Submission to Standing Committee on Indigenous and Northern Affairs on the Study of Long-Term Care on Reserve

June 2018

Introduction: First Nations Health Authority and Our Work

The First Nations Health Authority (FNHA) is the first province-wide health authority in Canada focused on First Nations. On October 13, 2011, First Nations in BC, the Province of British Columbia, and the Government of Canada signed the *British Columbia Tripartite Framework Agreement on First Nations Health Governance*[1] (Tripartite Agreement).

FNHA is responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC. FNHA works to transform the way health care is delivered to First Nations through direct services, provincial partnership and collaboration, and health systems innovation, including ensuring that cultural safety and humility and intergenerational trauma informed care are embedded throughout the health system.

FNHA collaborates with the federal and provincial governments, regional Health Authorities and other system partners to coordinate and integrate health programs and services to achieve better health outcomes for First Nations in BC. Services are largely focused on health promotion and disease prevention and include:

- Primary Health Care
- Children, Youth and Maternal Health
- Mental Health and Wellness
- Communicable Disease Control
- Environmental Health and Research
- First Nations Health Benefits (Non-Insured Health Benefits)
- eHealth and Telehealth
- Health and Wellness Planning
- Health Infrastructure and Human Resources

FNHA is guided by its Seven Directives[2] and Shared Values[3] and is committed to creating the space for First Nations and Indigenous communities to self-determine their path towards wellness and Nation rebuilding.

Key Areas of Consideration

The scope of the study the committee is undertaking is restricted to the population in First Nations communities (on reserve); however due to the nature of the Tripartite Agreement, the *Health Partnership Accord*[4], and the creation of FNHA, this has created a unique setting in BC where our mandate includes responsibility to represent **all** First Nations people, regardless of where they live in the province. It is from this perspective that our submission is framed.

In accordance with the *British Columbia Tripartite Framework Agreement on First Nations Health Governance,* it is our strong expectation that the federal government will continuously partner with FNHA in all processes and decisions that impact the health and wellness of First Nations in BC.

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[1] https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/health-care-services/british-columbia-tripartite-framework-agreement-first-nation-health-governance.html
[2] http://www.fnha.ca/about/fnha-overview/directives
[3] http://www.fnha.ca/about/fnha-overview/vision-mission-and-values
[4] http://www.fnhc.ca/pdf/Tripartite_Health_Partnership_Accord-_December17.2012_.pdf

An integral focus of First Nations healing and wellness is the balance and inter-relationships of physical, mental, emotional and spiritual aspects of wellbeing as represented by the *First Nations Perspective on Health and Wellness*[5]*.* In line with the Perspective, there are a number of key issues for the Committee to consider in its study of long term care that as it relates to quality and access for First Nations in BC.

FNHA has identified several areas that reflect the needs and values of First Nations in BC, including:

Cultural Safety and Humility, and Trauma-Informed Care
First Nations in BC continue to be impacted by the process of colonialism, both at the individual and system level, and experience stigma, racism, and discrimination in their health care interactions. FNHA works with partners from across the health and wellness system in BC to embed Cultural Safety and Humility and Trauma-Informed Care[6] into practice in order to make health care a safer experience for Indigenous people.

Cultural Safety and Humility is an approach to care which acknowledges that "First Nations people have a right to access a health care system that is free of racism and discrimination and to feel safe when accessing health care. This means people are able to voice their perspectives, ask questions, and be respected by health care professionals on their beliefs, behaviours and values. First Nations individuals are entitled to be the main decision-maker in regards to their health care when they fully understand their health situation and treatment options."

FNHA works with our partners, including regional health authorities, to embed culturally relevant practices and programs into the health system, and hopes to work with private care providers in BC to further embed the practices of Cultural Safety and Humility and Trauma-Informed Care into their long term care facilities and programs.

As part of this study, we recommended that cultural safety and humility and trauma-informed care be adopted by ISC in addressing gaps and opportunities in its long term care programs in First Nations.

Elders and Elder Care
First Nations elders are pivotal in the health and wellness of their communities and people. They provide guidance, advice and support to community members through teachings and are knowledge keepers. It is with this in mind that FNHA works to support elders to live well and healthy, and remain in their communities and homes for as long as possible. Given that the elders have such a key role in the holistic well-being of their communities and families, when they have to leave to access long term care

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[5] http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness

[6] Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.
Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.
Trauma-Informed Care recognizes and acknowledges the impact of trauma and the need for awareness and sensitivity to its dynamics in all aspects of service delivery. It teaches practitioners and organizations to avoid and mitigate re-traumatization, understand the cycles of trauma and intergenerational trauma, and recognize trauma symptoms.
http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf

or assisted living, it is a loss of guidance, advice, and support, and likely a lost opportunity for further transmitting of cultural knowledge (2018a).

Elders who have to leave also face the possibility of social and cultural isolation, as their community may be far from the facility, their families have poor access to transportation or technology to keep in touch, and they will no longer be able to go out on the land or water and take part in traditional activities or have frequent access to traditional food and medicine. This can significantly impact the mental health and well-being of the elders, and open the door not only to emotional effects such as depression or anxiety, but also to possible physical effects such as a worsening physical trajectory of their conditions, or potentially elder abuse.

Work is underway internally and with partners across the health and wellness sector to address gaps and opportunities related to elder abuse, ageing well, falls prevention, Alzheimer's and dementia, and the needs of the complex medically frail.

For example, FNHA is currently analyzing a community-driven model for reducing and preventing elder falls, which it hopes will be a model for other communities across the province. The Nlaka'pamux Nation Tribal Council[7], in cooperation with Fraser Health Authority and Interior Health Authority, has created a series of helpful resources called 'Safe for Elders, Safe for All' to help elders prevent falls within their communities, but has recently gone one step further to incorporate children and youth into the efforts, making elders falls prevention something the whole community can work toward. Knowing that elder falls are often a precipitating event leading to the need for long term care, models like this one may prove vital to keeping elders in their homes and communities longer.

FNHA is also working to improve the quality of its Home and Community Care program in order to keep elders at home in their communities longer (more below). **We recommend to the Committee that elders be engaged in any program refresh or redesign of federal programs serving elders.**

Individuals with Chronic Illnesses

Recently, FNHA completed an analysis of health services utilization by First Nations people in BC, using BC Health System Matrix data linked to the First Nations Client File, in order to make comparisons about use between First Nations and other residents in BC (2018b).[8] The results supported much of what we already know about the prevalence rates of chronic illnesses in First Nations, and provided new insights.

For example, the data indicated that First Nations:

- were two times more likely than other BC residents to have had a stroke, and three times more likely to have rheumatoid arthritis;
- saw an increased rate in First Nations younger than 50 years of age of mood anxiety, a category that includes Alzheimer's Disease and Dementia;
- who were frail or had high needs aged 50 to 64 were three times more likely to have diabetes, three times more likely to have Osteoarthritis, and two times more likely to have hypertension.

All of these conditions alone can increase costs and acuity needs for First Nations; combined with other conditions or with complex medical frailty, this could lead to earlier contact for First Nations people with

[7] https://www.safeforelders.com/

[8] http://www.fnha.ca/wellnessContent/Wellness/FNHA-First-Nations-Health-Status-and-Health-Services-Utilization.pdf

long term care or assisted living facilities needed to address the patient's care needs, and removing them from their homes and communities sooner.

In an effort to address the growing needs of those with chronic conditions, FNHA has sought to create key partnerships which would address some issues. One such partnership is with the BC Cancer Agency, which led to the creation of an Indigenous Cancer Strategy[9] aimed at improve Indigenous People's Cancer Journeys through Partnerships, Prevention, Screening, Cultural Safety, Survivorship, End-of-Life, and Knowledge Development.

The data also indicated that those First Nations patients who were 75 years and older and who were at the end of life, were frail or had a high complexity of chronic diseases, when compared to other residents, were less likely to stay in hospital awaiting discharge after their acute care needs were met. What is not clear from the data is whether the reason for this is because First Nations patients prefer to return home as soon as possible, or whether they did not want to wait for placement in a residential care facility. In either case, discharge planning is a key consideration as the issue of long term care is studied. **Therefore, we recommend that the committee note in its report the importance of ISC regions working with their provincial/territorial partners to close the gaps in discharge planning created by jurisdictional issues.**

Long Term Care and Home and Community Care

FNHA does not own, operate or fund any long term care facilities, assisted living facility, elder lodge or similar institutions. The small number of these types of facilities that do exist or operate in the territory of a BC First Nation are the responsibility of the Nation or Nations involved, and their partners.

While responsibility for Home and Community Care programming was taken over by FNHA at transfer in 2013, one area of health service delivery which did not entirely transfer was the full continuum of services that fall under long term care. That is because Long Term Care provided in institutional facilities fall under the mandate of Indigenous Services Canada's (ISC) Assisted Living program, which was not an original party to the Tripartite agreement that led to the transfer of the First Nations and Inuit Health Branch (FNIHB) programming to FNHA.

As ISC assumes legal responsibility for the commitments made by Health Canada in the Tripartite Agreement, it remains to be seen how programming changes may simplify the administrative complexity that has long plagued the interactions between to the two programs in BC.

Within the guidelines for FNHA's Home and Community Care program, the funding provided to communities can support clients with meeting their personal care needs; getting home support not provided by the In Home Care covered by ISC's programming; nursing care for assessment, case management and treatment; and respite. There are a number of further supportive services elements which could be included once essential services are fully delivered, all designed to help people remain in their homes and communities as long as possible.

What the program does not do is fund the construction and/or delivery of Long Term Care or institutional services, nor does it duplicate funding for existing community adult care services. As FNHA continues to work with communities and further its partnership with ISC, there may be avenues to explore how FNHA can support First Nations people who need Long Term Care or Assisted Living services.

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[9] http://www.fnha.ca/wellnessContent/Wellness/improving-indigenous-cancer-journeys-in-bc.pdf

All of this complexity demonstrates why it is important that FNHA work with its health and wellness partners to improve quality and access to programs and services in our communities, as well as in health authority operated or funded facilities, and in private facilities across BC. As BC works with all of its partners, including communities, to identify the gaps and opportunities for smoother program interaction and develop lessons learned, **we recommend that FNHA be included as a partner in ISC program renewal or refresh.**

Palliative Care and Hospice

FNHA embraces the *First Nations Perspective on Health and Wellness* in its work to address health and wellness throughout the life course, including how to best support our clients and their families at the end of life. The perspective not only focuses on the physical, but also the spiritual, mental and emotional health that is so important to our peoples and communities. A key priority in FNHA's End-of-Life work is to engage with First Nations individuals and communities and learn from them what they consider a "good death" or a "healthy death", and how FNHA can work as an organization to support those beliefs.

Our work on palliative care and related issues is largely driven by what we hear as we engage with First Nations. At the 2016 BC Elders Gathering (2016), we heard that:

- Elders want physical spaces and care providers that are culturally safe, flexible in accommodating cultural practices, and practicing cultural humility.
- Elders want to see conversations about advance care planning in their families and communities, but are looking for leadership and resources to encourage the discussions.
- Elders want to see a return to the traditional ways for the end of life, but see challenges in dealing with the health care system, funeral homes, coroners and related institutional barriers.
- Elders want to find ways to have people who are at the end of life die in their communities, or at least when leaving the community, to find ways to stay/keep connected to family and home.
- Elders want to see supports developed to help cope with sudden loss.

These insights have been key drivers of our palliative and end-of-life work; FNHA is working to embed culturally relevant practices and programs into the BC health and wellness system. The following are examples underway specific to palliative and end of life care:

- Development of Indigenous Palliative Care toolkit and ACP resources: Based on the resources developed by Cancer Care Ontario for its Indigenous population, FNHA is developing a 'Made-for-BC', culturally-safe toolkit designed to inform and assist Indigenous people, their families and care providers, and health practitioners who are in the midst of a palliative or end-of-life journey.
- Applying "Jordan's Principle" to EOL care: FNHA and its provincial partners are actively working to improve access to palliative care, both in our communities and across BC, with some success. A Joint Issue Paper by FNHA and Interior Health Authority led to a province-wide change which now allows First Nations to access BC's Plan P Drug Benefits, giving palliative First Nations patients access to much needed pain and symptom relief in their own communities. What may seem like a small administrative change opens the door to allowing palliative First Nations people to remain at home in their community longer, or to return home to complete their journey to the spirit world.

To that end, **FNHA recommends that a similar palliative care toolkit can be developed for First Nations across Canada. Furthermore, we recommend that ISC consider taking a similar "Jordan's Principle" approach to elders/seniors, and consider this frame in its programming which serves palliative patients.**

Recommendations

Based on the analysis, FNHA recommends to the Committee the following for consideration as it completes its report on the issue:

1. That Cultural Safety and Humility and Trauma-Informed Care be adopted by ISC in addressing gaps and opportunities in its Long Term Care programs in First Nations.
2. That elders be engaged in any program refresh or redesign of federal programs serving their needs.
3. that the committee note in its report the importance of ISC regions working with their provincial/territorial partners to close the gaps in discharge planning created by jurisdictional issues.
4. That FNHA be included as a partner in program renewal, in order to ensure that First Nations across Canada receive equitable care.
5. that a series of Indigenous palliative care toolkits be developed for First Nations across Canada.
6. that ISC consider taking a similar "Jordan's Principle" approach to elders/seniors, and consider this frame in its programming which serves palliative patients.

Conclusion

FNHA is focused on maintaining and furthering our partnerships with the federal government around public health issues relating to First Nations in BC. **In accordance with the *British Columbia Tripartite Framework Agreement on First Nations Health Governance,*** there are opportunities to address key issues related to First Nations interactions with long term care, including jurisdiction questions which may increase the possibility for elders and those with complex or chronic care needs to stay attached to their homes and communities longer.

Further References

Buchholz, M., Dangwal, J., Stinson, S., and Khan, D. (2018a). *Elder Health and Wellness: A Report Prepared in Partnership with the First Nations Health Authority*. Simon Fraser University School of Public Policy: Unpublished Report.

First Nations Health Authority. (2018b). *First Nations Health Status & Health Services Utilization: Summary of Key Findings, 2008/09 – 2014/15*. Unpublished Report.

First Nations Health Authority. (2016). *Synthesis Report: Feedback from BC Elders Gathering on End-of-Life/Palliative Care Issues*. Unpublished Report.

Appendix: Response to a request by the Honorable Rachel Blaney on information regarding Medical Assistance in Dying

Question:

Are you collecting data on the consideration of Medical Assistance in Dying (MAiD) in indigenous communities? Have there been many cases? Would you be able to share any data that you do have with us and the committee?

Answer:

There are no mechanisms in British Columbia to collect data on contemplation, requests, approvals, denials, completions or non-completions of MAiD from First Nations people or communities.

As British Columbia worked to develop its protocols to align with the then-forthcoming Bill C-14, the decision was made in consultation with FNHA and its provincial health partners not to ask potential patients to self-identify at any point in the request or process. There is also no way to track anyone through health insurance.

As such, we are unaware of any cases in British Columbia that include a First Nation person. This is not to say that none have occurred, it just reflects that FNHA has not been alerted to provide support to any patients, assessors or providers.