, Gespeg
SECONDED BY: Grand Chief Serge Simon, Kanesatake
ADOPTED BY CONSENSUS ON JUNE 9, 2015 IN THE INNU COMMUNITY OF ESSIPIT

Ghislain Picard
Chief of the AFNQL

LE GRAND CERCLE DE NOS PREMIÈRES NATIONS – THE GREAT CIRCLE OF OUR FIRST NATIONS

FIRST NATIONS OF QUEBEC
AND LABRADOR HEALTH
AND SOCIAL SERVICES
COMMISSION

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Ministère de la Santé et des Services sociaux (2007). Delivery and funding of health services and social services for aboriginal people (First Nations and Inuit), Bibliothèque et Archives nationales du Québec. Consulted at http://publications.msss.gouv.qc.ca/msss/fichiers/2007/07-725-02A.pdf

APPENDIX B

DEFINITION OF CLIENTS WITH DECREASING INDEPENDENCE

SENIORS/ELDERS

People aged 55 years and over whose physical or cognitive impairments are related to aging (such as elderly people with diabetes, cardiovascular problems or dementia).

ADULTS WITH MENTAL HEALTH PROBLEMS

People 18 years of age and older whose mental, physical, spiritual and emotional balance has been altered by mental health and substance abuse issues.[22]

ADULTS WITH CHRONIC DISEASE

People 18 years of age and older whose physical faculties are significantly impaired by a disease or chronic health problem (such as diabetes, cancer, cardiovascular and respiratory diseases, musculoskeletal conditions, etc.).

ADULTS WITH IMPAIRMENTS

People 18 years of age and older with a significant and persistent physical or intellectual impairment or an autism spectrum disorder (ASD). Regarding physical impairment, there are four types of impairment, namely motor impairment, visual impairment, hearing impairment and impairment related to language and speech. Intellectual disability is characterized by significant limitations in intellectual functioning and adaptive behaviour, which manifest in conceptual, social and practical skills. ASD is a neurodevelopmental disorder that significantly interferes with social interactions and verbal and non-verbal communication. Finally, people with impairments may see their level of autonomy affected by their impairments and, therefore, be limited in terms of their ability to perform routine activities or play a social role.

[22] INDIGENOUS SERVICES CANADA (2015). *First Nations Mental Wellness Continuum Framework – Summary Report.*

APPENDIX C

SUMMARY TABLE OF COMMITMENTS

PRIORITY FOCUS AREA OF THE FNQLHSSC'S 2021-2024 STRATEGIC PLAN

Governance and self-determination

PRINCIPLES	ISSUES
The First Nations in Quebec and Labrador have the right to self-government and self-determination	
Accountability and an understanding of the roles and responsibilities of each partner are prerequisites for establishing continuing care.	Accountability, role and responsibilities
Partners must adhere to the goals, objectives, principles, themes, commitments and processes of the Framework Policy on Continuing Care.	Information sharing
An approach focused on health, wellness, well-treatment, benevolence, development, security and the rights of people with decreasing independence must be favoured.	Access to quality care and services
Capacity development must be done at all levels while respecting the cultural realities of the First Nations.	Skills development and strengthening
The provision of continuous, integrated and culturally appropriate services must meet the needs of First Nations.	Equitable and culturally appropriate services

ENGAGEMENTS

1. Strengthen communication, collaboration and partnerships between local First Nations governments, the Government of Quebec, and the Federal Government I.
2. Support harmonized and complementary federal, provincial and local programs.
3. Define the administrative logistics for developing the continuum of care.
4. Promote effective and reciprocal accountability.

5. Facilitate information exchange between facilities in the Quebec health and social services network (RSSS) and in First Nations communities and organizations.
6. Foster concerted efforts between stakeholders involved in individual's process.

7. Support the development of long-term collaboration and service agreements between the RSSS and First Nations.
8. Ensure health and social services are equitable.
9. Support the culturally appropriate palliative and end-of-life care that is required in First Nations communities and organizations.
10. Recognize, assist and support caregivers.
11. Increase the number of housing resources for all care levels.
12. Promote and support the use of telehealth to help people with decreasing independence remain in their living environment.

13. Support capacity-building and development for staff working in First Nations communities and organizations as well as caregivers.

14. Improve cultural competencies and knowledge among RSSS professionals and caseworkers.
15. Support the integration of cultural practices in the services offered in First Nations communities and organizations and in RSSS facilities.
16. Promote access to services in English and First Nations languages.

APPENDIX D

DESCRIPTION OF HEALTH AND SOCIAL SERVICES

ORGANIZATION OF SERVICES IN FIRST NATIONS COMMUNITIES

The community health centres mainly offer, depending on the funding granted, preventive community health services subject to the program guidelines of Indigenous Services Canada (ISC). Funding for home care services offered in the communities comes mainly from two ISC programs: the First Nations and Inuit Home and Community Care Program (FNIHCCP) and the Assisted Living Program (ALP).

Medical services (provided by physicians) can be offered in communities and are covered by the Health Insurance Act. In this situation, the frequency and duration of medical visits vary depending on the availability of resources. Few communities have a full-time physician.

Other services can be offered by professionals (dentists, ophthalmologists, psychologists, nutritionists, etc.) who travel to communities on an ad hoc and cyclical basis. They are then remunerated by existing federal government programs (e.g., Non-Insured Health Benefits) or according to agreements with local community health authorities. Note that, given the often-insufficient resources of the communities in terms of health and social services to meet all the needs, they must prioritize the services that will be offered to the detriment of the services of other professionals from which the population could benefit.

ACCESS TO SERVICES OFFERED BY QUEBEC'S HEALTH AND SOCIAL SERVICES NETWORK (RSSS)

First Nations individuals who go to RSSS establishments are entitled to access services, on the same basis as all Quebecers, be it for primary care services or for specialized services. These services are then covered under the Health Insurance Act and the Hospital Insurance Act, regardless of the user's place of residence.[23]

The RSSS does not fund health care or social services within the territories of non-agreement communities, with the exception of care provided by a physician which is covered by the Régie de l'assurance maladie du Québec.

In addition, the services provided by Quebec can be offered in non-agreement First Nations communities if a specific agreement between Quebec and local authorities (band council), or even with the federal government, is signed. These agreements must be validated and ratified at all times by the CISSS, the CIUSSS or the establishment that is not merged or not covered by the Act, as well as the Ministère de la Santé et des Services sociaux (MSSS), to ensure respect for shared responsibilities.

[23] MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2007). *Delivery and funding of health services and social services for aboriginal people.*

FUNDING OF HEALTH AND SOCIAL SERVICES FOR PERSONS WITH DECREASING INDEPENDENCE

The First Nations and Inuit Home and Community Care Program (FNIHCCP) provides funding for needs assessments and, depending on these assessments, certain services may be funded such as nursing, personal care, palliative care, case management, home respite and equipment loan.[24]

The Assisted Living Program (ALP) aims to ensure that eligible low-income individuals maintain their independence for as long as possible in their communities by providing them with non-medical social support services through funding for adult placement and home management. This program also provides funding for the fourteen care facilities for adults with decreasing independence requiring less than two-and-a-half hours of care per day (stable Iso-SMAF profile of less than 9).[25] The majority of communities are responsible for managing these two programs within the boundaries of ISC directives. Each of the programs is complementary and offers specific and distinct services.

Tables 1 and 2 present the services of the federal programs[26] for First Nations adults with decreasing independence and those of the health and social services network (RSSS) for adults with decreasing independence according to their needs, abilities and place of residence.

[24] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2013). *Portrait – Assessing continuing care requirements in First Nations and Inuit communities.* Wendake.

[25] Ibid.

[26] FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION (2006). *Assessing continuing care requirements in First Nations and Inuit communities.* Wendake.

TABLE 1

Programs funded by ISC for First Nations adults with decreasing independence

FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE PROGRAM (FNIHCCP)

Professional care and services

- Nursing care
- Hygiene care
- Palliative care
- Nutrition, rehabilitation and respiratory therapy services and adult day programs are complementary services and depend on the service delivery plan of each community

Home support services

- Personal care services
- Home management services
- Home respite services

Traditional care and services recognized by the band council, tribal council or health professional (excluding transportation)

Medical supplies[27] and loan of equipment and technical aids

ASSISTED LIVING PROGRAM (ALP)

Home care

- Meal programs and meal planning and preparation
- Day programs
- Ancillary services
- Short-term respite care
- Group care
- Laundry
- Ironing
- Mending
- Water transport
- Cutting and transport of wood
- Household management
- Minor house maintenance tasks
- Non-medical transportation

Placement/accommodation

- Adult foster care (IR, FTR)
- Type 1 and 2 institutional care (Iso-SMAF profile of 1 to 8)

TABLE 2

Services offered by establishments of the health and social services network (RSSS) for clients with decreasing independence

SERVICES FOR PEOPLE WITH DECREASING INDEPENDENCE PROVIDED BY THE RSSS

Home Support Services

Professional care and services:

- Psychosocial services
- Nursing care
- Basic rehabilitation services (occupational therapy, physiotherapy)
- Respiratory therapy
- Nutrition, audiology, speech therapy services
- Medical and pharmaceutical services
- Promotion and prevention activities

Home help services:

- ADL personal assistance
- ADL home help
- Civic support activities
- Learning assistance
- Support for family tasks
- Activities for social integration or to counter social isolation

Rehabilitation services for people with impairments (physical, intellectual or autism spectrum disorder)

Residential care services

- IR or FTR (Iso-SMAF profile of 4 to 9)
- CHSLD (Iso-SMAF profile of 10 to 14)
- Rehabilitation centre

[27] Until the required equipment is obtained through the Non-Insured Health Benefits (NIHB) Program.

TABLE 3

Types of resources

Family-type resource – Foster care **Intermediate resource – Foster home (max. 9 residents)**				
In/outside the community	Permit / certificate / accreditation	Iso-SMAF profile	Federal classification	Hours of care/day
Outside the community	CISSS/CIUSSS Family-type resource - Foster home agreement	9 or less	Type of care I	1.5 or less
Clientele				
Elders with decreasing independence, adults with intellectual or physical limitations, persons with mental health issues, etc.				
Type of staff on the premises				
Resource manager and his/her employees Professional care and services provided by Home care teams				
Services on the premises				
Lodging, meals, AVD (home support assistance) and personal assistance services Home care professionals are not on the premises fulltime but go there to provide the service				

First Nations adult foster care				
In/outside the community	Permit / certificate / accreditation	Iso-SMAF profile	Federal classification	Hours of care/day
In the community	Agreement with the health centre or First Nations organization	1 to 8-9	Types of care I to II	2.5 or less
Clientele				
Adults with decreasing independence related to intellectual or physical limitations, chronic illness, mental health issues, concurrent chronic illnesses and geriatric conditions; and elders				
Type of staff on the premises				
Resource manager Professional care and services provided by the health centre's teams				
Services on the premises				
Lodging, meals. AVD (home support assistance) and personal assistance services The health centre's professionals are not on the premises fulltime, but go there to provide the service				

Intermediate resource

- **Group home**
- **Rooming house**
- **Supervised apartment**
- **Other (specific needs)**

In/outside the community	Permit / certificate / accreditation	Iso-SMAF profile	Federal classification	Hours of care/day
Outside the community	Specific agreement with the CISSS/ CIUSSS	Between 6 and 12 and exceptionally 13 to 14.	Types of care I to III	1 to 3

Clientele

Elders with decreasing independence, adults with intellectual or physical limitations, mental health issues, concurrent chronic illnesses and geriatric conditions, etc.

Type of staff on the premises

Resource manager and his/her employees provide support services to residents

Professional care and services provided by home care teams

Services on the premises

Lodging, meals, AVD (home support assistance) and personal assistance services

And AVQ (daily living assistance) (solely for supervised apartment, rooming house and other (specific needs))

Home care professionals are not on the premises fulltime but go there to provide the service

Private seniors' residences (PSR)				
In/outside the community	Permit / certificate / accreditation	Iso-SMAF profile	Federal classification	Hours of care/day
Outside the community	PSR Certification	Independent to semi-independent May house residents with ISO-SMAF profiles of 6 or more	Types of care I to III	1 to 3

Clientele

Mostly individuals aged 65 or older.

Persons living in an PSR can be very independent, semi-independent or increasingly dependent (no criteria)

Type of staff on the premises

Category 4 only: nursing assistants, nurse (rare).

Category 3 only: Staff monitor, nursing assistants (rare).

Categories 3 and 4: attendants, PSR operator or manager.

Home care professionals go to the premises only when offering specific services to a resident (following an agreement with a CISSS)

Several residents receive no homecare services.

Services on the premises

Categories 3-4: PSR with basic services and personal assistance services (including the administration of medication)

Category 4: Nursing services are often limited to the administration of medication and invasive care provided by nursing assistants

First Nations care and residential facility for adults with decreasing independence				
In/outside the community	Permit / certificate / accreditation	Iso-SMAF profile	Federal classification	Hours of care/day
In one of the 11 communities having at least one care and residential facility for adults with decreasing independence	PSR certification	8-9 or less	Types of care I and II	2.5 or less
Clientele				
Independent and semi-independent individuals				
Type of staff on the premises				
Resource manager and his/her employees provide support services to residents Nursing assistants Nursing care provided by home and community care often at the health centre				
Services on the premises				
Lodging, meals, AVD (home support assistance) and personal assistance services (including the administration of medication) Home and community care professionals are not on the premises fulltime, but come and offer the service				

Private or public CHSLD Seniors' home and alternative home				
In/outside the community	Permit / certificate / accreditation	Iso-SMAF profile	Federal classification	Hours of care/day
Outside the community (private CHSLD not under agreement in some communities)	CHSLD permit	10 to 14	Type of care III to V	3 or more
Clientele				
Primarily elders experiencing significant decreasing independence and, to a lesser extent, adults with an intellectual or physical limitation				
Type of staff on the premises				
Lodging, meals, AVD (home support assistance) and personal assistance services (AVQ - daily living assistance, help with mobility, communication etc.) 24/7 care and nursing services. Other professional services (nutrition, rehabilitation, psychological, social, leisure activities, etc.).				
Services on the premises				
Nurses, healthcare team, professionals and technicians specializing in rehabilitation, social services, leisure activities and pastoral services, etc. Service assistants and volunteers. During the night, possible presence of a nurse for 100 or 200 residents. Technical services staff (plumbing, bed repairs, etc.) Laundry service staff.				

APPENDIX E

EXISTING MODELS

ALASKA: NUKA SYSTEM OF CARE[28]

Nuka is an Alaskan Indigenous word used for strong, giant structures and living things. Southcentral Foundation's Nuka System of Care is a name given to the whole health care system created, managed and owned by Alaska Indigenous people to achieve physical, mental, emotional and spiritual wellness.

The approach is based on customer relationships and ownership to transform healthcare, improve outcomes and reduce costs.

BASIC PRINCIPLES:

1. CUSTOMER-OWNERSHIP

SCF is a Tribally owned and managed health care system. Customer-Owners truly own the health care system. In addition, customer-owners own their own health and drive their health care decisions, both individually and systemically.

2. CULTURALLY-RESPECTFUL CARE

All SCF employees receive customer experience training, which emphasizes respect for all cultures. This is also a value SCF places at the centre of all organizational decisions.

3. COMPASSIONATE CARE

All SCF employees also attend a training to develop interpersonal skills, including communication, compassion and story-telling tools, to encourage trusting and accountable relationships with customer-owners and co-workers.

4. SAME-DAY ACCESS

Customer-Owners lead busy lives and convenient access to health care should be the least of their worries. SCF strives to provide that access.

5. TEAM-BASED CARE

Customer-Owners are not only designated a primary care provider, but an entire team dedicated to customer-owner wellness. This ensures a convenient experience and access to a panel of experts.

ALBERTA: 7 INNOVATIVE APPROACHES[29]

Alberta Health Services has identified seven innovative approaches to consider when developing continuing care.

- A continuing care facility can include multiple levels of care. For example, there could be supportive and long-term care beds located in the same facility, as well as mental health and addiction beds.
- A residential facility offering continuing care could designate one or two beds for end-of-life care. These rooms can be designed with additional space for family and visitors, including an extra bed and a kitchen.
- Consider the need to create larger family suites or adjoining suites for family members to stay together.

[28] https://www.southcentralfoundation.com/nuka-system-of-care

[29] ALBERTA HEALTH SERVICES (July 18, 2019). *Continuing Care in Indigenous Communities: Guidebook.*

- If adults with impairments (for example, an adult with a brain injury or spinal cord injury) require continuing care, you may consider placing family apartments near the long-term care facility so that adults can receive appropriate health care and services and still live with their families.
- A continuing care facility can also serve as a community hub:
    - The rooms for social activities could also be used by the community for other functions.
    - Having the health centre next to an existing school or community centre allows for interaction between elders and young people in the community.
    - Other community health and support services may be located in the long-term care facility, particularly addiction or mental health treatment services.
    - Accessible bathing facilities could also be used by community members who do not have adequate or accessible bathing facilities in their homes.
- Consider partnering with other communities, such as a nearby town or another First Nation or facility, to share resources and staff for a long-term care facility.
- Consider partnering with an already established continuing care centre that can help you start-up and operate the centre.

ONTARIO: TWO MODELS

1. WIKWEMIKONG[30]

Wikwemikong First Nation, which is located east of Manitoulin Island in Ontario, offers elder care programs, including home and long-term care programs that follow a holistic approach to health based on the medicine wheel and guided by the "Grandfather Teachings". Comprehensive care includes 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.

It should be noted that Wikwemikong First Nation follows a principle according to which it will honour the wishes of elders by letting them stay at 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 seniors and people with decreasing independence to remain in their community even when their care needs involve institutionalization.

The main features of Wikwemikong's elder care programs are as follows:

- Most of the home care providers and workers of the long-term care facilities speak the language (communication and information sharing with seniors is therefore optimal);
- In-home meal services and meals in long-term care facilities have incorporated traditional foods into the meal plan;
- The family participates in the provision of care and social activities;
- The programs offer social activities which often include young people;
- The health centre provides transportation for seniors and people with decreasing independence to see traditional healers locally or outside the city;
- Local physicians and health care providers are knowledgeable about traditional medicine;
- The health centre has a traditional medicine pavilion which offers ceremonies as needed.

The Wikwemikong long-term care facility accommodates both Indigenous and non-Indigenous people. It is a 60-bed facility staffed primarily by members of the local community who speak the language. Priority is given to First Nations customers. The facility is located next to the health centre.

[30] CORBIERE AND PITAWANAKWAT, *Creating a Culturally Appropriate and Integrated Model of Care for Aboriginal/First Nation/ Métis Seniors*, presentation at the Seniors' Health Summit, March 18-19, 2008.

2. KIRKLAND LAKE[31]

The Kirkland Lake Aboriginal Elders Program, which serves the Kirkland Lake region of Ontario, offers social activities to seniors (aged 55 years and over) in home care or long-term care facilities. The program, which is offered two days a week, organizes transportation and social activities and offers a healthy snack or breakfast. On one day, the program provides tea and bannock and facilitates an activity. On the other day, the program offers breakfast and organizes a conference or outing. The program also celebrates birthdays and community traditions. One of the main goals of the program is to reduce social isolation among the elderly. For those living in long-term care outside the community, the program provides an opportunity to interact with community members, speak their traditional language, and participate in community traditions and celebrations. The program has fifteen regular clients, including two in long-term care facilities. The program is funded by Health Canada through the Aboriginal Peoples Alliance (Northern Ontario).

MANITOBA: A PARTNERSHIP MODEL FOR AN INDIGENOUS PERSONAL CARE HOME[32]

A partnership between the Winnipeg Regional Health Authority and the Southeast Resource Development Council has resulted in the creation of a one-of-a-kind facility in Winnipeg. The Southeast Personal Care Home is designed to meet the long-term needs of First Nations, Métis and Inuit seniors. This facility provides Indigenous seniors with a welcoming and culturally appropriate home.

This 80-bed facility is owned and operated by First Nations and ensures respect for holistic values and cultural traditions. The Winnipeg Regional Health Authority's long-term care program manages the health services provided at the facility. This facility honours the uniqueness and traditions of the First Nations, Métis and Inuit people who reside there, while providing them with the long-term health services they need.

The 52,000 square foot facility consists of four units, each with a multi-purpose area including a dining room, living room, recreation area and kitchen area. Each unit consists of 20 private rooms.

The new nursing home is located on land adjacent to Southeast Collegiate, a school for First Nations youth. This provides significant opportunities for intergenerational interaction and activities that reflect the diverse cultures and heritage of both residents and students.

The new personal care home also includes many green design elements that emphasize the importance of the environment in Indigenous cultures while reducing energy costs over the life span of the building.

BRITISH COLUMBIA

INVESTMENT IN NURSING[33]

Interior Health (IH) and the First Nations Health Authority (FNHA) have invested $3 million to bring senior care closer to their homes. IH will provide $2 million on an annual basis for improved nursing care to support First Nations seniors and those living with chronic conditions. The FNHA will provide $1 million to support communities in their organization efforts. Together, this joint investment will benefit approximately 4,450 seniors from seven nations (Dākelh Dené, Ktunaxa, Nlaka'pamux, Secwepemc, St'át'imc, Syilx and Tsilhqot'in). Interior Health has shown leadership in allowing the seven nations to come together and define how best to meet the needs of their communities, following a decision-making process that works for them.

[31] GROSSINGER, DARLENE (2010). Personal Communication. Program director, Kirkland Lake Aboriginal Elders Program.

[32] WINNIPEG REGIONAL HEALTH AUTHORITY AND THE GOVERNMENT OF MANITOBA. *Aboriginal Personal Care Home opens in Southeast Winnipeg: Partnership between Winnipeg Health Region and Southeast Resource Development Council results in unique one-of-a-kind facility in Winnipeg.* News Release, June 21, 2011.

The decision to invest was motivated by data from the FNHA – Interior Health Authority Expenditure Project. Analysis of this data showed that, compared to other residents in 2013-2014, First Nations seniors were less likely to see physicians, but had higher prevalence rates for many chronic conditions. Thus, First Nations seniors were more likely to go to the emergency room. These and other findings suggest that key early intervention points in a person's care journey may be missed due to inaccessible or unavailable primary health care services. The funds are intended to ensure that care is provided where First Nations seniors live, so that they can be partners in their own care, with their families and an interdisciplinary care team.

3 TYPES OF AFFORDABLE HOUSING FOR SENIORS[34]

Low-income seniors who are able to live independently without support, or with the assistance of home care, may apply to live in affordable housing.

There are three types of affordable housing in British Columbia:

- Social housing – managed by BC Housing;
- Non-profit housing – managed by non-profit corporations;
- Housing cooperative – managed by the residents.

IN QUEBEC… A FEW EXAMPLES

ANISHNABE LONG TERM CARE CENTRE

The Anishnabe Long Term Care Centre in Timiskaming First Nation has 27 beds, including two beds for respite care. It also serves the communities of Kebaowek and Winneway. In addition, 20 beds are funded by the provincial government to serve First Nations members outside the community as well as non-Indigenous people. It offers services to its residents related to bedding maintenance, housekeeping, a medical clinic (on site), clothing maintenance, meals, food assistance, nursing care, assistance with bathing, assistance with dressing, invasive care, assistance with daily living, hygiene care, administration of medicines and distribution of medicines.

WENDAKE

The Résidence Marcel-Sioui (RMS) is a residential care facility reserved for people with decreasing independence. The RMS has 12 individual rooms and offers services such as nursing care, personal hygiene care, weekly medical follow-up, medication management, foot care, psychosocial and nutritional consultations, entertainment and recreational activities, meal and snack services, laundry and housekeeping services, and end-of-life care.

In 2018, the Government of Quebec announced, on June 18, the granting of $6.8 million in funding to the Conseil de la Nation huronne-wendat (CNHW) to finance the construction of a 24-bed CHSLD for members of the community of Wendake.

[33] FIRST NATIONS HEALTH AUTHORITY. *$3 million Dollar Joint Investment Brings Enhanced Elder Care to Interior Nations. Elder care in the seven First Nations of the Interior to be delivered closer to home.* News. Nov 8, 2017.

[34] SENIORS BC AND FIRST NATIONS HEALTH AUTHORITY, *Elder's Guide*, 2014.

MASHTEUIATSH

The Centre Tshishemishk is a 20-room residential care facility that provides supervision, assistance with daily living and nursing services, including medication management, to the Pekuakamiulnuatsh. To do this, the Centre offers a full range of meal, laundry and concierge services as well as recreational activities. Its staff is made up of nurses, nursing assistants, patient attendants and support staff.

UASHAT MAK MANI-UTENAM

In 2015, a regional residential facility for people with Huntington's disease (HD) was established in Uashat. This facility provides various services to a clientele with multiple issues as well as their family members. Currently, the majority of people affected by the disease remain in Uashat mak Mani-Utenam, but it is spreading and affecting neighbouring communities: Pessamit, Matimekush, Kawawachikamach, Unamen Shipu, Nutashkuan and Ekuanitshit.

Current services to date:

- Client follow-up agreement with a neurologist specializing in HD (regular visits to the community) and coordination of meetings
- Service agreement with geneticists (community visits and/or videoconferences with clients as needed) and coordination of meetings
- Service protocol with the CSSS de Sept-Îles (written agreement in progress): this component includes the psychiatric component, the agreement for occupational therapy, the emergency protocol, etc.
- Home care services
- Individual and family psychosocial care
- Family support
- Psychological care (clients, caregivers)
- Various assessments (MCAT, home, dysphagia, mobility)
- Support for medical / pharmacological procedures
- Services of a nutritionist
- Services of a kinesiologist
- Coordination / preparation / support for the research project (specialists go to Mani-Utenam for the ENROLL research)
- Drug distribution
- Transportation, assistance, various support services

Vision

First Nations individuals, families and communities are healthy, have equitable access to quality care and services, and are self-determining and culturally empowered.

Mission

To accompany Quebec First Nations in achieving their health, wellness, culture and self-determination goals.

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

CSSSPNQL • FNQLHSSC