

# First Nations Advisory Committee

**Home and Community Care in First Nations Communities in Ontario**

**FINAL REPORT**

**June 2, 2017**

# First Nations Advisory Committee

## Home and Community Care in First Nations Communities in Ontario

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## INTRODUCTION

In many First Nations communities, particularly in northern Ontario, accessing a variety of timely and adequate home and community care services remains challenging. Disparities in the availability of services for First Nations people results in unequal access to care. Communities require adequate health clinics and access to medical professionals and health care providers in their homes and in the community. Many First Nations people have to travel to hospitals hundreds of kilometers from their families to receive services not specifically designed for First Nations patients, which impact their health outcomes and quality of care.

Providing improved services in a culturally safe way close to home is the key objective for the committee tasked with developing this report. The purpose of this report is to describe the specific home and community care needs of First Nations communities and make recommendations to support new initiatives with the province of Ontario investments that complement and enhance existing services.

### Ontario's First Nations Health Action Plan

In May 2016, the Ontario government announced an investment of nearly \$222 million over three years, "...To ensure Indigenous people have access to more culturally appropriate care and improved outcomes."<sup>1</sup> The initial investment will be followed by sustained funding of \$104.5 million annually to address health inequities and improve access to culturally appropriate health services over the long term.

"Ontario's First Nations Health Action Plan, which will be implemented and evaluated in close partnership with Indigenous partners, includes initiatives in primary care, public health and health promotion, seniors' care, hospital services, and life promotion and crisis support."<sup>2</sup> "While focused on northern First Nations, the plan also includes opportunities for investments in Indigenous health care across Ontario."<sup>3</sup>

As part of the seniors' care component of Ontario's First Nations Health Action Plan, "...The province will continue to work with Indigenous partners to invest \$25 million over

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<sup>1</sup> Ontario Launches \$222 Million First Nations Health Action Plan:  
<https://news.ontario.ca/mohltc/en/2016/05/ontario-launches-222-million-first-nations-health-action-plan.html>

<sup>2</sup> Ontario Launches \$222 Million First Nations Health Action Plan:  
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three years and \$14 million ongoing in home and community care.”<sup>4</sup> Enduring collaboration will ensure that these investments are culturally appropriate, safe and effective.

“Investing in the health and wellness of Indigenous communities is one of many steps on Ontario's journey of healing and reconciliation with Indigenous peoples. It reflects the government's commitment to work with Indigenous partners, creating a better future for everyone in the province. It is also part of the government's plan to build a better Ontario through its Patients First: Action Plan for Health Care, which provides patients with faster access to the right care; better home and community care; the information they need to live healthy; and a health care system that is sustainable for generations to come.”<sup>5</sup>

### **First Nations Advisory Committee**

The investment designated for home and community care through Ontario's First Nations Health Action Plan includes funding to work with First Nations partners to expand home and community care services. To facilitate engaging communities, the Ministry of Health and Long-Term Care and the Chiefs of Ontario have worked together to form the First Nations Advisory Committee.

The mandate of the committee is to lead the development of recommendations to improve home and community care services, including palliative care, for First Nations communities on reserve across the province. Recommendations will be submitted to the Ontario Regional Chief, the Political Confederacy and the Minister of Health and Long-Term Care.

The Advisory Committee includes representatives appointed by the Ministry of Health and Long Term Care, the Chiefs of Ontario and each of the First Nation Provincial-Territorial Organizations, including: the Association of Iroquois and Allied Indians, Union of Ontario Indians (Anishinabek Nation), the Independent First Nations, Grand Council Treaty #3, Nishnawbe-Aski Nation, and the Six Nations of the Grand River.

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<sup>4</sup> Ontario Launches \$222 Million First Nations Health Action Plan: <https://news.ontario.ca/mohltc/en/2016/05/ontario-launches-222-million-first-nations-health-action-plan.html>

<sup>5</sup> Ontario Launches \$222 Million First Nations Health Action Plan: <https://news.ontario.ca/mohltc/en/2016/05/ontario-launches-222-million-first-nations-health-action-plan.html>

The committee met multiple times by teleconference and in-person beginning in October 2016 to identify the needs of First Nations communities. The themes and recommendations included in this report reflect the discussions and conclusions of the committee. It is noted that many communities have existing home care service delivery infrastructure funded by the federal government and that some have access to services funded by the Province of Ontario or by Local Health Integration Networks (LHINs). A small number of First Nations communities have access to services provided by Community Care Access Centres (CCACs) (or LHINs, after the implementation of the *Patients First Act, 2016*)<sup>6</sup>. It is also noted that the priorities of communities vary based on existing investments and population needs.

The following section of the report includes the guiding principles that supported the work of the committee throughout its deliberations and will also inform the new investments. The next section provides an overview of the key themes and recommendations of the committee. There are seven themes that are informed by the experiences of First Nations communities and by the guiding principles. Community services profiles are included throughout the presentation of the themes. The profiles describe some existing services and successful approaches to home and community care in select First Nations communities. They are not intended to reflect the services in all communities or service delivery that could work in all communities. The report concludes with the next steps for home and community care enhancements through Ontario's First Nations Health Action Plan.

### **Recommendations in the Report**

The recommendations in this report are aligned with the Truth and Reconciliation Commission's Calls to Action and the articles in the United Nations Declaration on the

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<sup>6</sup> Between May 1 and June 30, 2017, CCAC services will be transitioned to LHINs and CCACs will no longer be operational organizations. For this reason, the term "CCAC/LHIN" is used throughout this report.

### **Key Terms**

Throughout this report, the term "home and community care services" generally refers to:

- Home care services: Provided in homes, schools and other community settings and includes nursing, personal support services, homemaking, and other professional services such as rehabilitation therapies; and
- Community support services: Additional supports that help people live in the community independently and safely such as meal services, transportation, caregiver supports, social/recreation services and others.

Palliative care is identified as its own suite of services and is defined on page 15 as an approach that improves the quality of life of patients and their families facing the problems associated with life limiting illness through the prevention and relief of suffering.

Rights of Indigenous Peoples. (See the appendix for full text of the Truth and Reconciliation Calls to Action and United Nations Declaration that informed this report.)

The recommendations are intended to guide provincial investment through Ontario's First Nations Health Action Plan. They are also intended to inform ongoing co-development of programs and initiatives by the ministry and First Nations and to inform planning and initiatives to strengthen home and community care by First Nations communities.

An important objective of this committee is to ensure that Ontario's First Nations Health Action Plan initiatives for home and community care complement existing services. Initiatives should enhance service delivery rather than duplicate or replace existing services. The recommendations are not intended to signal any change in roles and responsibilities of CCACs/LHINs or the federal government in funding and/or delivering services. The committee recognizes that changing the model of service delivery is the scope of government-to-government discussions.<sup>7</sup>

### Existing Programs and Services

The provincial and federal levels of government each provide funding for home and community care services.

- Home care and community care services are funded by the province of Ontario to address the needs of people of all ages – seniors, frail elderly, persons with physical disabilities and chronic diseases, children and others – who require ongoing health and personal care to live safely and independently in the community. These are delivered or funded by LHINs (and CCACs up to the transition under the *Patients First Act, 2016*) and include community support services, homemaking services, personal support services and professional services such as nursing.
- Ontario also funds homemaking and nursing services through a cost-shared, claims-based program that enables First Nations and municipalities to purchase homemaking and nursing services from contracted agencies, or who are directly

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<sup>7</sup> In a letter to Ontario Regional Chief Day on December 21, 2015, the Minister of Health and Long-Term Care stated, "As Ontario's health care system evolves, we have an opportunity to configure transformative change for First Nations' Health in Ontario in partnership with First Nations. The recent Political Accord between First Nations and the Government of Ontario provides important guidance to our work moving forward. Building and maintaining productive and respectful working relationships will be critical. As we begin this conversation I want you to know that I am open to exploring a wide range of possible approaches to ensure that the voices of First Nations are heard in the planning and delivery of health care for your communities." The ministry continues to work with First Nations Leadership to identify the appropriate relationship processes to discuss potential system-level changes to configure transformative change for First Nations' health. The ministry is also supporting the Chiefs of Ontario to develop a First Nations Position Paper on Health focused on achieving transformative change. This Position Paper will be informed by engagement with First Nations.

employed to support elderly people, persons with disabilities and some families in crisis in their communities.

- The First Nations Home and Community Care Program (FNIHB) was established in 1999 by Health Canada in order to provide basic home and community care services. The program is intended to provide services to patients of any age and who live on a First Nations reserve. FNIHB services are culturally sensitive, accessible, effective, and equitable to that of other Canadians, and responsive to the unique health and social needs of First Nations. First Nations home and community care services consist of structured client assessment, case management, home care nursing services, home support services, provision or access to in-home respite, access to medical equipment and supplies, information and data collection, management and supervision, and established linkages with other services.

Many First Nations communities have their own service delivery infrastructure that is culturally safe and available on reserve. First Nations communities deliver nursing services, personal support worker services, case management, palliative care, spiritual health, emotional/mental health, aging at home for seniors, medical equipment and supplies to support care, and technology-based health services.

## GUIDING PRINCIPLES

*The Guiding Principles below are largely reflective of the 1994 document “Aboriginal Health Policy for Ontario” prepared by the Ministry of Health, the Chiefs of Ontario, the Association of Iroquois and Allied Indians, Grand Council Treaty #3, Nishnawbe-Aski Nation, Union of Ontario Indians, Ontario Federation of Indigenous Friendship Centres, Ontario Métis Aboriginal Association, Ontario Native Women’s Association, Six Nations of the Grand River Territory, and Walpole Island First Nation. They have been reviewed and adapted to support the work of this committee.*

1. Nothing in the discussions or in this report suggests either directly or by implication the consent of the First Nations communities to any amendment in the meaning and intent of their original treaties or First Nations rights or to any measure that would constrain or prevent the full implementation of their treaties or First Nations rights.
2. A holistic approach, through all developmental stages of life, will guide home and community care programs and services. First Nations communities have diverse needs pertaining to their cultures, traditional ways, languages, lifestyles, geographic locations and status. Flexible policies, programs and services are required to respect and address First Nations diversity.
3. Traditional First Nations approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system, including home and community care.
4. Addressing First Nations health determinants in a holistic manner will require coordination and collaboration between First Nations communities and federal and provincial government ministries.
5. Any provincial investment in or provision of services by the government of Ontario is intended to complement but not replace investment in or provision of services by the federal government.
6. First Nations people must have input into home and community care planning and resource management processes pertaining to First Nations polices, programs and services.
7. To realize the goal of improving First Nations home and community care, effective co-ordination of all health services is required.



- 8.** Equitable access to provincial home and community care services must be assured for all First Nations people living on reserve.
- 9.** Technology-facilitated access to care is essential for First Nations communities.
- 10.** A First Nations person's choice of services will be acknowledged and respected.
- 11.** First Nations communities' partnership with the provincial government in home and community care needs assessment, planning, design, development and delivery of community-based health programs and services is essential to improving First Nations health. First Nations people will define and negotiate the level of their participation in the governance of home and community care programs and services available to and accessed by their communities.
- 12.** Accountability processes require assessment of program effectiveness and financial expenditures with annual reports to First Nations people and governments.
- 13.** The interrelationship between the environment and individuals, families and communities, as well as protection of the environment, is essential to the survival of all First Nations people.
- 14.** First Nations communities and Ontario will continue their collaborative relationship, which will include joint and regular review and evaluation of Ontario's First Nations Health Action Plan home and community care initiatives to ensure they continue to meet the needs of all First Nations communities.
- 15.** New investments in home and community care are guided by Jordan's Principle, which is an interim approach designed to address the health and social needs of First Nations children with an ongoing disability affecting their daily living or for those with a short-term issue where there is a critical need for health or social services.

## KEY THEMES AND RECOMMENDATIONS

### Theme #1 – Integration & Seamless Coordination of Care

The committee discussed enhancing home and community care services by developing closer connections between key components of the health care system and delivering culturally safe services within the context of the circle of care.

Committee members noted that First Nations communities would be well-served by a client-centred, multi-disciplinary, and holistic circle of care approach to service delivery. This involves service care planning with the patient, the family, and the community as the core client supported collectively by the entire care team from all relevant health care services.

Often this does not occur and First Nations patients do not get the adequate and timely support they need. Committee members indicated that the relationship between care teams varies. In some communities, there are formal governance models in place to conduct care planning and monitor service delivery, while in others, collaboration does not occur and new relationships and services could be established. A key priority and requirement for improving care is developing a formal connection between Health Directors and/or community caregivers in communities and primary care nurses. Collaboration with existing Aboriginal Health Access Centres, other Indigenous primary care and inter-professional care practices, Tribal Councils and Health Authorities should also be encouraged where appropriate.

The committee acknowledges that co-location of care teams can improve collaboration and consideration should be given to encourage co-location when possible. Where co-location is not possible, community-based professionals and health care providers may be preferred by some communities.

First Nations patients are served most effectively when the relevant health care providers work with each other, the community, patients and families to address the health care needs of patients in a way that acknowledges the specific cultural approaches to care of First Nations.

### Capacity Building

One of the most significant challenges is securing additional professionals and health care providers such as care coordinators, nurses and personal support workers. Many communities cannot attract and retain full-time professional staff and health care providers. First Nations communities report that jobs with wages that attract new staff are not available, primarily due to a lack of funding.

Another specific retention issue includes travel-related stress and fatigue for professionals and health care providers serving multiple remote communities.

Also, for many First Nations communities, building capacity for more front-line service providers requires additional physical space, transportation, office infrastructure and equipment to accommodate existing and additional staff.

### Theme #1 Recommendations

1. The province should provide ongoing additional funding for the enhancement of home and community care services, including palliative care in First Nations communities. This funding should support more front-line health care providers such as nurses, case managers, care coordinators, personal support workers and homemakers, including consistent access to clinical supervision.
2. The province, First Nations and care partners should encourage the integration of care provider teams to the benefit of First Nations home care clients. This includes identifying strategies to encourage collaboration among primary care and home and community care providers, including among federally and provincially-funded care providers so that the needs of patients are collectively identified and comprehensive care can be provided.
  - The province should work with the federal government and First Nations to strengthen communication between federal primary care nurses and home and community care staff and/or other health care providers as determined in the community.
  - The province should work with LHINs to review home care procurement guidelines for obstacles to First Nations service providers providing home and community care services.
3. Provincial investment should include the flexibility for First Nations communities to provide compensation to attract and retain home and community care professionals and health care providers.
4. First Nations communities should inform spending decisions with a community-based and community-owned assessment (either recent or new) of existing capacity, needs, opportunities and/or risks.

## WALPOLE ISLAND: COMMUNITY SERVICES PROFILE

The goal of Walpole Island's home and community care service is to promote independence and allow clients to live in their own home as long as possible while receiving care.

Walpole Island has an Intense Case Management model that is holistic, community-based and client focused. The model provides as much or as little intervention as clients need based on their unique circumstances. It includes the following key features:

- Service delivery and a client care plan are based on identified needs rather than eligibility criteria
- Initial assessment is completed by an experienced Registered Nurse
- The Registered Nurse identifies client needs and develops a client care plan
- An appropriate case manager is identified and assigned
- Complex clients are managed by the Registered Nurse
- Clients with more simple service needs may be case managed by the Supportive Counsellor or the personal support worker
- Any changes in condition or circumstances are reported to the Registered Nurse and the client is re-evaluated
- Regular reassessment every 3 – 6 months

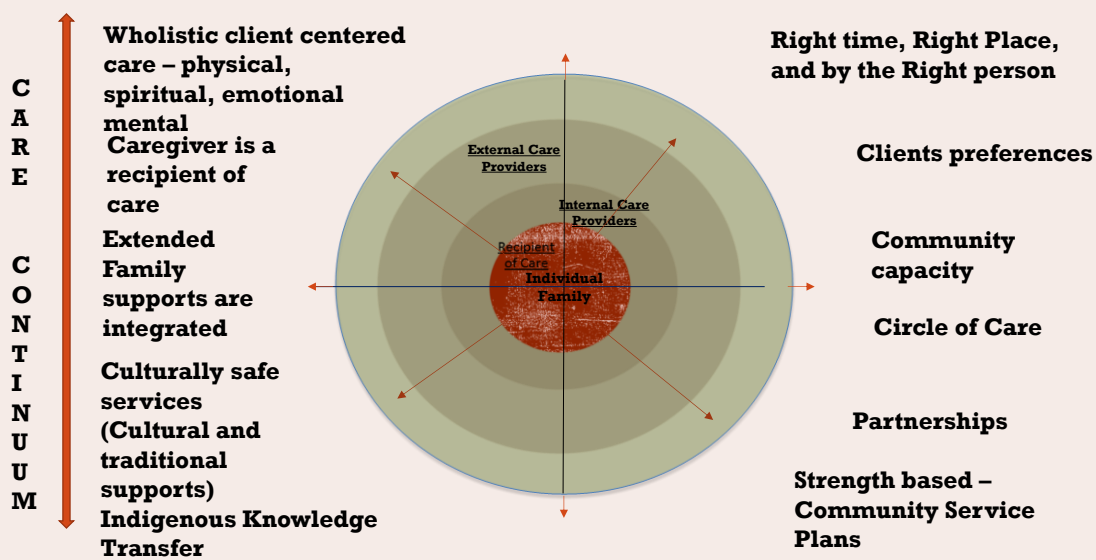
Positive client outcomes include improved overall health, increased self-esteem, harm reduction due to decreased use of drugs and alcohol, improved financial status and an overall sense of wellness.

Positive system outcomes include reduced costs for home support services, reduced visits to the emergency department and hospital admissions, reduction in missed medical appointments, improved communication, appropriate allocation of healthcare resources, minimizing diagnostic testing and decreased costs for medications.

## ALGONQUINS OF PIKWAKANAGAN: COMMUNITY SERVICES PROFILE

The Algonquins of Pikwakanagan deliver services specifically designed for aging First Nations seniors in their communities. The program is informed by research into community needs for seniors and a community service plan for patients that connects primary care, home care, CCAC services and families.

Services are culturally appropriate for First Nations patients and are based on the circle of care and the following care continuum:



## Theme #2 – Discharge Planning

Improving discharge planning is an important priority for committee members. In many communities, there needs to be sufficient communication and information sharing between hospitals and home and community care teams to plan for patients transitioning to or returning to home care. Too often, this does not occur and the community finds itself unprepared to provide adequate services to support patients' needs.

There are some service features that have been identified by the committee as important for improving discharge planning:

- Formal relationships with hospital discharge planners, including an open channel of communication that begins as soon as the patient enters a hospital.
- One community develops a discharge care plan for patients supported by a care team that includes hospital, primary care and home care representatives to help to ensure an easier transition for patients. This includes the specific involvement of home and community care services.
- Intake services available 24 hours/day so that patients can transition to communities after hours.

However, these services are currently not available to many First Nations patients. The committee indicated that many communities require more integrated discharge planning, transition supports outside of regular working hours and timely access to medical equipment and devices. Often hospitals will connect with CCACs to share a discharge plan, but that information is not delivered to the community.<sup>8</sup> Many communities would prefer that their Health Directors become the recognized first point of contact for discharge planning for First Nations patients.

Also, there are instances where privacy concerns may obstruct coordinated service planning often to the detriment of the patient. In cases such as these, there may be very little communication and information sharing between care teams. This is a particular concern in challenging circumstances such as when family support does not exist for patients close to home.

By working closely with hospital and primary care teams, home and community care services in First Nations communities will be able to more effectively plan for the arrival and care of patients returning home. Patients will have quicker access to services and necessary equipment and advanced planning for their safety and care.

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<sup>8</sup> See Theme Six of this report for more context on First Nations communities and CCACs.

## Theme #2 Recommendations

5. The ministry should provide direction to LHINs and hospitals to work with First Nations to improve discharge planning, including establishing a formal communication process with First Nations home and community care services.
6. First Nations patients should have a discharge plan that includes input from hospitals and provincial and federal health care providers from First Nations communities as well as CCACs/LHINs as needed. When possible, planning should begin when patients enter the hospital.
7. Provincial investment should include opportunities to enhance home and community care services to support discharge services at non-regular working hours, including evenings and weekends.

### **Theme #3 – Palliative Care**

Palliative care refers to an approach that improves the quality of life of patients and their families facing the problems associated with life limiting illness through the prevention and relief of suffering.<sup>9</sup> Specifically for First Nations, Inuit and Métis people, palliative care also means “comfort care”:

- Kind, compassionate care that is given with understanding and respect
- Care that relieves a person’s pain and symptoms for the best quality of life
- Care that honours a person’s spiritual beliefs, traditions and customs
- Care for the whole person and support for the whole family.

Committee members noted that the availability of palliative services varies widely between First Nations communities, with some having little or no access to palliative services and others with more established levels of support and services.

Committee members discussed options to provide and improve palliative care in First Nations Communities through enhanced health human resources, support for patients and caregivers and residential hospices. This included the Improving End-of-Life Care in First Nations Communities research project at Lakehead University, which promotes the development of palliative care capacity in First Nations communities.<sup>10</sup>

#### **Enhanced Health Human Resources**

The committee suggested providing health human resources for 24/7 care from nurses and personal support workers, including e-shift. The committee also suggested providing more training opportunities in local First Nations communities to reach more health care providers and support broader community involvement.

#### **Building Community Capacity through Palliative Care Training**

Palliative and end-of-life training for First Nations health care providers should focus on building capacity and understanding the specific cultural context and terminology associated with palliative care. For example, Advance Care Planning to support end-of-life care wishes is a complex concept that is governed by different laws regarding informed consent and substitute decision making. As part of this, First Nations communities have noted that it is important to increase understanding of legal systems and roles and responsibilities in preparing for end-of-life (e.g., who can legally be a substitute decision maker and when informed consent is needed for end-of-life care wishes). In addition, First Nations communities have different cultural and spiritual

<sup>9</sup> See: <https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=325087>

<sup>10</sup> See: <http://eolfn.lakeheadu.ca/> for more information about the project.



beliefs that are important considerations in discussions about end-of-life care. This requires First Nations communities to find common ways of appropriately discussing concepts about end-of-life care planning and agreed upon vocabulary in relevant languages.

### **Support for First Nations Patients and Caregivers**

Palliative care in First Nations communities is delivered inconsistently. CCACs and federally-delivered health care providers have different standards for determining when patients are eligible for palliative care, which results in inconsistent approaches within communities. Committee members noted that many patients often require palliative care services prior to being determined eligible given the definition of palliative care is linked to being in the last stages of life. Additional work is required to determine how First Nations patients should be assessed and when they receive palliative care.

The committee addressed the need for more respite care services to support families and community members who provide 24/7 care for patients who are receiving palliative care at home. Committee members also recognized that providing palliative care at home requires flexibility and consideration of housing needs, including long-term care homes or congregate living, as well as the importance of ensuring that specialized services, equipment, training and supports are made available on short notice in the patient's home. The committee also noted that supports for patients and families who must leave their communities to access palliative and/or respite care should be considered. These supports include funding of caregiver/provider travel through non-insured benefits when accompanying patients, enabling cultural ceremonies related to end-of-life and building on existing best practices in palliative care.

The approach to palliative and end-of-life care in First Nations communities includes aftercare, bereavement and spiritual care. Training and services available to First Nations communities should reflect these important components, including allowing for adaptations to First Nations traditions and models of aftercare.

In addition, to support communities in providing end-of-life care at home, the development of protocols with the police and coroner are encouraged. In many cases, the family and health care providers are restricted from entering the home after the death of patients for an investigation and declaration of death, which impacts aftercare and healing. The development of protocols could provide for alternative approaches in cases where end-of-life is predictable and approaching.

### ***Residential Hospice***

A residential hospice is a home-like environment where adults and children with life-threatening illnesses receive end-of-life care services<sup>11</sup>. Currently, many patients and their families must travel a distance from First Nations communities to access Residential Hospice services. The committee discussed the need for more First Nations hospice models in northern and southern communities and that decisions about where these should be located should be made with input from First Nations. There was also discussion of partnering with hospices to train First Nations volunteers in palliative care.

### ***Co-Location Model***

Committee members discussed that some First Nations communities are considering expansion of current Assisted Living or Long-Term Care facilities to include palliative care rooms and family relief space to accommodate families.

### **Patient Navigators**

Committee members acknowledged the important role that culturally safe Patient Navigators have in connecting patients and their families to culturally appropriate care, including palliative services. Patient Navigators provide a broad range of patient supports including support at clinic visits and hospital discharge planning; helping patients and families find services and communicate with doctors and nurses; arranging language and cultural translation services; and connecting with traditional healers.

### **Ontario Palliative Care Network**

The Ontario Palliative Care Network (OPCN) attended the February 2017 Advisory Committee teleconference meeting to share information about their role in supporting quality palliative care in Ontario. The OPCN is a partnership among Cancer Care Ontario, Ontario's LHINs, Health Quality Ontario and others, including members from diverse care settings and caregivers, clinical representatives and associations. It has a provincial mandate to support consistent, quality palliative care across the province. It was officially launched in March 2016 and its structure and mandate are evolving. The OPCN is aiming to ensure an equitable and inclusive approach to support First Nations communities in accessing culturally safe palliative care.

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<sup>11</sup>See the, "Environmental Scan for Strengthening Residential Hospice Care in Ontario, Report of the Residential Hospice Working Group March 2015" <http://www.hpco.ca/wp-content/uploads/Environmental-Scan-for-Strengthening-Residential-Hospice-Care-in-OntarioFINAL-March-16.pdf>

### Theme #3 Recommendations

8. The province and other care partners should provide flexible funding that supports culturally safe palliative and end-of-life care at home.
  - Support for palliative and end-of-life care should include aftercare, bereavement and spiritual care services, and respite care in and out of community.
  - First Nations communities should develop resources to help caregivers of First Nations patients understand the range of available palliative care services.
9. The province should continue to provide ongoing funding for palliative care training for health care providers and friends and family that supports traditional practices in First Nations communities. This includes training for culturally safe end-of-life Advance Care Planning.
10. The province and other health care providers should recognize there are different determinations of when a person is palliative, which impact service planning and delivery. The province and health care providers should review those determinations to inform a more consistent approach to accessing services and provide First Nations communities with the opportunity to determine which is most appropriate.
11. First Nations communities and the ministry should support a broader understanding of processes for dying at home, including understanding the role of the police and coroner.
12. The province and/or partners such as the OPCN should collaborate with First Nations communities to identify and support the implementation of flexible hospice models to address palliative care needs including co-location and models to support community members to remain at home.
13. The province and OPCN should encourage the LHINs to collaborate with First Nations leadership in their region to explore opportunities to address First Nations palliative care needs as part of the government's commitment to expand hospice capacity with up to 20 hospices across the province.

## SIX NATIONS OF THE GRAND RIVER: COMMUNITY SERVICES PROFILE

The Six Nations of the Grant River has established Shared Care Outreach Teams so that First Nations palliative care patients can receive palliative care at home if they choose.

Integrated and seamless shared care involves primary care providers forming a partnership of care with expert clinicians, including palliative care physicians, clinical nurses and psychosocial/bereavement counsellors.

Teams rely on partnerships throughout the region from Six Nations Long-Term Care and Home and Community Care, the CCAC, Red Cross Care Partners, Community Nursing Agencies, and pharmacies and laboratories.

Eligible patients include those:

- With a life threatening or chronic illness who could benefit from a palliative care approach, and
- Who can still be seeking curative treatments, but would benefit from pain/symptom management.

Patients continue to see their family physician for routine follow-up, tests and medications; however, a physician from the Outreach Team monitors for pain and symptom management.

The Shared Care Outreach Team model has resulted in a more formalized palliative care program in First Nations communities with 24/7 care and greater instances of First Nations patients receiving palliative care at home.

## Theme #4 – Training and Development

The committee has identified training and development of home and community care professionals and health care providers, particularly personal support workers and nurses, as an important area of focus to improve services, including palliative care. Skills development and training to ensure that services are culturally appropriate and safe are two of the most immediate training needs.

Some of the most common challenges in accessing training include securing funding to participate in courses, travel to training locations, and understanding when training and funding are available in order to undertake required planning. As a result, communities are reporting that professionals and health care providers do not get the opportunity to upgrade their skills and build communities of practice.

Another significant challenge is the timely approval of funding proposals to the ministry. First Nations communities often submit proposals and approval times are long and overlap with the start of training opportunities. Training opportunities are either missed or communities do not receive the financial support for the training provided.

The committee suggests that more funding be made available on a predictable basis to support access to training and developing more courses. Financial support could also be directed to developing more training opportunities in, or close to, more First Nations communities. Participation in locations away from their communities limits the number of participants that can take advantage of learning opportunities. Electronic delivery of training can be a good option; however, bandwidth quality and reliability is a concern in several communities. In-community training supports the development of care teams and the dissemination of knowledge.

Another potential focus could be to develop a mechanism for broadly distributing notifications of available training in key occupations in a format that is streamlined and accessible for care teams in communities. First Nations communities could benefit from regular updates of training opportunities with advanced notice.

The committee has noted that First Nations communities may be interested in collaborating on the development and delivery of new training opportunities – or building training networks between communities – if they can be tailored to their needs while supporting broad participation of home and community care professionals and health care providers.

Other opportunities include encouraging more people to bridge personal support worker careers from their existing experience, developing a network of mentors, self-care, building networks between care teams from First Nations communities and team building.

## Theme #4 Recommendations

14. The province should support the continued provision of training for culturally appropriate and culturally safe care for home and community care professionals and health care providers and service providers in First Nations communities.
  - The province should provide funding that enables timely, predictable access to training and development opportunities. The process for funding should enable communities to utilize training throughout the fiscal year. For example, proposals should be due in January, assessed by the end of March and funding should flow in April so communities can access training opportunities through the year.
  - Funding for training should support training and development for career advancement as well as knowledge/skills enhancement for First Nations home and community care professionals and health care providers who are located on reserve.
15. First Nations communities should determine how funding is directed to training and development based on their own priorities.
16. Communities of practice among First Nations home and community care professionals and health care providers should be encouraged and supported.
17. The province and First Nations should invite the federal government to a meeting bi-annually to share best practices and priorities for home and community care.

## Theme #5 – Data and Reporting

Committee members shared their experiences with data collection and reporting for health care services. There is a clear preference among committee members to ensure that any new data requirements associated with Ontario’s First Nations Health Action Plan funding align with – and build on – existing data systems. There are specific data systems that have been referenced by committee members as good models to assess and build on:

- The Ontario government’s data and reporting system for the Homemakers and Nurses Services Act, and
- The federal government’s First Nations and Inuit Home and Community Care program.

Aligning provincial and federal reporting requirements for similar services is preferred where possible.

Restructuring provincial data collection is a priority. First Nations communities would prefer data collection from LHINs to be less complex and focused on outcomes such as quality of care rather than activities and administration. Updating data collection and reporting procedures could also be considered as part of the transformative change referred to on page 5 (see footnote).

There may also be one-time opportunities to invest in specific systems and infrastructure in First Nations communities to enhance data collection and reporting capabilities. This investment opportunity should include the ability to purchase and update data software that is not currently available in many communities and capture additional outputs and outcomes data. Additional data collection or reporting requirements would also need to be supported by staff for administration. First Nations communities are already working bilaterally with the federal government on these issues with respect to the federal program.

An important aspect of data collection raised by the committee is determining ownership and storage of patient assessment data. While First Nations communities have a preference to own and store First Nations health data, Ontario requires data for program assessment and evaluation to inform future program development and investment. Data sharing agreements that acknowledge these perspectives will need to be considered.

Other data and reporting priorities identified by the committee include:

- Integrating assessment software with reporting and data requirements
- Ensuring support and central coordination for software procurement with basic and advanced functionality
- Training for staff to use systems
- Providing guidelines and support for completing reporting requirements, and

- Potentially developing First Nations' interRAI that is integrated with other data systems.

### Theme #5 Recommendations

18. The province should work with other funders and LHINs to review and streamline provincial and federal data and reporting requirements for home and community care services. The review of data collection must include First Nations communities in order to develop more relevant metrics to reflect the goals and objectives of the services they provide.
19. The province and the federal government should provide funding for data collection and reporting software that respects the principles of ownership, control, access and possession.



## Theme #6 – Clarification of Roles and Responsibilities

Throughout the committee's discussions, members have articulated different relationships between First Nations communities and Ontario government services available through CCACs. In some communities, a formal Memorandum of Understanding (MOU) exists that outlines negotiated roles and responsibilities. The MOUs are intended to ensure First Nations services and those provided by CCACs are complementary. In other communities, the First Nations service provider holds a CCAC contract. There are also many circumstances where the roles and responsibilities are not defined or where First Nations communities do not receive any CCAC services. There are also some communities interested in being more responsible for service delivery. However, overall there is confusion about the services that should be available in communities.

The committee reviewed the 2006 Client Services Policy Manual, which includes instructions for CCACs to deliver services in First Nations communities in a coordinated way:

### 2006 Community Care Access Centre Client Services Policy Manual Section 3.11 Services to First Nations Persons

#### Services to Persons Residing in First Nations Communities

Health and social services in First Nations communities are funded by both federal and provincial levels of government through the Federal Department of Indian and Inuit Affairs, Health Canada's Medical Services Branch and the Ontario Ministry of Health and Long-Term Care. The First Nations manage and deliver various health and social services such as healing centres, clinics offering medical services and some long-term care services for their members. The numbers and types of such services have been negotiated over time, under various initiatives and funding sources, and vary from community to community. Individuals residing in First Nations communities are eligible for CCAC services. CCACs must first assess whether these individuals require CCAC services if similar services are provided through the First Nations community. CCAC services should coordinate with and complement services available in the First Nations community rather than duplicate those services. To achieve this goal, CCAC staff need to be aware of the services available in First Nations communities within their service area. The CCAC may enter into formal agreements with First Nations or organizations representing First Nations (e.g., Union of Ontario Indians) in order to formalize a process that will facilitate and ensure that ongoing, effective linkages are maintained.

In addition to CCAC services, through the Federal FNIHB program, the federal government provides over \$20 million per year to First Nations communities to deliver services. Funding from the provincial government needs to complement these investments by building on existing service delivery infrastructure.

The committee's preference is to, where possible, clarify roles and responsibilities of CCACs, LHINs, federal programs and First Nations communities, with the objective of enhancing services and improving care. This clarification should be done in partnership between provincial and federal governments and First Nations. Governments and First Nations communities are encouraged to share and build on best practices such as the MOUs and identify opportunities to improve services where they are required.

The recommendations below recognize that the Minister has agreed to a collaborative process with First Nations regarding future and ongoing health care delivery to First Nations, which may include structural and funding changes to home and community care. These recommendations are intended to support First Nations objectives for home and community care prior to the completion of that government-to-government process.

### Theme #6 Recommendations

20. The ministry should confirm that CCACs, and after transition LHINs, along with the federal government and other home and community care programs, have a responsibility for home and community care in First Nations communities.
21. Recognizing that CCACs have often not fulfilled the responsibility to provide home and community care in First Nations communities, the ministry should immediately provide funding to promote equity of home and community care services among First Nations and between First Nations and other home care clients. This funding should be in addition to the existing allocation under Ontario's First Nations Health Action Plan.
22. The ministry and LHINs should ensure collaborative partnerships are in place with First Nations in the planning and delivery of home and community care. This should include visits to First Nations communities.
23. The ministry should work with First Nations communities and CCACs, and LHINs, after transition, to develop a process to determine the appropriate role of CCAC/LHIN funding and services in First Nations communities, which will vary by community.

## SIX NATIONS OF THE GRAND RIVER: COMMUNITY SERVICES PROFILE

To ensure better communication between the community and the CCAC for the benefit of clients, an MOU has been negotiated by the Joint Six Nations and the Hamilton Niagara Haldimand Brant CCAC.

The goal of the MOU is to provide a framework for information sharing and a platform to communicate:

- Proposed substantive changes to respective services
- Information to ensure smooth transitions for clients
- When there are issues/complaints to address and resolve in a timely manner.

The MOU includes a governance structure with obligations for interdisciplinary, Director-level, and Senior Director-level meetings.

### Important Results:

- Once the framework and management structure was in place, trust developed along with opportunities to regularly meet to gain a better understanding of each other's realities
- Clear expectations for communication resulted in a more streamlined and open dialogue between front-line staff
- Improved frequency and quality of communication between staff at all levels of both organizations
- Better understanding of services offered on Six Nations
- Understanding of one another's policies and procedures, e.g. complaints and appeals
- Fewer complaints
- Debriefing following any significant event to improve outcomes for next time
- Improved transitions for clients between the CCAC and Six Nations and between the hospital and the client's return home
- Meetings continue as per the communication framework
- Trust and partnerships continue to flourish.

## Theme #7 – Technology Assisted Home and Community Care Services

Geographic isolation limits the degree to which many First Nations are able to integrate and coordinate care for their communities. As a result, technology-based care is considered by First Nations communities to be an essential service.

During the past 15 years, technology-enabled solutions for primary, specialist and, (recently) emergency health care, have been embedded in First Nations community clinics. Infrastructure investments by Ontario and Canada as well as First Nations support reliable, high-quality virtual connections at health, education, and administrative centres such as health clinics, schools, and band offices.

Some advantages of technology-based health care services include strengthened oversight, more frequent interactions with health care providers, and the delivery of services even during inclement weather, and reduced travel costs for patients and nurses. In addition, family members can attend and support patient participation since the services take place in patient homes or community locations without travel.

By far the most substantial challenge continues to be access to infrastructure, technology and quality internet connections in First Nations communities. Many do not have consistently reliable connections and/or high-speed internet that would support the delivery of services. The provision of quality services cannot exist without access to high-speed internet. Appointments are often interrupted or cancelled due to the poor quality of the connection. Another challenge is that the introduction and use of new equipment requires health care providers to support patients in administering the technology. Care providers often require training to understand how to use the technology. Despite these challenges, enhancing technology-based approaches continues to be a priority for First Nations communities.

Some First Nations are taking steps to enhance technology-based services. For example, Keewaytinook Okimakanak (KO) and the Ontario Telemedicine Network established a working partnership in 2002. Today, there are 26 First Nations points-of-care located in the Northwest LHIN that enables thousands of virtual care events each year. Broadband connections are available in 21 of 26 KO eHealth sites – including the Treaty 3 offices of the Kenora Chiefs – while five (Fort Severn, Peawanuck, Neskantaga, Eabemetoong and Webequie) are served by a much slower and less flexible legacy C-Band satellite service. The KO e-health telemedicine services are profiled on page 29 of this report.

## Theme #7 Recommendations

24. The province and federal government should support the expansion of access to technology-based home and community care services in First Nations communities for care delivery, care integration and training.
- The province should include First Nations in the design and implementation of province-wide initiatives on technology-based home and community care services.
  - Investments in technology should include ongoing support for capacity building, staff training and maintenance.
25. First Nations communities should consider developing or using an existing resource to share training and development opportunities with each other and local trainers through a shared and accessible web-based platform. All home and community care partners should contribute relevant and up-to-date content.

## **KEEWAYTINOOK OKIMAKANAK: COMMUNITY SERVICES PROFILE**

Launched in 1998, KO eHealth Telemedicine Services is Canada's only comprehensive First Nations operated regional telemedicine system.

The network serves 26 of Ontario's most remote First Nations. All of which are located in Northwestern Ontario.

A range of e-health services are available, they include:

- Room based consultations: connecting 26 isolated and remote First Nations communities to over 30 different types of medical specialist and allied health professionals
- Dental, Diabetes, Mental Health and Addiction Clinics
- Tele-Dermatology program
- Tele-ophthalmology program
- Health education sessions
- Administration
- E-visitation.

In winter 2016, KO's Home and Community Care service team piloted the delivery of technology-based home care services. During this day-long trial, a nurse consultant saw seven patients. Benefits of technology-assisted care observed by provider and clients include: availability for more frequent check-ups and consultations; capacity to attend appointments despite inclement weather; reduced travel logistics particularly for clients who may be bedridden or mobility-challenged, and increased opportunities for family members to attend, ask questions, and learn.

The trend toward use of personal devices to connect with service providers is much-anticipated in northern First Nations. Apps such as PCVC (personal videoconferencing)/Guestlink that enable smartphone, tablet or personal computer access to providers are an ideal platform for home-based access for clients of home and community care services. KO is monitoring local network capacities on an ongoing basis.

## DISTRIBUTION OF FUNDING

As noted throughout the report, the committee discussed the variety of barriers to equitable services for people living in First Nations communities. Members noted that the funding in Ontario's First Nations Health Action Plan is likely not adequate to address those barriers. Recommendation #1 of this report refers to ongoing additional funding for services. In addition, the committee encourages the governments of Ontario and Canada to continue to increase investment in First Nations home care, including palliative and end-of-life care.

The Ontario government has stated that provincial funding for Ontario's First Nations Health Action Plan will be phased-in beginning in 2017-18 and then increase to an annualized amount in 2018-19.

While it is not in the scope of this report to provide recommendations about the amount of funding provided in Ontario's First Nations Action Plan, the committee did consider how to distribute funding among First Nations communities.

Committee members suggested that funding be distributed to each First Nations community according to an allocation formula based on the following components: a base amount, a population factor and a remoteness factor. The committee noted that there are challenges with current population data, which may underestimate the number of people served by First Nations home and community care programs.

An equitable distribution of provincial funding during the first year will help support service developments and/or enhancements as well as start-up costs throughout First Nations communities.

Recognizing that First Nations communities are partners in designing and delivering home and community care programs, the committee recommends that communities be authorized to determine how to allocate the funding to improve home care in their communities.

Any accountability mechanisms should be reasonable in that they will leverage the data collection and reporting processes for existing programs, as well as capacity to support new reporting.

The committee also noted that transparent, multi-year funding allocations would support planning, recruitment and service delivery.

## Distribution of Funding Recommendations

26. The Ministry should work with First Nations to inform the ongoing allocation of funding to First Nations communities for home and community care services available through Ontario's First Nations Health Action Plan.



## APPENDIX: TRUTH AND RECONCILIATION CALLS TO ACTION

The recommendations of the First Nations Advisory Committee are informed by the following Calls to Action of the Truth and Reconciliation Commission.

- 16.** We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.
- 17.** We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
- 22.** We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.
- 23.** We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals.

## APPENDIX: ONTARIO'S COMMITMENT TO RECONCILIATION

May 30, 2016

Thank you, Mr. Speaker. I rise today to express a personal commitment as Premier -- and the commitment of the government of Ontario -- to being full partners with Indigenous Peoples on our journey towards reconciliation and healing.

I first want to thank the other parties for their co-operation in convening this special assembly and recognize those whose presence makes today a historic and hopeful occasion:

Ontario Regional Chief Isadore Day and other Chiefs in attendance; Métis Nation of Ontario President, Margaret Froh; Ontario Federation of Indigenous Friendship Centres President, Sheila McMahon; President of the Ontario Native Women's Association and of the Native Women's Association of Canada, Dawn Lavell-Harvard; Inuit Tapiriit Kanatami President, Natan Obed; Cree Elder and residential school survivor, Andrew Wesley; and all of the residential school survivors, Indigenous leaders and youth who are here today. I also want to thank Elder Jim Dumont for his opening prayer with Elder Shelley Charles and Métis Senator Verna Porter-Brunelle, who will provide a closing prayer.

Indigenous Peoples are the original occupants of this land we call Ontario and, over thousands of years, they developed distinct languages, cultures, economies and ways of life. This long history means that we're assembled in a sacred and traditional gathering place for many peoples of Turtle Island. I want to show respect for this by acknowledging that we're on the traditional territory of several Indigenous Nations and pay special recognition to the Mississaugas of the New Credit, and by recognizing the history and contributions of First Nations, Inuit and Métis Peoples.

Our shared history begins around 400 years ago. When Europeans first arrived, the generous partnership of Indigenous Peoples helped them establish profitable enterprises and settlements. In 1763, the Royal Proclamation confirmed the original occupancy of Indigenous Peoples and paved the way for nation-to-nation treaties between the British Crown and Indigenous Peoples. Treaties were negotiated and signed with the intent of delivering mutual benefits.

In Ontario, most of this happened hundreds of years ago. To some, seven generations ago can seem disconnected. Yet we know that our history is always shaping our present. And for some of us, treaties are part of the history that shapes our prosperity. Treaties granted us land to live on and water to drink. They are the foundation on which

the short history of our country has carried forward -- a history in which every generation has built a better life by building on the achievements of the past.

But it's only one side of our story. For Indigenous people in Ontario, this same history created a very different reality. Despite the promise of early treaties and the respectful, nation-to-nation partnerships they established, Indigenous Peoples became the target of colonial policies designed to exploit, assimilate and eradicate them. Based on racism, violence and deceit, these policies were devastatingly effective. They disempowered individuals and disenfranchised entire communities. When Canada became a country 149 years ago, the legacy of violent colonialism only gathered momentum.

From coast-to-coast-to-coast, the residential school system set out to "take the Indian out of the child," by removing Indigenous children from their homes and systematically stripping them of their languages, cultures, laws and rights. Children were physically, emotionally and sexually abused. Many died.

These heartbreaking stories are hard to hear. For generations of Indigenous people, these stories were their lives. Canada's residential schools are closed, but they have been closed for not even one generation. Echoes of their racist, colonial attitudes can still be heard. And the echoes of a society-wide, intergenerational effort of cultural genocide continue to reverberate loudly and painfully in the lives of Indigenous people today.

However we measure a person's opportunity and security in life, a disturbing gap exists between the Indigenous and non-Indigenous population. It is the gap created by a country that abused and betrayed its Indigenous Peoples. It is a gap that swallows lives and extinguishes hope across generations. For a long time, Indigenous Peoples' calls for justice could not be heard across this yawning gulf because Canada did not want to hear them. It is thanks to the resiliency of those who endured the abuses of the past that we are finally listening.

Thank you for finding the strength and courage to come forward and tell your stories -- and the stories of those who were lost. In opening our eyes, you have given us this chance to move forward as partners and the opportunity to say we are sorry. So before I go on, I want to show my respect for all the survivors and all the victims by offering a formal apology for the abuses of the past.

As Premier, I apologize for the policies and practices supported by past Ontario governments and for the harm they caused. I apologize for the province's silence in the face of abuses and deaths at residential schools. And I apologize for the fact that the

residential schools are only one example of systemic, intergenerational injustices inflicted upon Indigenous communities throughout Canada.

By adopting policies designed to eradicate your cultures and extinguish your rightful claims, previous generations set in motion a force so destructive that its impact continues to reverberate in our time. And so I want to apologize for all of this by saying I am sorry for the continued harm that generations of abuse is causing to Indigenous communities, families and individuals.

No apology changes the past, nor can the act of apology alone change the future. In making this apology, as in making the Political Accord last summer, I hope to demonstrate our government's commitment to changing the future by building relationships based on trust, respect and Indigenous Peoples' inherent right to self-government. The act of apology is not the end, nor is it the beginning. It is but one step on the journey to reconciliation and healing that we are committed to walking together.

Last year at this time, we took one of these steps when Canada's Truth and Reconciliation Commission held its closing ceremonies in Ottawa. I was honoured to participate in the Walk for Reconciliation. I want to thank Justice and now Senator Murray Sinclair, the Commission, and all the survivors who participated for helping illuminate a dark past, for honouring all those who lost their lives and for pointing the way forward.

Ontario has already taken first steps on this journey forward. They are highlighted in The Journey Together, the report we are releasing today. It outlines how Ontario is further responding to the Truth and Reconciliation Commission's findings and calls to action.

Today, Ontario commits to working in partnership with Indigenous leaders and their communities to undertake 26 new initiatives that will help build trust and respect into our relationships and build opportunity and security into the lives of Indigenous people. These next steps begin, as I have today, with efforts to help everyone in our province understand the truth about our history.

We will educate all Ontarians about the horrors of the residential school system, the betrayals of past governments and our rights and responsibilities as treaty people -- because in Ontario, we are all treaty people. This will include the work we are doing to ensure our education curriculum teaches every child in Ontario the truth about our past and what it means for all of us today.

In addition to further actions to commemorate victims and educate Ontarians, Minister Zimmer intends to introduce legislation today that would declare the first week of November as Treaties Recognition Week.

The Journey Together also introduces and enhances programs focused on closing opportunity gaps and ending intergenerational cycles of trauma. It guides our actions to enhance Indigenous voices in the administration of justice, and build a justice system that is responsive to Indigenous legal principles, autonomy and cultures. And because Indigenous languages and cultures are critical to the well-being of communities and to reconciliation itself, we will take a number of actions to support Indigenous communities in protecting and promoting traditional knowledge, languages and oral histories. Finally, we will rename The Ministry of Aboriginal Affairs the Ministry of Indigenous Relations and Reconciliation.

The commitments Ontario is making in The Journey Together are supported with an investment of more than \$250 million over the next three years. But funding commitments alone cannot undo generations of racism and abuse.

To do that, we truly need to learn from our past, which is why our programs and actions will be developed and evaluated in close partnership with our Indigenous communities -- openly and respectfully. We are also working to incorporate Indigenous elder and youth perspectives into decision-making across government, because reconciliation cannot be compartmentalized. It is a society- and government-wide journey. And so we will also work closely with Canada's federal government, whose commitments to reconciliation are encouraging and vital to our success.

We understand that there will be setbacks as we walk this road, unlearn the patterns of previous generations and replace them with new, healthy relationships. But setbacks will not weaken our resolve to walk together to a place of trust, accommodation and friendship. We do not approach reconciliation as something we need to get over with -- we approach it as something we need to get right.

Mr. Speaker, Indigenous partners, my fellow Ontarians -- there is no more denying the past or hiding from the truth. The duty owed to Indigenous partners is enshrined in our laws and in our values as Canadians.

Building trusting, respectful relationships with Indigenous Peoples and taking steps to end intergenerational cycles of trauma and inequality -- this is our present task. One day, it will be history.

With the steps we are taking together to build a country that lives up to its laws, its values and its reputation as a force for good in the world -- we are walking a path that connects us across generations. We are undoing the harm caused by our past, and building a society where future generations of Indigenous and non-Indigenous can walk together as equals -- living in peace and harmony on the land we now share.

Walking this journey together, we will not fail.

Chi miigwetch; Nia:wen; Marsi; Merci; Thank you.

## **APPENDIX: UNITED NATIONS DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES**

### **Article 21**

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.
2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

### **Article 24**

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
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.

## APPENDIX: SUMMARY OF RECOMMENDATIONS

### Theme #1 – Integration & Seamless Coordination of Care

1. The province should provide ongoing additional funding for the enhancement of home and community care services, including palliative care in First Nations communities. This funding should support more front-line health care providers such as nurses, case managers, care coordinators, personal support workers and homemakers, including consistent access to clinical supervision.
2. The province, First Nations and care partners should encourage the integration of care provider teams to the benefit of First Nations home care clients. This includes identifying strategies to encourage collaboration among primary care and home and community care providers, including among federally and provincially-funded care providers so that the needs of patients are collectively identified and comprehensive care can be provided.
  - The province should work with the federal government and First Nations to strengthen communication between federal primary care nurses and home and community care staff and/or other health care providers as determined in the community.
  - The province should work with LHINs to review home care procurement guidelines for obstacles to First Nations service providers providing home and community care services.
3. Provincial investment should include the flexibility for First Nations communities to provide compensation to attract and retain home and community care professionals and health care providers.
4. First Nations communities should inform spending decisions with a community-based and community-owned assessment (either recent or new) of existing capacity, needs, opportunities and/or risks.

### Theme #2 – Discharge Planning

5. The ministry should provide direction to LHINs and hospitals to work with First Nations to improve discharge planning, including establishing a formal communication process with First Nations home and community care services.
6. First Nations patients should have a discharge plan that includes input from hospitals and provincial and federal health care providers from First Nations communities as well as CCACs/LHINs as needed. When possible, planning should begin when patients enter the hospital.



7. Provincial investment should include opportunities to enhance home and community care services to support discharge services at non-regular working hours, including evenings and weekends.

### **Theme #3 – Palliative Care**

8. The province and other care partners should provide flexible funding that supports culturally safe palliative and end-of-life care at home.
  - Support for palliative and end-of-life care should include aftercare, bereavement and spiritual care services, and respite care in and out of community.
  - First Nations communities should develop resources to help caregivers of First Nations patients understand the range of available palliative care services.
9. The province should continue to provide ongoing funding for palliative care training for health care providers and friends and family that supports traditional practices in First Nations communities. This includes training for culturally safe end-of-life Advance Care Planning.
10. The province and other health care providers should recognize there are different determinations of when a person is palliative, which impact service planning and delivery. The province and health care providers should review those determinations to inform a more consistent approach to accessing services and provide First Nations communities with the opportunity to determine which is most appropriate.
11. First Nations communities and the ministry should support a broader understanding of processes for dying at home, including understanding the role of the police and coroner.
12. The province and/or partners such as the OPCN should collaborate with First Nations communities to identify and support the implementation of flexible hospice models to address palliative care needs including co-location and models to support community members to remain at home.
13. The province and OPCN should encourage the LHINs to collaborate with First Nations leadership in their region to explore opportunities to address First Nations palliative care needs as part of the government's commitment to expand hospice capacity with up to 20 hospices across the province.

#### **Theme #4 – Training and Development**

14. The province should support the continued provision of training for culturally appropriate and culturally safe care for home and community care professionals and health care providers and service providers in First Nations communities.
  - The province should provide funding that enables timely, predictable access to training and development opportunities. The process for funding should enable communities to utilize training throughout the fiscal year. For example, proposals should be due in January, assessed by the end of March and funding should flow in April so communities can access training opportunities through the year.
  - Funding for training should support training and development for career advancement as well as knowledge/skills enhancement for First Nations home and community care professionals and health care providers who are located on reserve.
15. First Nations communities should determine how funding is directed to training and development based on their own priorities.
16. Communities of practice among First Nations home and community care professionals and health care providers should be encouraged and supported.
17. The province and First Nations should invite the federal government to a meeting bi-annually to share best practices and priorities for home and community care.

#### **Theme #5 – Data and Reporting**

18. The province should work with other funders and LHINs to review and streamline provincial and federal data and reporting requirements for home and community care services. The review of data collection must include First Nations communities in order to develop more relevant metrics to reflect the goals and objectives of the services they provide.
19. The province and the federal government should provide funding for data collection and reporting software that respects the principles of ownership, control, access and possession.

#### **Theme #6 – Clarification of Roles and Responsibilities**

20. The ministry should confirm that CCACs, and after transition LHINs, along with the federal government and other home and community care programs, have a responsibility for home and community care in First Nations communities.

21. Recognizing that CCACs have often not fulfilled the responsibility to provide home and community care in First Nations communities, the ministry should immediately provide funding to promote equity of home and community care services among First Nations and between First Nations and other home care clients. This funding should be in addition to the existing allocation under Ontario's First Nations Health Action Plan.
22. The ministry and LHINs should ensure collaborative partnerships are in place with First Nations in the planning and delivery of home and community care. This should include visits to First Nations communities.
23. The ministry should work with First Nations communities and CCACs, and LHINs, after transition, to develop a process to determine the appropriate role of CCAC/LHIN funding and services in First Nations communities, which will vary by community.

### **Theme #7 – Technology Assisted Home and Community Care Services**

24. The province and federal government should support the expansion of access to technology-based home and community care services in First Nations communities for care delivery, care integration and training.
  - The province should include First Nations in the design and implementation of province-wide initiatives on technology-based home and community care services.
  - Investments in technology should include ongoing support for capacity building, staff training and maintenance.
25. First Nations communities should consider developing or using an existing resource to share training and development opportunities with each other and local trainers through a shared and accessible web-based platform. All home and community care partners should contribute relevant and up-to-date content.

### **Distribution of Funding**

26. The Ministry should work with First Nations to inform the ongoing allocation of funding to First Nations communities for home and community care services available through Ontario's First Nations Health Action Plan.