

Continuing Care in Indigenous Communities

GUIDEBOOK



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The Blood Tribe's Journey to Continuing Care

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The journey to the Kainai Continuing Care Centre (KCCC) was a long rocky road, full of confusing twists and turns. A few times I thought I had gotten lost on the back roads and pondered turning back. My journey to the KCCC was a good metaphor for the community's long journey towards continuing care. The Blood Tribe had set out on a path to establish their own continuing care centre a long time ago and it would be a long, arduous and difficult journey.

In 1928, the Blood Indian Hospital was built in Cardston and was one of six hospitals built and owned by the federal Department of Health and Welfare. In 1957, the new Cardston Clinic opened its doors, but the physicians' outpatient clinics were held in the hospital until 1974. After 1974, the outpatient clinics were moved to the Shot Both Sides building at Standoff, on the Blood Reserve. Eventually the Department of Health and Welfare moved to close the six on-reserve hospitals.

Tribal leadership authorized the Blood Tribe Department of Health Inc. (BTDH) to regulate and administer medical and health services on the Blood Indian Reserve and in 1985, a new Blood Tribe Health Centre opened its doors. Since its inception, the BTDH introduced health services that include physicians, pharmacy, optometry, dental, physiotherapy, laboratory, radiology, mental health services, community health services, home care services, emergency services (fire and ambulance), a non-insured health benefits program and support services that include administration, security, maintenance and housekeeping.

Construction of a new multi-level care facility commenced in 1997, but without sustainable funding from the federal or provincial governments, the BTDH eventually designated it a long-term care facility and on October 12, 1999, the KCCC opened its doors for the first time. A lot of the community was disappointed with the new designation, hoping for their own in-community hospital but the federal government was clear, on-reserve hospitals were phased out.

By 2007, the BTDH was struggling with the costs of continuing care. They were without provincial continuing care funding and what was coming in from Health Canada was insufficient. They were eventually forced to offset the cost of continuing care with a contribution from the elders' personal income.

"Many of the elders felt betrayed when they were told they'd have to contribute to the cost of their care because they viewed healthcare as a treaty right." – Derek Fox, Acting CEO, BTDH

Cecilia Blackwater was brought in as the CEO of the BTDH in 2011. She was previously the administrator of the Blood Indian Hospital and came to the table with a wealth of experience in hospital management and implementation of healthcare policies and procedures. However, continuing care was an area of healthcare new to her.



“I had previously managed the Blood Indian hospital and completed a three-year Health Service Management course through Canadian Healthcare Association in my own time...but continuing care was new to me, so I enrolled in further study at Lethbridge Community College.” – Cecilia Blackwater, Former CEO (retired)

Derek Fox was brought in as the new Director of Finance for the BTDH in 2012 and in a few short months a newly automated finance program confirmed that the long-term care program was unsustainable with existing funding, so they initiated talks with Alberta Health Services (AHS) about funding continuing care.

“The Chinook Health Region (South Zone) was instrumental in helping us move forward with long term care. Dr. Vanessa McLean and Colin Zieber were very supportive...helping us with recruiting physicians, negotiating for licensing the facility, and funding for KCCC.” – Cecilia Blackwater, Former CEO (retired)

In preparation for AHS partnership, the BTDH began the process of renewing their accreditation with Accreditation Canada. The process was challenging in terms of program improvement and development but would ultimately pay dividends in the months ahead.

“Accreditation enhanced our ability to improve and expand services...when we went through provincial licensing, we found that many of the standards we developed not only complied with provincial standards but in many cases exceeded them. That would not have been possible without the accreditation process.” – Derek Fox, Acting CEO, BTDH

Health Minister Sarah Hoffman visited the KCCC in July 2015 and committed to advocating for the Blood Tribe in terms of a long-term care partnership with AHS. Following Ms. Hoffman’s visit the BTDH began the process of provincial licensing.

The first step in licensing would prove to be quite a challenge as the “due diligence” document required by AHS was written entirely for private businesses. Once the document was adjusted to reflect the unique status of first nations, the document was signed, submitted and accepted.

Following the due diligence work, the KCCC had to undergo various AHS health and safety inspections. The inspections were similar to the survey inspections conducted by Accreditation Canada and after addressing a few corrective actions, the facility was approved by AHS so the contracting process could begin.

In the last leg of the journey towards continuing care partnership with AHS, the KCCC had to work through a checklist with AHS Contracting and Procurement, which was a long and tedious process.



“Ongoing communication with AHS was crucial at that stage. We had a number of meetings to discuss the bigger items but it was also about maintaining consistent communication with AHS...keeping that momentum...always moving forward.”

– Cecilia Blackwater, Former CEO (retired)

The KCCC is now in the final stages of the contracting and certification process and is poised to open 25 long-term care beds with 60 staff. In talking about the journey to the continuing care partnership, Derek wasted no time looking to the past and instead remained focused on the future.

“It’s really great the partnership is going ahead, and it was a long time coming, but right now we’re focused on the construction of the new Wellness Centre. Once complete, we will move 20 staff over to it which will free up 20 offices...with some renovation those 20 vacant offices would be perfect for supportive living beds.” – Derek Fox, Acting CEO, BTDH

As I ready myself for my long journey home, I’m reminded it’s the end of one long journey for the Blood Tribe Department of Health and maybe only the beginning of another. But I’m certain the dedication and commitment that has gotten them this far will ensure further successes in the years to come.

Update: Since this interview was completed, the Kainai Continuing Care Centre successfully met accreditation and licensing requirements and is contracted with Alberta Health Services for operational funding of their 25 long-term care beds.



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1. Introduction

In a spirit of partnership and mutual respect, Alberta Health Services (AHS) is committed to Métis and First Nations communities in supporting the development of continuing care services that meet their unique needs. This work was undertaken with recognition of the guiding principles and values of the *United Nations Declaration on the Rights of Indigenous Peoples*, the *Truth and Reconciliation Commission of Canada: Calls to Action*, and specifically:

- recognizing the health-care rights of Indigenous peoples,
- recognizing the value of Indigenous healing practices, and
- identifying and closing the gaps in health outcomes between Indigenous and non-Indigenous communities.

The development of continuing care services supports Indigenous people to remain in their community, close to the support of family and friends, as they age or as their care needs change. The development of culturally sensitive continuing care helps to ensure that health services are provided in a way that works best for First Nations and Métis people.

This guide was created by Alberta Health Services, in partnership and consultation with First Nations and Métis representatives and the Government of Alberta (Ministries of Health, Indigenous Relations, Seniors and Housing). Special thanks to the members of the following groups for sharing their wisdom and expertise (refer to **Appendix I** for a full list of contributors):

- Métis Settlements General Council Health Board
- Joint Action Health Plan Continuing Care Sub-Working Group
- Continuing Care in Indigenous Communities Working Group

2. Background

First Nations in Alberta, along with their federal and provincial partners, identified the need for a First Nations Continuing Care model based on cultural best practices. This work was undertaken with significant First Nations consultation and was supported by the Health Services Integration Fund (HSIF). The Continuing Care in Indigenous Communities Guidebook is intended to build on the First Nations Continuing Care Model in order to support the implementation of continuing care in Indigenous communities. Refer to **Appendix A** for the Model of Care and the supporting HSIF documents.



3. Continuing Care in Alberta

In Alberta, the responsibility for continuing care is shared between Government of Alberta Ministries (i.e., Alberta Health, Alberta Seniors and Housing, Alberta Infrastructure and Alberta Community and Social Services). The Ministry of Health, also known as Alberta Health, leads the development of directional policies and standards and provides funding to Alberta Health Services (AHS). Alberta Health Services is a separate entity that is responsible for managing operations and the delivery of health services.¹ (Refer to **Appendix B** for more information on program roles.)

Partnerships between Métis and First Nations communities and Alberta Health Services are essential when developing continuing care services in order to meet the unique needs of the community.

Alberta Health Services recognizes the importance of traditional wellness services and culturally appropriate practices in continuing care for First Nations and Métis peoples. This guidebook is intended to encourage discussion of the unique and specific continuing care needs of the community and how continuing care may support the entire community. Continuing care services are developed to meet the needs of community members who are:

- Elders
- Adults or children with physical disabilities
- Adults or children with intellectual disabilities
- Adults or children with addiction and/or mental health needs

Continuing care can be defined as an integrated range of services supporting the health and wellbeing of individuals. People who receive continuing care are not defined by age, diagnosis or the length of time they may require service, but by their specific unmet need for care. Continuing care services are viewed as a continuum; home services at one end (known as Home Care) and facility based services at the other.

How do people access continuing care in Alberta?

Access to continuing care services is standardized for all residents of Alberta, according to the AHS *Access to a Designated Living Option in Continuing Care Policy*. Persons who would benefit from continuing care services are assessed by a case manager or care coordinator, using a standardized assessment tool, to determine their unmet health needs. This assessment is done in partnership with clients and families and the information is used to identify what care services are needed, including what living option is most appropriate. Clients who want to access continuing care services should call Health Link at 8-1-1 for information about the process in their zone.

¹ Throughout this Guidebook, the term “Alberta Health” will be used to reference the Ministry of Health.



Home Care

Home Care typically refers to personal care services and supports that are provided to a person in their home. Home care services fall into five broad categories: professional case management, professional health services, personal care, home/community support and caregiver support/respite care. For First Nations and Métis communities, Home Care services vary greatly in their availability due to funding and geographic location.

Métis Settlements:

- For persons living on a Métis Settlement, as with clients residing in other areas of the province, Home Care is authorized by AHS and services are provided by AHS staff or contracted providers. It is recognized that due to the rural and remote locations of the Settlements that the availability of Home Care services may be limited.
- Self-Managed Care is a service delivery option that provides personal support and informal caregiver respite for people who have unmet health needs. For example, when an elder is living at home and being cared for by family members.
 - The client is assessed by an AHS Case Manager to determine their unmet needs and Home Care eligibility.
 - If it is determined that Self-Managed Care would be an appropriate option, the client enters into a contract with AHS, whereby AHS provides them with funding and the client is responsible for contracting or employing their own care provider.
 - In certain exceptional circumstances, and only with AHS approval, the client may be able to hire a family member as their care provider.

First Nations On-Reserve:

- Home Care services are provided through Indigenous Services Canada. Funding is provided to First Nations, who are then responsible for ensuring that the mandatory service elements are met, such as the hiring of a registered nurse.
- Visit [First Nations and Inuit home and community care \(sac-isc.gc.ca\)](https://www.sac-isc.gc.ca) for more information.



Seniors Lodges

- Seniors Lodges are run by Housing Management Bodies with grants from Alberta Seniors and Housing to ensure affordability. They offer meals, housekeeping, recreational activities and other services. The operation of lodges is governed by the Alberta Housing Act and is independent of AHS. Refer to **Appendix D** for more information on the Seniors Lodge Program.
- Residents are independent, with or without community-based services.
- Health services would typically be provided through Home Care. There is no 24-hour health care staff on-site.
- The Housing Management Body could be the First Nation or Métis Settlement.
- Some existing buildings that are called a lodge; may actually be a Designated Supportive Living Level 3 or 4 facility (see descriptions below).

Designated Supportive Living

Supportive living provides accommodation in a home-like setting, where people can remain as independent as possible while they have access to accommodation, health services and supports. **Designated Supportive Living (DSL)** is where AHS coordinates access to a specific number of spaces according to an agreement between AHS and the facility operator. Designated supportive living clients are assigned an AHS case manager, who works with them to coordinate their care needs and health services.

In Designated Supportive Living, the individual typically provides, or pays for, their own:

- Accommodation charges/rent (which may include a damage deposit)
- Room furnishings
- Cable, telephone and internet charges
- Personal laundry
- Hair salon fees
- Toiletries and other personal supplies

Refer to **Appendix C** for a description of coverage for medical supplies, equipment and drugs, and **Appendix D** for information on financial assistance.

In Alberta, there are different levels, or types, of designated supportive living that are based on the client's care requirements and assessment of their unmet needs. There are also private supportive living residences that do not receive funding from AHS. Clients do not need to be assessed to determine if they can live in the residence, but make the decision based on consultation with the operator. These private facilities will not be addressed in this guidebook.



Designated Supportive Living Level 3 (DSL3)

- Offers 24-hour on-site scheduled and unscheduled personal care and support provided by Health Care Aides with the availability of 24-hour on-call Registered Nurse services (i.e., assistance for dressing, personal hygiene and meals may be provided).
- Residents have a stable medical condition. They may have mild dementia but have stable behavior. They mobilize independently or with one-person transfer.
- A Personal Care Home is an example of a DSL3 home. It is a residential home that has been specifically built with modifications for people with disabilities. There are typically four to six residents with private bedrooms and shared living spaces, kitchen and dining areas.

Designated Supportive Living Level 4 (DSL4)

- Offers 24-hour on-site scheduled and unscheduled professional and personal care and support, provided by Licensed Practical Nurses and Health Care Aides with the availability of 24-hour on-call Registered Nurse services.
- Residents may have complex medical conditions, including dementia, but are stable and can be managed safely. They may require complete meal assistance, mechanical transfers, two-person transfers and/or assistance to help them mobilize.

Designated Supportive Living Level 4 – Dementia (DSL4-D)

- Services are similar to DSL4 but with a higher level of staffing.
- Typically, a smaller grouping of residents in a secured environment with specific dementia supports.
- Residents have moderate dementia that may progress to later stages of dementia. They may have unpredictable behaviors that may include risk of elopement.

Supportive Living Options for Individuals with Other Conditions

There are also different options for individuals with other medical or health issues. This may include individuals with addiction or mental health issues, as well as adults or children with physical or intellectual disabilities.² Depending on the needs of the community, there is the potential of sharing resources with continuing care. Consider if this should be included in your planning process and then discuss your options with AHS.

² An intellectual or learning disability may include problems with memory, thinking, communication, behavior and social skills. Physical disabilities may include physical problems such as poor coordination, difficulty with balance or walking, impaired hearing or vision. These disabilities would also include Fetal Alcohol Spectrum Disorder (FASD). Contact your zone Indigenous Health Program for more information on supports/resources in your area to assist individuals with any of these conditions.



Long-term Care

Also referred to as Nursing Homes or Auxiliary Hospitals, long-term care provides services for people with complex, unpredictable medical needs requiring **24-hour on-site Registered Nurse assessment and treatment**. In addition, professional services may be provided by Licensed Practical Nurses and 24-hour on-site unscheduled and scheduled personal care and support will be provided by Health Care Aides. This may also include a secured dementia care unit.

Residents have complex, unpredictable needs but are medically stable and can be managed safely with scheduled and unscheduled on-site support. This may include complex end-of-life care, complex medication management and complex nursing interventions. Unscheduled assessments are often required to address the changing care needs of the resident.

Respite Services

Respite Services are for people who are still living at home that are being taken care of by a family caregiver. The idea is to temporarily give the caregiver a break to help them maintain their own health and well-being. Respite services can be provided in the home, in the community or in a facility. (Some respite services may be funded for First Nations by the Assisted Living Program, Indigenous Services Canada.)

Examples of respite services include:

- Adult day support programs: A program that is located in the community, at a community centre or at a continuing care centre, which provides recreation and leisure activities, family teaching and support, basic personal care, meals and snacks.
- Respite beds within a supportive living or long-term care centre where the client can stay for short term care (i.e. while family caregiver is away for a period of time).

Restorative Care

Restorative care focuses on maximizing an optimal level of functioning, enabling clients to regain/retain their independence following the effects of injury, illness or hospitalization.

Restorative Care usually applies to certain beds that are designated, usually within an existing facility. Clients would generally stay for up to six weeks, with the goal of returning back to their previous living arrangement or transitioning to another living option, based on their needs.



Palliative and End-of-Life Care

- Palliative Care aims to improve the quality of life of clients and families facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments, and appropriate life interventions.
- End-of-life Care is care provided to an individual and their family when they are approaching a period of time closer to death, which may be exemplified by an intensification of services and assessments.

There are some unique considerations for the development of Palliative and End-of-Life Care services in continuing care. Alberta Health Services has developed a resource guide to support communities through this process and this can also be discussed with your AHS Zone partners.

Visit [Palliative and End of Life Care | Alberta Health Services](#) for more information.

Visit [A Resource Guide for Community Development of Palliative and End-of-Life Care within Alberta \(albertahealthservices.ca\)](#) to access the resource guide.

4. Starting the Conversation

When you are interested in finding out more about continuing care and the potential options for your community, please contact continuingcare@ahs.ca any time for further information.

5. Determining the Needs of the Community

After you have contacted AHS, the next step is to do a Needs Assessment. This helps to determine what types of services are needed, and potentially the number of spaces (beds), for the size of the community. This will be based on current needs and future projections.

A Needs Assessment would include the following:

- Consultation with AHS Capacity Planning and Seniors Health in your zone. Zone Capacity Plans, combined with forecasts and population data, are used to determine the size and type of continuing care services needed for a community.
- Consultation with members of the community to determine what services and care requirements are needed (i.e., what is the most appropriate level of care required for the community and what resources are available, such as availability of staffing).
- Data on the population of the community, such as the number of residents and age ranges. Data sources may include Alberta Health, Métis Settlements census data, Alberta First Nations Indigenous Governance Centre (AFNIGC), the Department of Indigenous Services Canada (DISC) and Statistics Canada. AHS Capacity Planning will be able to provide support in this area.



- Consideration of the available facilities in surrounding areas, such as a neighboring town, and if those existing services could be adapted to include culturally safe care.
- Consideration of a shared facility with another First Nation, Métis Settlement, or affiliated Tribal Council that is nearby.



6. Funding

This information applies to both First Nations and Métis Settlements, unless indicated otherwise.

There are two different areas of funding to consider for continuing care:

- i. **Operational funding:** This is funding for day-to-day operations, which can be divided into accommodation and care services:
 - **Accommodation:** Residents of supportive living and long-term care pay accommodation charges that are intended to cover the cost of meals, housekeeping and building maintenance. Refer to **Appendix D** for more information on accommodation charges and financial assistance programs for residents.
 - **Care Services:** Funding for health and personal care services is provided by AHS, based on pre-determined funding formulas for supportive living and long-term care. Refer to **Appendix H** for information on staffing and funding models.

- ii. **Capital or infrastructure funding:**

Métis Settlements and First Nations are encouraged to investigate multiple sources of potential capital funding, which may include the Canada Mortgage and Housing Corporation (CMHC) and private partnerships, such as with an established continuing care operator. Refer to **Appendix E** for more information on CMHC programs.

First Nations should also contact these capital funding sources:

- First Nations Development Fund: Government of Alberta lottery grant program that is available exclusively to the First Nations Band Councils of Alberta. Applications are submitted and reviewed on a quarterly basis. Funds may be used for new construction or renovation projects. Visit [First Nations Development Fund Grant Program | Alberta.ca](https://www.alberta.ca/first-nations-development-fund-grant-program).
 - Indigenous Services Canada (ISC), formerly known as Indigenous and Northern Affairs Canada (INAC), to discuss potential capital funding options.

When capital grant funding is available through the Government of Alberta, the most common source has been through Alberta Health's capital grant programs. These programs are offered on a periodic, time-limited basis. Any future capital grant opportunities will be posted on the Ministry of Health's website. Please note that there is no continuing care capital grant program available at this time; if a program is announced, details will be available at [Continuing care | Alberta.ca](https://www.alberta.ca/continuing-care).

It is important to note that, *when* capital grant funding is available, the approval of applications will depend heavily on whether a community has conducted an appropriate needs assessment (as outlined in Section 5 *Determining the Needs of the Community*) and compiled a business case. If grant funding is available, all applications will be subject to fund availability and a rigorous review to determine



which communities need the continuing care services the most. Additional criteria such as project design, project readiness to proceed, operator qualifications, operational funding agreements, agreement to be licensed under the *Supportive Living Accommodation and Licensing Act* and financial feasibility and sustainability of the project may also be considered in prioritizing applications.

For more information on the current status of Alberta Health's capital grant programs and availability, contact:

Alberta Health, Health Facilities Planning Branch
Phone: 780-644-7648

7. How to Build a Business Case

As mentioned above, your community will develop a Business Case to demonstrate the need for continuing care services. This is required for capital grant applications when capital grant funding is available. Some communities may have resources to develop the business case themselves, or they may choose to hire an independent consultant.

8. Contract Process

If there is more than one request for continuing care services in an area (i.e., neighboring communities or municipal districts), there may be a competition process to determine where AHS resources would be best utilized. AHS Capacity Planning in your zone can provide information about the necessary requirements and approvals.

If AHS approves the continuing care proposal and capital funding is obtained, the Indigenous Community will enter into a contract with AHS in collaboration with the Contracting, Procurement & Supply Management (CPSM) department. This contract is a Master Services Agreement (MSA) that is specific to the type of continuing care that will be provided. The contract outlines the service model requirements and will include such items as:

- A description of the type and number of spaces (beds)
- Staffing obligations of the service provider
- Reporting requirements
- Funding and fee schedule

The Indigenous Community will work with CPSM if there are amendments needed to the MSA to reflect unique circumstances for the provision of continuing care for the First Nation or Métis Settlement.

When a First Nation is entering into a contract with AHS, the contractual requirements depend on the nature of the legal entity that is entering the contract. For example, the Band or a legally incorporated Board of Health or other legal entity might sign the contract. If a Band is entering



into the contract, a Band Council Resolution supporting the Master Services Agreement will be required. In all cases, the Band will need to grant access to reserve lands by AHS staff for the purposes of fulfilling the terms of the contract. Refer to **Appendix F** for a sample Band Council Resolution for continuing care.

Métis Settlements who are entering into a continuing care contract with AHS require a Métis Settlement Council Resolution.



9. Quality, Safety and Licensing Requirements in Continuing Care

In Alberta there are specific mandatory requirements and standards that govern both accommodation and health services in continuing care. These requirements ensure the safety of residents and that care provided is of the highest quality. The *Supportive Living* and *Long-Term Care Accommodation Standards* are mandated requirements for all licensed supportive living settings and long-term care. The *Continuing Care Health Service Standards* (CCHSS) are mandated requirements for all continuing care health services that are publicly funded. The licensing and certification processes, as well as these standards, ensure a certain level of quality and safety for all residents. Refer to **Appendix G** for more information on these important requirements.

10. Innovative Approaches

You may want to consider how your continuing care services could enhance both the wellness and quality of life of the elders, and of the community. You may want to engage members in the process of developing a continuing care facility and perhaps “brain storm” to come up with ideas that would benefit the whole community.

The following examples are some of the approaches that can be used when developing continuing care. This list is not exhaustive but represents a sampling of ideas for your consideration. AHS does not support one approach over another, but we encourage you to “think outside the box” to find the right solutions for your community. Not every idea will be feasible or financially viable but start thinking about them early on in the process and discuss them with your AHS partners.

- A continuing care facility or building can include more than one level of continuing care. For example, there could be supportive living and long-term care beds located in the same building, along with mental health and addiction beds.
- A supportive living centre could designate one or two beds for end-of-life care. These rooms can be designed with additional space for family and visitors, including some extra sleeping space and kitchen facilities.
- Consider the need for larger family suites or adjoining suites to keep family members together.
- If there is a need for continuing care for disabled adults with families (for example, an adult with a brain injury or a spinal cord injury), you could consider locating family apartments adjacent to the continuing care centre so that adults can receive the appropriate health services and still live with their family.
- A continuing care building can also serve as a community hub:
 - Social activity spaces could also be used by the community for other functions.
 - Locating the care centre next to a school or existing community centre enables interaction between the elders and youth of the community.



- Other community supports and health services can be located within the continuing care centre, in particular services for treatment of addiction or mental health.
- Accessible bathing facilities could also be used by community members who do not have appropriate or accessible bathing facilities in their homes.
- Consider partnering with other communities, such as a neighboring town, or another First Nation or Settlement, to share resources and staffing for a continuing care centre.
- Consider partnering with an established continuing care operator who can assist with start-up and operation of the centre.

Building Design

The physical design and construction of the continuing care centre can also involve innovation. There are options that do not involve the costly construction of a new building from the ground up. Consider if the centre can be designed to add or remove spaces as demand and needs change. A few examples include:

The Age-in-Place Laneway Housing Project is an initiative of the University of Calgary, Faculty of Environmental Design, under the leadership of Professor John Brown. The interior of the house can be customized to meet the mobility and health needs of the individual to support them to age-in-place. These portable houses could be clustered together to provide a continuing care community, perhaps attached to a central building that provides meals and recreation. For more information, visit [v \(aref.ab.ca\)](https://www.airef.ab.ca).

- Manufactured homes and modular classroom buildings can also be modified for continuing care living units.
- In the Netherlands, the Hogeweyk Dementia Village demonstrates how the design and construction of continuing care in a village-like setting can support elders living with dementia. Visit [The Hogeweyk Dementia Village ~ Care concept](#).

In Alberta, it is a mandatory requirement that any new continuing care centre (i.e. DSL and LTC) must be designed and built to a Group B Division 3 (B3) occupancy classification as defined in the Alberta Building Code. The document, *Design Guidelines for Continuing Care in Alberta (2018)*, is intended to promote best practices and innovative design for supportive and facility living. It can be found at:

infrastructure.alberta.ca/Content/docType486/Production/DesignGuideConCareFac.pdf



11. Approaches to Care

When you integrate traditional wellness services into your continuing care, consider if there are any other person-centred approaches that may be complementary. The following are some examples of leading practices. This information is provided for your reference as AHS does not endorse any one particular model of care over another.

St. Elizabeth First Nations, Inuit and Métis Program

St. Elizabeth has many innovative Indigenous health initiatives with on-line educational opportunities which may be a worthwhile resource for your community. Visit their website for [SE First Nations, Inuit & Métis Program \(sehc.com\)](https://sehc.com) more information.

Supportive Pathways

Carewest has developed a training program for dementia care called “Supportive Pathways”. This program helps caregivers to improve the quality of life for elders with dementia. Visit [Dementia care training – Carewest](#) for more information.

Dementia Care

The Alzheimer’s Society of Alberta has resources and information that can assist elders with dementia, and they have experience working with Indigenous communities in Alberta and the NWT. Visit their website at [Alzheimer Society of Alberta and Northwest Territories](#) or phone them at 1-866-950-5465 and they will connect you with a local representative.

The Eden Alternative

The Eden Alternative is a person-centered approach that commits to creating a human habitat where life revolves around close and continuing contact with plants, animals and children with the belief that “care is a collaborative partnership”. For more information, visit their website [The Eden Alternative® - Improving the Lives of the Elders](#).

The Green House Project

This care approach evolved from the Eden Alternative and is based on creating a home-like environment for 7–12 people. Each home is self-contained, but they can be grouped together as free standing houses in a cluster or within the same building. The basis for this model is that the Health Care Aides are trained in universal roles to assist the elders with personal care, perform housecleaning tasks and do meal preparation. For additional information, refer to the website [Welcome Home — The Green House Project](#).

The Butterfly Model

This is a person-centered philosophy for dementia care that was developed in the UK. There are several sites in Alberta that have adopted this model as a way of improving the quality of life for people living with dementia. Visit [Dementia Care Matters](#) for more information.



12. Alberta Health Services Links

AHS Indigenous Health

[Indigenous Health | Alberta Health Services](#)

AHS Continuing Care

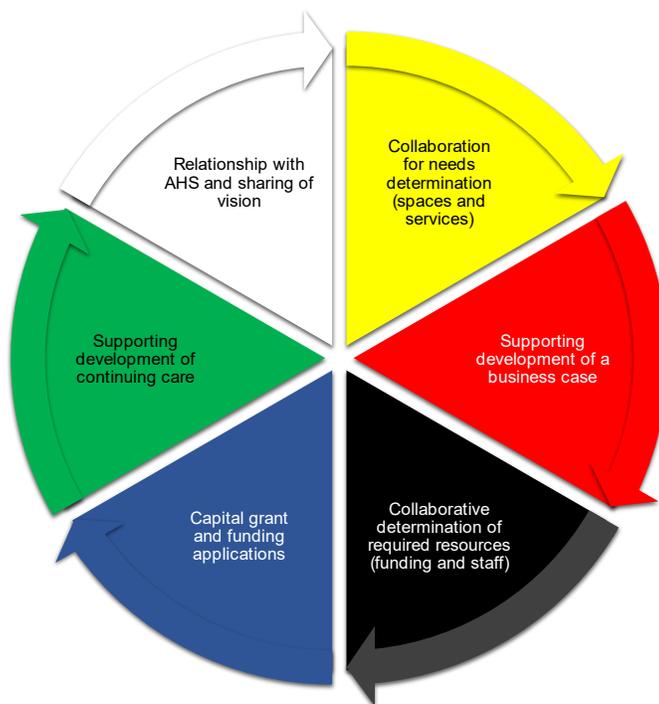
[Continuing Care | Alberta Health Services](#)

AHS Continuing Care Policies, Procedures and Standards

[Policies, Procedures and Standards | Alberta Health Services](#)

13. Summary

Every First Nation and Métis community is unique. There may be different challenges due to geographic location, proximity to other health services, transportation, staffing and financial resources. The common thread is the desire to care for elders and family close to home, with care that is culturally appropriate. Alberta Health Services wants to support you in this vision.





APPENDIX A

References

United Nations Declaration on the Rights of Indigenous Peoples

[DRIPS_en.pdf \(un.org\)](#)

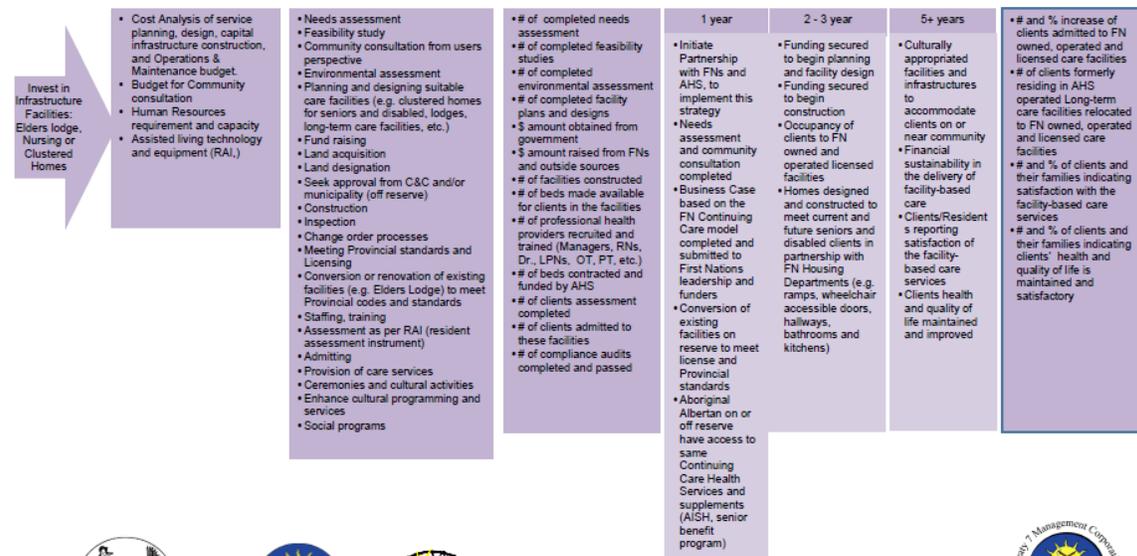
Truth and Reconciliation Commission of Canada: Calls to Action

[Calls to Action English2.pdf \(trc.ca\)](#)

Development of a First Nation Continuing Care Model - Health Co-Management (HCoM)

[HCOM - Treaty 8 First Nations](#)

Excerpt from “HSIF – Continuing Care Model: Aging in the Right Place”





APPENDIX B

Clarifying Program Roles

Government of Alberta

Alberta Health

Ongoing work with Indigenous communities has brought awareness to the need for more culturally appropriate approaches to the funding and provision of continuing care infrastructure and services for First Nations and Métis communities. Culturally appropriate care in community is recognized as having positive impacts to the wellbeing of communities. The Ministry of Health is in support of Indigenous people remaining in or near their community as they age or as their care needs change. Alternate ways of assessing community need, supporting the development of business cases and coordinating the various provincial and federal funding sources are all critical to ensuring that the continuing care needs of each community are appropriately identified and addressed

A new targeted and focused approach to funding continuing care capacity for Indigenous communities is being developed by the Ministry of Health. Communities will be notified of the program details once the program is released.

Indigenous Relations

Alberta's Indigenous Relations Ministry is the doorway to the provincial government for many Indigenous peoples, communities and organizations. This has resulted in a strong network of relationships across Alberta. As a result of these relationships, the department has a strong understanding of the needs Indigenous people in Alberta face.

At the same time, Alberta Indigenous Relations supports other government departments, as needed, when it comes to providing insight and advice on Indigenous-related initiatives, projects, programs and services. This expertise can help other ministries refine their offerings.

The First Nations Relation Branch is also responsible for the First Nations Development Fund (FNDF) supporting First Nations economic, social and community development projects. The FNDF grant program is a Government of Alberta lottery grant program available exclusively to First Nations Band Councils in Alberta. FNDF grant program funding may only be used for economic, social and community development projects, such as education, health, and infrastructure activities. All applications must clearly demonstrate this eligibility.

Seniors and Housing

The Housing Division works with over 400 community-based organizations to provide a basic level of housing accommodation for persons who because of financial, social or other circumstances require assistance to obtain or maintain housing accommodation. Over 110,000 Albertans are served by provincial housing programs, including low-income seniors, families, individuals and



those with specialized housing needs. The Housing Division works with housing management bodies, municipalities, not-for-profit organizations, and for-profit organizations to deliver housing programs, which include community housing and rent supplements, housing under the Capital Grants Program, seniors self-contained program and seniors lodge program. All programs are targeted towards low-income Albertans, and all have specific eligibility criteria.

The Urban Native Housing (UNH) program was created by the federal government in the 1980s to assist low-income Indigenous families and individuals secure safe and affordable housing in urban settings. The program provides subsidy assistance to Urban Native non-profit housing providers and direct mortgage financing to support the organization's goal of providing rental accommodation to low and moderate-income Indigenous peoples. The maximum annual subsidy payable to any project is equal to the difference between acceptable operating costs and annual project revenues. Under this program, rents are established according to a rent-geared-to-income (RGI) scale; rent is capped at 25 percent of a tenant's income. In 2016, the federal government transferred administrative responsibility for off-reserve Indigenous housing to the Province of Alberta. The UNH program continues to provide subsidy to recipients of the remaining operating agreements; Operating agreements have started to expire, with the last operating agreement set to expire in 2028.

The Government of Alberta is investing \$120 million, through capital grants, to increase the supply of off-reserve, on- and off-Settlement housing for Indigenous peoples in need through the Indigenous Housing Capital Program (IHCP). Indigenous governments and organizations, as well as housing management bodies, municipalities, and not-for-profit organizations who formally partner with Indigenous governments and organizations (as demonstrated through Memorandums of Understanding, etc.), will be eligible to apply for IHCP grants for planning and project funding beginning in June 2018. See [Funding to plan or build affordable housing | Alberta.ca](#) for more information and application documents.

Alberta Health Services (AHS)

The current model for assessing continuing care capacity needs is based upon the entire population of Alberta, which includes the Indigenous population. Enhancements to this model are required to better inform the capacity requirements of Indigenous communities within standard planning areas. An Indigenous Community Needs Assessment Model is in development. The model will be integrated with the current Continuing Care Capacity Needs Assessment (CCCNA) to account for the unique cultures, demographics, access deficits and service delivery considerations of Indigenous communities.

While the Indigenous Community Needs Assessment Model is in development, it is recommended that AHS work with Indigenous communities that have expressed an interest in having the needs of their community assessed. Communities can work together with AHS, and the appropriate capital funding partners (e.g., the Ministries of Health and/or Seniors and Housing, Indigenous Services Canada, the Canadian Mortgage and Housing Corporation), to identify solutions that best meet community needs.



Indigenous Services Canada (ISC)

Housing and community infrastructure on-reserve are funded by ISC, including larger structures such as apartment buildings. These funds are applied for by First Nations, based on individual First Nation long-term capital plans.

ISC's Assisted Living program provides non-medical home supports or funding for room and board to eligible clients living at home or in a lodge/supportive living (up to the provincial co-pay for room and board). More information on ISC's Assisted Living program can be found at [Indigenous Services Canada - Canada.ca](https://www.indigenousservices.ca).

ISC's Home and Community Care programs in FN communities are not funded to provide 24/7 and on call services. Currently, ISC does not have the mandate to fund or provide staffing for facility-based continuing care on-reserve.

Program Area	Familiarity with community needs	Needs Assessment	Funding for business case development	Capital funding	Operational funding for facility-based care	Operational funding for home care and/or home supports	Other community/social programs
Government of Alberta							
Alberta Health			✓*	✓*			
Indigenous Relations	✓			✓(FNDF)			✓(FNDF)
Seniors and Housing		✓**	✓**	✓**			
Alberta Health Services							
AHS Zones	✓	✓			✓ care only	✓	
Continuing Care Capacity Management		✓			✓ care only		
Indigenous Wellness Core	✓	✓					
Government of Canada							
Indigenous Services Canada (formerly INAC and FNIHB)	✓				✓ room and board only	✓ Mon-Fri 8-4:30pm only	✓
Canadian Mortgage and Housing Corporation	✓ as it relates to housing	✓	✓	✓		✓ home repairs and or modifications	✓

(✓ = on reserve only; ✓ = for off reserve FN populations/Métis communities; ✓ = either)



APPENDIX C

Medical Supplies, Equipment and Drugs

Designated Supportive Living:

- Status First Nation persons have coverage for items such as medical equipment and supplies, bandages and dressings, incontinence supplies and medication through the Non-Insured Health Benefit Program of Indigenous Services Canada. Visit their website for eligibility criteria and benefit details [Non-insured health benefits for First Nations and Inuit \(sac-isc.gc.ca\)](https://sac-isc.gc.ca).
- Métis persons:
 - The Alberta Aids to Daily Living Program provides coverage for basic medical equipment and supplies. This is a cost-share program but low income individuals may be eligible for cost share exemption. Visit [Alberta Aids to Daily Living \(AADL\) | Alberta.ca](https://alberta.ca) for more information on benefit details.
 - Drug coverage is available for Métis seniors through the Government of Alberta's Alberta Blue Cross program. Visit [Seniors health benefits | Alberta.ca](https://alberta.ca).
 - Drug coverage is available for Métis adults who are covered by the Assured Income for Severely Handicapped (AISH) Program. Visit [Assured Income for the Severely Handicapped \(AISH\) | Alberta.ca](https://alberta.ca) for information on this program.

The cost of medical supplies, equipment and medication, that are not covered by the programs listed above, are the responsibility of the individual.

Long-Term Care:

In long-term care, the contracted provider is responsible for providing routine dressings/bandages, incontinence supplies, medical supplies and drugs (some exclusions apply). Other supplies and equipment would be funded as above.



APPENDIX D

Accommodation Charges and Financial Assistance

1. Accommodation Charges

In Alberta, residents of long-term care and supportive living pay an accommodation charge to the contracted provider (facility operator) to cover the cost of accommodation-related services, such as meals, housekeeping and routine building maintenance. The maximum accommodation charge is set by Alberta Health for designated supportive living and long-term care. Each July 1st, these charges are increased, based on the percentage increase of the Alberta Consumer Price Index.

For details and more information, visit [Continuing care – Accommodation charges | Alberta.ca](#)

Depending on financial resources, the Indigenous Community may decide to subsidize the operational funding for supportive living or long-term care, rather than charging residents the full accommodation fee. First Nation and Métis Settlement members may be eligible for the following financial assistance programs through the Government of Alberta that would assist with their continuing care accommodation charges.

2. Financial Assistance for Disabled Adults Living in Care:

Assured Income for the Severely Handicapped (AISH)

- Provided for adults 18-64 years of age, with a severe, permanent handicap that limits their ability to earn a living. Eligibility is dependent on meeting income and asset criteria.
- Provides a monthly modified living allowance consisting of a personal allowance and an accommodation rate to assist clients living in a facility.
- Status Indians are not eligible for the health benefit portion of AISH but may be eligible for the other benefits.
- Visit [AISH eligibility | Alberta.ca](#) for more information.

3. Financial Assistance for Seniors (Elders) in Care:

Alberta Seniors Benefit (ASB)

The ASB program provides monthly income supports to eligible Alberta residents 65 years of age or older. First Nations seniors whose annual income is within program thresholds are eligible to receive a benefit from the Alberta Seniors Benefit (ASB) program. The maximum benefit available will differ depending on whether a senior lives on or off-reserve. The maximum benefit amount available from the ASB program is described on the Seniors and Housing website at [Alberta Seniors Benefit | Alberta.ca](#). An eligible senior living on-reserve (in a home setting or a lodge) is considered under the “Other Residence” category.

Approximately three months before turning 65, individuals will normally receive an information package about the benefits available to seniors from Alberta Health. The Seniors Financial



Assistance application included in this package must be completed to provide consent to verify annual income with the Canada Revenue Agency and to enroll them in the ASB program.

Visit [Alberta Seniors Benefit | Alberta.ca](#) for more information.

Supplementary Accommodation Benefit (SAB)

The SAB is intended to assist seniors with low income who reside in long-term care and designated supportive living facilities with their monthly accommodation costs. The maximum SAB available is \$695 per month. Eligibility for SAB is reviewed annually according to any changes to accommodation charges and is calculated based on previous year's total income (combined total income for couples). The amount received will vary depending on each individual's reported income. Average SAB is currently \$495 per month.

SAB is in addition to any ASB received and is calculated to ensure a senior has at least \$315 in disposable income each month after paying room, meals and housekeeping charges. Maximum monthly SAB is reviewed annually based on any changes to accommodation charges and is calculated based on total income (line 150) from the previous year's tax return.

Other Financial Assistance

Low-income seniors who reside in a lodge or supportive living facility may also be eligible for assistance with health and personal supports through the *Special Needs Assistance for Seniors* program. Visit [Special Needs Assistance for Seniors | Alberta.ca](#) for details.

4. Seniors Lodge Program

The Seniors Lodge Program offers single and double bed/sitting rooms, meals, housekeeping and other services and recreational opportunities for seniors who are functionally independent with or without the help of existing community-based services.

Lodges receive funding under the *Lodge Assistance Program Regulation*.

Local Housing Management Bodies (HMB) are responsible for lodge management and tenant selection. Applicants are prioritized, by basis of need. Taking into consideration housing needs, level of support required and the applicant's income. In some cases, applicants must also meet local residency requirements.

Lodge rates are set by the local HMB, so they may vary between regions. To protect lower income residents, HMBs must adjust the monthly rate to ensure that each resident has at least \$315 per month in disposable income.

For information on the Seniors Lodge Program and other types of affordable housing, visit [Affordable housing programs | Alberta.ca](#)



APPENDIX E

Canada Mortgage and Housing Corporation (CMHC) Funding Options

First Nations

CMHC, in partnership with Indigenous Services Canada, has affordable housing programs and funding initiatives specifically for First Nations communities. CMHC does not provide funding for the construction or operation of health facilities but there may be opportunities to access funding for affordable or mixed-use housing in the community, which could be co-located with a health facility.

CMHC programs and funding are subject to change periodically. For more information on First Nations funding opportunities, visit

[Funding Programs for New Construction and Renovation Projects | CMHC \(cmhc-schl.gc.ca\)](https://cmhc-schl.gc.ca)

Contact a CMHC First Nations Housing Specialist for Alberta at 780-670-2538:

[Indigenous and the North Housing Solutions \(cmhc-schl.gc.ca\)](https://cmhc-schl.gc.ca)

First Nations On-Reserve Renovation Programs

CMHC funding is available to support elders and individuals with disabilities with accessible home modifications to enable them to live in their own homes.

- Residential Rehabilitation Assistance Program for Persons with Disabilities (RRAP-D) On-Reserve (up to \$60,000 for home modifications, may be a forgivable loan if criteria are met) [Residential Rehabilitation Assistance Program for Persons with Disabilities \(RRAP-D\) \(cmhc-schl.gc.ca\)](https://cmhc-schl.gc.ca)
- Home Adaptations for Seniors Independence (HASI) Program On-Reserve (up to \$10,000 for age-related home adaptations, may be a forgivable loan if criteria are met) [Home Adaptations for Seniors' Independence | CMHC \(cmhc-schl.gc.ca\)](https://cmhc-schl.gc.ca)

Métis Settlements

For information on CMHC programs for Metis Settlements, contact:

CMHC – Alberta Regional Office

Telephone: (780) 423-8700

For information on the National Housing Strategy and Indigenous housing, visit

[National Housing Strategy | A Place to Call Home](https://cmhc-schl.gc.ca)



APPENDIX F

Band Council Resolution Template

The following is a sample template that can be adapted for a Continuing Care Band Council Resolution:

Band Council Resolution

Insert name of First Nation

Date

Province of Alberta

WHEREAS the _____ First Nation Chief and Council are in full support of entering into a Master Services Agreement with Alberta Health Services with respect to *type of service (i.e., supportive living or long-term care)* services at *name of facility/location*.

WHEREAS the __ First Nation Chief and Council are in full support of granting access to Alberta Health Services employees and agents to *name of facility/location*, located on lands described as *legal land description*, and the facility known as *name* for the purpose of performing the terms and conditions of the Master Services Agreement.

AND WHEREAS a quorum of Council affirms that the intended purpose of the Master Services Agreement and the granting of access to Alberta Health Services employees and agents are for the general welfare of the band and the betterment of continuing care and health services.

THEREFORE, BE IT RESOLVED that _____ First Nation Chief and Council is hereby authorized and approved to sign the Master Services Agreement and any agreements or documents ancillary to the Master Services Agreement or the *type (i.e., supportive living)* services.

THEREFORE, BE IT RESOLVED that _____ First Nation Chief and Council are hereby authorized and approved to grant access to Alberta Health Services employees and agents to *name of facility/location*, located on the lands described as *legal land description* to perform the terms and conditions of the Master Services Agreement or the *type (i.e., supportive living)* services.



APPENDIX G

Licensing, Standards and Quality

Licensing

In Alberta, supportive living settings with four or more adults must be licensed under the *Supportive Living Accommodation Licensing Act*. Operators of long-term care must obtain a certificate if they have a contract with AHS for the provision of long-term care services. Accommodation standards must be met in order to be licensed or receive a certificate.

Refer to the Alberta Health website for more information:

[Continuing care accommodation and health service standards | Alberta.ca](#)

Standards

In Alberta, the Government (Alberta Health) has developed mandatory provincial standards for both accommodation and health services for home care, supportive living and long-term care. The purpose of these standards is to ensure a minimum level of quality, as well as safety, for residents.

1. *Supportive Living and Long-Term Care Accommodation Standards*

- Supportive living and long-term care operators must be compliant with these standards, as required under the *Supportive Living Accommodation Act* and the *Nursing Homes General Regulation*.
- Standards address the accommodation and related services, such as building cleanliness, maintenance, food preparation and laundry.
- Licensing inspections are conducted annually by Alberta Health staff.

Supportive Living and Long-term Care Standards: [Continuing care accommodation and health service standards | Alberta.ca](#)

Alberta Continuing Care Health Service Standards

- These standards address the publicly funded basic health and personal care services (apart from home care services funded by Indigenous Services Canada) provided by nurses, health care aides, and other health care professionals.
- According to the AHS Policy *Continuing Care Health Service Standards Compliance Audit*, AHS will “monitor, audit and support compliance to the Alberta Health *Continuing Care Health Service Standards* for all publicly funded continuing care services to ensure that standards are met”. These audits occur at a minimum of every two years for each site.
- For more information on the Continuing Care Health Service Standards visit the Alberta Health website: [Continuing care accommodation and health service standards | Alberta.ca](#)



2. Accreditation

Accreditation is a mandatory requirement for supportive living, long-term care facilities and home care providers in Alberta. This process ensures that providers are operating with continuous quality improvement, resident safety and person-centred care. The continuing care operator would contract an accreditation service provider, who will visit the facility to see if standards are being met and make recommendations for improvement. This occurs on a regular time frame, determined by the accreditation body. (The standards are not the same as the Continuing Care Health Service Standards.) Ask your Seniors Health zone contacts for a list of approved accrediting organizations.

3. Quality Indicators

In Alberta, quality indicators help us measure the quality of care across several keys areas of continuing care. Data is gathered using the interResident Assessment Instrument (RAI). For supportive living, the interRAI Home Care (RAI-HC) tool is used and long-term care uses the interRAI MDS 2.0 (RAI-MDS 2.0). Visit [interRAI | Improving Health Care Across The Globe](#). Assessments are done when the resident moves into continuing care and then on a regular basis, or if there is a significant change in health status. The information from the RAI helps to determine the care needs of the resident. Data on quality indicators collected from the RAI may be shared with the Canadian Institute for Health Information (CIHI), which collates the information and produces annual reports on the health system and the health of Canadians. For more information, visit [Canadian Institute for Health Information | CIHI](#).

Refer to the AHS website for more information on current continuing care quality indicators [Continuing Care Quality | Alberta Health Services](#).

The **Health Quality Council of Alberta (HQCA)** gathers and analyzes information, monitors the healthcare system and collaborates with Alberta Health, AHS, health professions and other stakeholders to translate that knowledge into practical improvements to health care quality and patient safety in the healthcare system. They have developed the *Alberta Quality Matrix for Health* as a way of visualizing how dimensions of quality and areas of need might intersect and assist in strategic planning. To view the Matrix, visit [The Alberta Quality Matrix for Health - HQCA](#).

HQCA periodically conducts surveys of home care, long-term care and supportive living clients and families in order to report on their experience and degree of satisfaction with services. For more information on these surveys, and for other healthcare provider resources, visit [Home - HQCA](#).



APPENDIX H

Staffing

The Indigenous Community will need to determine how their continuing care centre will be staffed with respect to the number and type of health care staff. This will be determined in part by what level of services have been agreed upon (i.e., DSL or LTC), government regulations, local resources, traditional wellness services and operational funding. AHS will work with you to help determine your staffing needs.

Funding for designated supportive living is currently based on the *Interim Provincial Model*, which calculates funding based on a ratio of paid hours of care, type of care provider and the number of beds. The level of designated supportive living also determines staffing requirements.

- DSL3: Health Care Aide on site 24/7. Registered Nurse available on-call.
- DSL4/4D: Health Care Aides and Licensed Practical Nurse(s) on site 24/7. Registered Nurse available on-call.

The Government of Alberta *Nursing Homes Operation Regulation* outlines the minimum staffing requirements of nursing and personal services staff for long-term care facilities. This includes:

- At least one nurse (i.e., registered nurse [RN], registered psychiatric nurse [RPN], or certified graduate nurse [CGN]) on duty at all times. If the nurse on duty is an RPN, then a CGN or RN must be on-call.
- At least two members of nursing and personal services staff on duty at all times.
- Provide an average of at least 1.90 paid hours of combined nursing and personal services per resident, per resident day.
- At least 22% of the total number of paid hours of combined nursing and personal services required is provided by RNs, RPNs or CGNs.
- Refer to Sections 12-14 of the Regulation for specific staffing requirements.
- To view the Regulations, visit [1985_258.pdf \(alberta.ca\)](#).

AHS has an operational funding formula, called *Patient/Care Based Funding (PCBF)*, for long-term care services. This includes funding for staff, equipment and supplies and excludes accommodation and capital funding. This funding formula is based on the assessment of the intensity of care/resource utilization for each resident.

AHS staff may provide professional consults and allied health services (i.e., physical therapy, occupational therapy), depending on the availability of these professionals in your region and AHS zone resources.



APPENDIX I

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- Métis Settlements General Council Health Board
- Joint Action Health Plan Continuing Care Subgroup
- Continuing Care in Indigenous Communities Working Group Members:

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		Debbie Halverson, Program Manager, Quality and Planning, Continuing Care
		Lori Little, Director, Facility Living
	Central Zone	Ellen Short, Capacity Coordinator, Seniors Health
		Lori Sparrow, Executive Director, Seniors Health
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