



# Contents

<b>EXECUTIVE SUMMARY</b>	<b>1</b>
<b>INTRODUCTION</b>	<b>3</b>
<b>CONTINUING CARE IN CANADA</b>	<b>4</b>
Care Assessment	4
Home and Community care	4
Single Entry Access (SEA)	5
Residential long-term care	5
Alternate Level of Care (ALC) in Hospital	5
Respite and other family caregiver supports	6
Palliative care	6
Administration, policy and planning	7
<b>CONTINUING CARE IN CIRCUMPOLAR COUNTRIES</b>	<b>8</b>
Denmark and Greenland	8
Finland	8
Iceland	8
Norway	9
Sweden	9
<b>CONTINUING CARE IN THE NORTHWEST TERRITORIES</b>	<b>10</b>
<b>CONTINUING CARE IN NUNAVUT 2014</b>	<b>10</b>
Home and Community Care	11
Care Assessment and Single Entry Access (SEA)	13
Levels of Care Descriptions with examples	14
Residential Long-term Care	15
Elders Homes	15
Continuing Care Centres (CCC)	15
Naja Isabelle Childrens' Home	16

Alternate Level of Care (ALC) in Qikiqtani General Hospital (QGH)	16
Out of Territory (OOT) Placement	16
Locations of care (chart)	17
Payment for residential long-term care (cost recovery)	18
Family Travel Benefit	19
Administration, policy and planning	19
<b>NEEDS ASSESSMENT</b>	<b>20</b>
Scope	20
Documents Reviewed	20
Source of statistics	20
Community Engagement	21
Elders	23
Health Care Professionals and Government Stakeholders	24
Needs Assessment Limitations	26
<b>DISCUSSION OF NEEDS</b>	<b>27</b>
Housing	27
Home and Community Care	27
Single Entry Access (SEA)	28
Demand for Residential Long-term Care	28
Administration, Policy, and Planning	36
<b>RECOMMENDATIONS</b>	<b>37</b>
Consolidate the Continuing Care system	37
Support Aging in Place	38
Increase capacity of residential long-term care	40
<b>Conclusion</b>	<b>42</b>
<b>Appendix A:</b>	
<b>Prioritization Criteria for Admission of Long-term Care Residents to Facilities providing Level 4-5 Care</b>	<b>43</b>

## EXECUTIVE SUMMARY

In April 2014, the Department of Health initiated a needs assessment of residential long-term care. This report provides a description of the elements of a Continuing Care system in Canada, a brief overview of continuing care in circumpolar countries, and a description of the Continuing Care system in Nunavut. The findings of the needs assessment are presented in terms of pressures on the Continuing Care system in Nunavut for 2015 – 2035. The report goes on to provide recommendations to address the ongoing pressures.

A Continuing Care system is a collection of programs and services to provide medical care and psychosocial support for anyone who requires ongoing support because of frailty, chronic disease, cognitive impairment or physical disability. The programs and services offered in a Canadian provincial or territorial Continuing Care system generally include: assessment of need, home help and home nursing care, central intake and waiting list for placement in residential care, residential supportive living, residential long-term care facilities, alternate level of care in hospital, respite, family caregiver supports, palliative care, and dementia care. In Canadian jurisdictions, either regional health authorities or the provincial/territorial governments are responsible for legislation, policies, processes and standards designed to guide and support delivery of Continuing Care services.

In Nunavut, Continuing Care programs and services are provided to adults and children with chronic illness, physical disability or cognitive impairment, according to assessed need. As of December 2014, the programs and services consist of:

- the Home and Community Care (HCC) Program;
- two Continuing Care Centres (CCCs), owned and operated by the Department of Health;
- three Elders Homes and a facility for children with significant disability funded by the Department of Family Services;
- beds as needed in the Qikiqtani General Hospital; and
- placement in residential long-term care out-of-territory.

These programs and services are delivered regionally by Government of Nunavut staff, agency contracted staff, and non-profit societies. There are no user fees for home care or for residential care.

Currently there are 44 beds for adults in the system, with an additional 7 beds in the Kitikmeot Regional Health Centre expected to be operational in 2015, bringing the total complement to 51 beds. In addition, there are 10 beds for children. All residential long-term care facilities in Nunavut for both the adult and child populations are consistently fully occupied. At any given time there are approximately 30 adults on the waiting list for residential long-term care.

Demand for residential long-term care, driven by an aging population, increasing life expectancy and a projected increase in the number of Nunavummiut living with dementia in the next 20 years, will necessitate adding capacity to the system.

In the short term, assuming no changes to the current utilization pattern, the waiting list will be cleared if at least 25 beds are added to the system as soon as possible, bringing the total complement to 76 beds.

In addition to those 25 beds, there is an estimated need for as few as 53 and as many as 72 more beds by 2035, depending on the method of calculating the estimate.

This report contains recommendations to address pressures on the Continuing Care system. The key recommendations include the following:

### **Consolidate the Continuing Care system**

- Consolidate the continuing care system so that all residential long-term care facilities, for adults and children, are the responsibility of the Department of Health.
- Formally disseminate information about the Single Entry Access system to all health care professionals in the territory.

### **Support Aging in Place**

- Investigate options to add programming to seniors 4plexes in the hamlets so that Nunavummiut can age in place.
- Increase home care service hours to include evenings and weekends.

### **Increase capacity of residential long-term care**

- Create a secure dementia care unit in Nunavut.
- Seek opportunities to re-purpose existing infrastructure in order to add beds in a timely manner.
- Work with the Nunavut Housing Corporation to mitigate the impact of public housing policies on seniors who require placement in residential long-term care.
- Begin planning for new Continuing Care Centre(s), taking into account potential economies of scale.

## **INTRODUCTION**

In April 2014, the Department of Health initiated a needs assessment of residential long-term care. This report provides a description of the elements of a Continuing Care system in Canada, a brief overview of continuing care in circumpolar countries, and a description of the Continuing Care system in Nunavut. The findings of the needs assessment are presented in terms of pressures on the Continuing Care system in Nunavut for 2015 – 2035. The report goes on to provide recommendations to address the ongoing pressures.

The terms “long-term care” and “continuing care” are often used interchangeably to convey the idea that ongoing care is being provided in response to a chronic condition rather than a short-term response to an acute condition. In Nunavut both terms are used extensively. For example, the residential long-term care facilities in Gjoa Haven and Igloolik are called Continuing Care Centres. In the Legislative Assembly, the Members generally use the phrase “long-term care” when discussing health care issues related to seniors. For the purpose of this report, both terms will be used according to common practice.

## CONTINUING CARE IN CANADA

A Continuing Care system is a collection of programs and services to provide medical care and psychosocial support for anyone who requires ongoing support because of frailty, chronic disease, cognitive impairment or physical disability. The programs and services offered in a provincial or territorial Continuing Care system generally include: assessment of need, home help and home nursing care, central intake and waiting list for placement in residential care, residential supportive living, residential long-term care facilities, alternate level of care in hospital, respite, family caregiver supports, palliative care, and dementia care. In Canadian jurisdictions, either regional health authorities or the provincial/territorial governments are responsible for legislation, policies, processes and standards designed to guide and support delivery of Continuing Care services.

### Care Assessment

The process of assessment to determine access to the Continuing Care system is relatively new. Just fifty years ago, Canadian seniors could live in a nursing home of their choice at will, and receive government-funded room and board but continue independent living to the extent of driving their own cars and coming and going as they pleased. Now, in all jurisdictions, the type of service provided is based on assessed need for medical and psychosocial support. In many jurisdictions the assessments are performed using standardized tools such as the RAI (Resident Assessment Instrument), or the MAPLe (Method for Assigning Priority Levels) score. The result of an assessment is to match the level of need with available supports.

### Home and Community care

The purpose of home care is to support an individual to live at home with the goal of delaying or eliminating the need for placement in a residential long-term care facility. Home care can be divided into two broad categories: of home help and home nursing. Home help generally includes assistance with meal preparation, housekeeping, personal care, and providing companionship. Home nursing generally includes skilled medical care such as wound management, medication management, and palliative care. In most Canadian jurisdictions, home nursing is provided at no cost to the recipient but there are fees for home help services.

## Single Entry Access (SEA)

An individual who does not have sufficient support in the community may require placement in a congregate living arrangement. Many Canadian jurisdictions use a Single Entry Access (SEA) system, in which an individual is added to a central or regional waiting list until a place becomes available in a facility providing the needed level of care. A case manager periodically reassesses the care recipient to monitor changes in need and offer as much support in the home as possible during the waiting period.

## Residential long-term care

Residential long-term care can range from very small 2 or 3 bed supportive living houses to large institutional nursing homes of a hundred beds or more. Canadian facilities can be government owned and operated, privately owned but government funded and licensed, non-profit society owned and operated, or privately owned for-profit. Residential long-term care is not an insured service under the Canada Health Act. The costs of residential long-term care can be separated into two components; a medical care portion for nursing care, personal care and similar services and a room and board portion for accommodations, meals and leisure activity programs. All provincial and territorial governments pay for the medical care portion and partially or completely subsidize the room and board portion. Residents in most Canadian jurisdictions can choose between government-licensed facilities with a long waiting list for entry or private for-profit homes for which the costs are not subsidized and the waiting lists are shorter.

## Alternate Level of Care (ALC) in Hospital

The term Alternate Level of Care is used in the acute care sector regarding patients who could be discharged from hospital because they no longer require acute care services but they do require an alternate level of care, such as in a residential facility. Instead of being discharged, these patients are occupying a hospital bed while waiting for placement in residential long-term care.

## Respite and other family caregiver supports

The majority of care for chronically ill or disabled individuals is provided by family members and friends. Respite provides a break so that a family caregiver feels refreshed and ready to continue with the caregiving responsibilities. A care recipient can be placed in a residential long-term care facility for a short stay, such as two weeks, so the caregiver can take a vacation. In other cases, home care support may be provided periodically so the caregiver can leave the house to attend a movie, visit with friends or engage in a hobby.

The contribution of family caregivers to the health care system is increasingly being recognized by government policies and programs. For example, Nova Scotia provides a Caregiver Benefit<sup>1</sup> payment of \$400 per month to family caregivers of care recipients with high needs. Other jurisdictions provide indirect compensation to family caregivers in the form of tax relief, including but not limited to the federal Family Caregiver Amount<sup>2</sup> and the Manitoba Primary Caregiver Tax Credit<sup>3</sup>.

Peer support groups in which caregivers can support each other, and educational workshops that offer information about their care recipient's condition, are also important. These are often provided by non-profit organizations and by long-term care facilities as part of their outreach programs.

## Palliative care

The purpose of palliative care is to enhance the quality of life and relieve suffering of an individual who is living with an illness for which a cure is no longer possible.<sup>4</sup> The psychological, social, spiritual and emotional needs of the patient and family members are also the focus of care.<sup>5</sup> Palliative care is provided in the home, in long-term care facilities and in hospitals.

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1 <http://novascotia.ca/dhw/ccs/caregiver-benefit.asp>

2 <http://www.cra-arc.gc.ca/tx/ndvdl/tpcs/ncm-tx/rtrn/cmpltng/ddctns/Ins300-350/fmlcrgvr-eng.html>

3 <http://www.gov.mb.ca/finance/tao/faq.html>

4 <http://www.hc-sc.gc.ca/hcs-sss/palliat/index-eng.php>

5 <http://www.chpca.net/family-caregivers/faqs.aspx>

## Administration, policy and planning

In Canadian jurisdictions, either regional health authorities or the provincial/territorial governments are responsible for legislation, policies, processes and standards designed to guide and support delivery of Continuing Care services. Since 2005, many jurisdictions have created and/or updated their Continuing Care strategic plans in the face of pressures on the system from Canada's aging population.

## CONTINUING CARE IN CIRCUMPOLAR COUNTRIES

The following information is contained in the report titled Conceptual Framework and Methods for Analysis of Data Sources for Long-term Care Expenditure, by the Organisation for Economic Co-operation and Development (OECD), December 2007.<sup>6</sup>

### Denmark and Greenland

In Denmark (and Greenland) home care is provided at no cost to the recipient. There is a user fee for residential care. Since 1987, no new nursing homes have been built and many older institutions have been closed, instead care is provided at home or in smaller facilities with single occupancy rooms. Everyone aged 75+ receives at least two preventative home visits annually to be assessed for care. Family caregivers receive an allowance in recognition of lost wages.

### Finland

In Finland, home care is provided at no cost to the recipient. There is a user fee for residential care charged on a sliding scale based on income. Since the 1990s the emphasis has been on decreasing nursing home placements and increasing smaller “service housing” facilities. An allowance is available for family caregivers.

### Iceland

Information about Icelandic home care was not readily obtainable. There is a fee for residential care which is paid from pension income. The extent of family caregiving is not well documented.

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<sup>6</sup> <http://www.oecd.org/els/health-systems/Conceptual%20Framework%20and%20Methods%20for%20Analysis%20of%20Data%20Sources%20for%20Long-Term%20Care%20Expenditure.pdf>

## Norway

In Norway, home nursing is provided at no cost to the recipient but there is a user fee for home help. Nursing homes and residential care homes are the responsibility of each municipality. Family and friend caregivers can receive a care attendance allowance, a carer wage, or a pension credit.

## Sweden

In Sweden, home help and home nursing are provided at no cost to the recipient. There is an income-based user fee for both the nursing care and room and board components of residential long-term care. Family caregivers can receive direct compensation or a pension credit.

## CONTINUING CARE IN THE NORTHWEST TERRITORIES

A description of the Northwest Territories (NWT) Continuing Care system is of interest because the NWT has a total population comparable in size to Nunavut, a shared history, and similar geographic challenges. The following information is contained in the report titled Government of Northwest Territories, Department of Health and Social Services, Continuing Care Review, November, 2013.<sup>7</sup>

The total population in 2012 was 43,349, in 33 communities, of which 10.6% were aged 60+. Approximately 2,000 residents of the NWT received home care. The 2012/2013 budget for home care was \$6.1 million core funding and \$3.7 million FNIHCC funding for a total of \$9.8 million.

There are nine residential long-term care facilities with a total of 160 beds, 12 respite beds and one palliative care bed in the NWT. Seven of the 9 facilities are accredited. The largest facility has 29 beds and the smallest has seven beds. The occupancy rate is over 95% and the majority of residents are aged 70+. There are no privately owned and operated for-profit residential long-term care facilities in the NWT. Actual combined expenditure for fiscal 2010/2011 was \$18.8 million and for fiscal 2011/2012 was \$20.7 million.

	Nunavut	Northwest Territories
Population	35,500	43,350
Estimated aged 60+	970	4,600
# home care recipients	730	2,000
Home care expenditures	\$8.7 million (2012/2013)	\$9.8 million (2012/2013)
# residential long-term care facilities	5	9
# beds	44	160
Facility expenditures	\$6 million (2012/13)	\$18.8 million (2010/11)
	\$6.4 million (2013/14)	\$20.7 million (2011/12)

7 <http://www.hss.gov.nt.ca/sites/default/files/continuing-care-review.pdf>

## CONTINUING CARE IN NUNAVUT 2014

In Nunavut, Continuing Care programs and services are provided to adults and children with chronic illness, physical disability or cognitive impairment, according to assessed need. As of December 2014, the programs and services consist of:

- the Home and Community Care Program;
- two Continuing Care Centres, owned and operated by the Department of Health;
- three Elders Homes and a facility for children with significant disability funded by the Department of Family Services;
- beds as needed in the Qikiqtani General Hospital; and
- placement in residential long-term care out-of-territory (OOT).

These programs and services are delivered regionally by Government of Nunavut staff, agency contracted staff, and non-profit societies. There are no user fees for home care or for residential care.

### Home and Community Care

Family members and friends from all generations are the first providers of care in the home in all Canadian jurisdictions, including Nunavut. Government-provided service supplements existing care or, in rare cases, is the only support when there are no friends or family members available, willing, or able to provide care.

The following information is contained in the report titled Home and Community Care Program in Nunavut, Evaluation Report, March 2012, prepared by Aarluk Consulting.

The Home and Community Care (HCC) program provides levels 1, 2, and 3 care, and palliative care. An individual may self-refer to the HCC program or be referred by a health care professional or a family member. A standard comprehensive Health and Social Services Assessment is completed to determine the level of care required.

The main services provided by the HCC program in Nunavut include:

- **Acute Care Replacement:** services provided to clients who are experiencing an acute illness, but who have the potential to return to a pre-illness level of functioning and self-care;

- **Chronic Disease Management:** services provided to clients with advanced disease(s) who can be maintained at home, with ongoing home care services and family assistance;
- **Long-Term Care Replacement:** services provided to home care clients with illness/ disability to aid them to increase their level of functioning or self-care so that they can function without the supports of home care services;
- **Palliative Care Active:** compassionate care offered to a person living with a progressive, life-threatening illness that does not respond to curative treatment. The primary objective is maintenance of the best possible quality of life. Palliative care provides family support, prevention, assessment, and treatment of pain and other distressing symptoms, and integrates the psychological, social, cultural and spiritual aspects of care; and
- **Post-Hospital Care:** short-term home care services, of an expected duration of 6 weeks or less, provided to stable clients who are post-surgical or have had an acute illness which has been diagnosed and treated.

The HCC program service delivery is funded by Vote 1 funds from the Government of Nunavut, and enhanced with Vote 4 funds from the federal government.

Home & Community Care Program	2012/13 Actual	2013/14 Actual
Vote 1	\$2,486,000	\$2,600,000
Vote 4	\$6,181,000	\$6,181,040
<b>Total</b>	<b>\$8,667,000</b>	<b>\$8,781,040</b>

In 2012/2013, 751 Nunavummiut received services through the HCC program. In 2013/2014 this increased to 830 Nunavummiut.

## Care Assessment and Single Entry Access (SEA)

The Department of Health assesses need based on 5 categories, known as the levels of care. A Social Services Care Assessment form unique to Nunavut is used across the territory. This is completed by a clinician in the community, and is then sent to the Territorial Home and Continuing Care Coordinator who acts as the Single Entry Access and maintains a central waiting list for residential long-term care. As part of this process, many conversations with front-line clinicians are held to support case management and to authorize increased hours of home care service during the wait for placement.

Referrals are also made by clinicians in the communities to the SEA process for individuals who require palliative care services.

An individual's care needs may increase due to catastrophic injury, chronic illness, or age to the extent that those needs are no longer manageable in a private home. As a result, the individual transitions along the continuum of care to congregate living in a supportive environment for levels 2 and 3 care needs, such as in an Elders Home. If the care needs are more significant, the individual may require placement in a Continuing Care facility that provides level 3 and 4 care.

In 2014 the Department of Health established a Central Intake Committee with representation from across the territory, Family Services, and Qikiqtani General Hospital; with the mandate to streamline the intake and waiting list for placement in the Elders Homes and the Continuing Care Centres. Prior to 2014, referrals for placement were made to an individual facility which had its own waiting list. In May 2014, the Department of Health finalized criteria to determine the priority of placement when a bed becomes available in a Continuing Care Centre. First priority is given to an individual who is waiting at home or in Qikiqtani General Hospital and is in crisis due to lack of community or family support needed to meet care needs. The second priority is spousal reunification, transfer for cultural reasons, or someone who is waiting in the community but will likely require admission within the next three months. A complete list of priority criteria can be found in Appendix A.

## Levels of Care Descriptions with examples

**LEVEL 1**  
< 4 hours  
of care

*Mary, 43, lives alone. She has arthritis and can manage most tasks, but receives support for light housekeeping from home and community care.*

**LEVEL 1:** The client can live independently with occasional support from family members and/or the home care program.

**LEVEL 2**  
4 – 8  
hours of  
care

*Pauloosie, 55, has a heart condition. He needs help with bathing and meal preparation. He and his family are supported by home and community care.*

**LEVEL 2:** The client requires some assistance to be mobile, may display some behavioral issues and requires minimal to moderate daily support, all of which can be provided at home with significant support from the home care program or in a facility that provides supportive care.

**LEVEL 3**  
8 – 12  
hours of  
care

*Jacobie, 26, needs evening and weekend care that is not available from home and community care, so he requires placement in an Elders Home.*

**LEVEL 3:** The client requires care and support that can be provided at home with significant support from the home care program or in a facility that provides supportive care.

**LEVEL 4**  
12 – 16  
hours of  
care

*Solomon, 92, had a severe stroke. He now has physical disabilities and cognitive decline. He requires placement in a Continuing Care Centre.*

**LEVEL 4:** The individual requires significant care and support in a Continuing Care Centre.

**LEVEL 5**  
>16 hours  
of care

*Rita, 76, is in the late stage of dementia. She is non-verbal and wanders. She requires placement in a secure dementia care unit.*

**LEVEL 5:** The individual requires 24 hour supervision and care. May include Nunavummiut who have been diagnosed with dementia.

## Residential Long-term Care

### Elders Homes

In Nunavut, Levels 2 and 3 care are provided in residential long-term care facilities known as Elders Homes. There are three Elders Homes in the territory that are the responsibility of the Department of Family Services and operated by third party organizations. The Pairijait Tigumivik Society operates the Elders Home in Iqaluit. This facility provides supportive care for eight residents. The catchment area is territorial. The Andy Aulatjut Personal Care Centre in Arviat, operated by the Pimaksirvik Corporation, provides supportive care for eight residents. The catchment area is territorial. The Baker Lake Hospice Society operates the Martha Talirug Centre in Baker Lake. This eight-bed facility provides supportive care. In practice, for some time in 2014, this facility operated five of the eight beds and accepted residents from Baker Lake only until. In 2015 the Martha Talirug Centre is returning to full occupancy.

The Elders Homes have a mandate to provide Level 2 and 3 care for adults, but Level 4 care is also being provided as residents age-in-place.

### Continuing Care Centres (CCC)

In the throne speech of November 2004, the government announced a commitment to open one 24-hour Continuing Care facility in each year of its four-year mandate. In 2005, the Interdepartmental Continuing Care Task Force presented to Cabinet a report with recommendations to address the impact of an aging population on the territorial continuum of care and site selection criteria for the mandated four Continuing Care facilities.

In 2009 and 2010, a Continuing Care Centre was built in each of Igloolik and Gjoa Haven. Each facility provides Level 3 and 4 nursing care to ten residents. Each Centre has one bed that can be used for short-term stays for palliative care or respite. The remaining two mandated Continuing Care Centres have not been built. Operations and Maintenance funding for the facilities is completely Vote 1.

## Naja Isabelle Childrens' Home

The Naja Isabelle is a 10-bed facility in Chesterfield Inlet providing level 4 and 5 care for severely disabled children. As of early 2015 there are eight children and two adult residents. There is one child on the waiting list. Residents can continue to live at Naja Isabelle as they get older when there are no beds in the adult facilities, although the stated age limit for eligibility is 40. Some residents move back to the family home or are placed in foster homes.

## Alternate Level of Care (ALC) in Qikiqtani General Hospital (QGH)

The term Alternate Level of Care is used in the acute care sector regarding patients who could be discharged from hospital because they no longer require acute care services but they do require an alternate level of care, such as in a residential facility. Instead of being discharged, these patients are occupying a hospital bed while waiting for placement in residential long-term care.

The Qikiqtani General hospital does not have formal ALC processes or protocols, however there have been ALC patients in GH for extended periods of time in the recent past.

## Out of Territory (OOT) Placement

As of December, 2014 several Nunavummiut have been placed in residential long-term care out of the territory. The monthly cost ranges from \$3,900 to \$5,900 for each out-of-territory long-term care resident. Family Services is funding at least one of the out-of-territory long-term care residents.

## Locations of care (chart)

Location of Care	Palliative	Respite	Level 2	Level 3	Level 4	Level 5	ALC	Secured dementia
Kivalliq Regional Health Centre	x	x					x	
Kitikmeot Regional Health Centre	x	x		x	x			
Gjoa Haven CCC	x	x		x	x			
Igloolik CCC	x	x		x	x			
Arviat Elders Home	x	x	x	x	x			
Baker Lake Elders Home	x	x	x	x	x			
Iqaluit Elders Home	x	x	x	x	x			
Naja Isabelle in Chesterfield Inlet (children)					x	x		
QGH	x	x					x	
Out-of-territory: Edmonton, Ottawa, Churchill		x				x		x

## Payment for residential long-term care (cost recovery)

Every Canadian jurisdiction except Nunavut charges residents for the room and board portion of residential long-term care costs as a mechanism for cost recovery.<sup>8</sup> The charge can be subsidized by the government based on the resident's income.<sup>8</sup> For example, in Ontario the maximum monthly payment expected from a resident is \$1,731.62 for a bed in a 4-bed ward, but this can be reduced depending on the resident's income and number of dependents. The charge for a semi-private room is \$2,066.21 and for a private room is \$2,438.81. There are no subsidies for semi-private and private rooms.<sup>9</sup>

Jurisdiction	Monthly accommodation rate / bed : government subsidized	Monthly combined accommodation and medical care rate / bed : Private facility
NWT	761	No private facilities in the territory
Alberta	1,500	1,000 – 4,500
Manitoba	1,700	1,500 – 2,500
Ontario	1,700	1,200 – 6,500

The combined monthly cost for medical care and room and board in Igloolik is \$25,500 and in Gjoa Haven is \$27,120 per bed. There is no charge to the residents.

	2012/13 Actual	2013/14 Actual
CCC – Igloolik (10627)	\$2,457,580	\$3,156,868
CCC – Gjoa Haven (10628)	\$3,132,893	\$3,254,620
<b>Total</b>	<b>\$5,590,473</b>	<b>\$6,411,488</b>

Nunavut has a mechanism for cost recovery that is not being used. Subsection 11(1) of the Territorial Hospital Insurance Services Act contains a provision regarding charges to patients receiving nursing home care or chronic extended care for their accommodation and meals in a hospital. The term "hospital" is defined to include a facility providing nursing home care for the purposes of the statute. This regulation has not been enforced to date.

<sup>8</sup> <http://irpp.org/wp-content/uploads/assets/research/faces-of-aging/residential-long-term-care-for-canadas-seniors/IRPP-Study-no1.pdf>

<sup>9</sup> [www.ontario.ca/health-and-wellness/find-long-term-care-home](http://www.ontario.ca/health-and-wellness/find-long-term-care-home)

## Family Travel Benefit

Until 2012, the Health and Social Services Client Travel Policy enabled government payment of travel and accommodation expenses for family members to visit residents of the Continuing Care Centers and Elders Homes. Since the Department of Health and Social Services divided into two departments, application is made by families under the Department of Family Services (DFS) Client Travel Policy. The DFS defines an adult “client” as being a person under court ordered public guardianship. This definition does not include all of the residents of Continuing Care Centers and Elders’ Homes. As a result, families who were eligible for the family travel benefit in the past became ineligible.

As of early 2015, the two departments are actively working together to resolve this matter. In the meantime, the DFS is covering the costs of the family travel benefit.

## Administration, policy and planning

The Continuing Care system is administered by the Department of Health – Operations Division for territory-wide planning, standards and policies. At the regional level, the Regional Directors provide leadership for the Home and Community Care program and the Continuing Care Centres.

Currently, there is no legislation in Nunavut to provide a framework for Continuing Care services. There are Continuing Care Standards for the Continuing Care Centres and Residential Care Standards for the Elders Homes.

## NEEDS ASSESSMENT

### Scope

In a Continuing Care system the need for care and eligibility for service throughout the life course can change with age. This assessment focused on residential long-term care for adults with a chronic physical or cognitive disability or illness, excluding adults receiving long-term residential mental health or addictions treatment. Residential care for children was not a focus because this sector is the responsibility of Family Services rather than Health.

In Nunavut, the term “Elder” refers to an individual with a role and status in his or her community that is not linked to age. The term “senior” refers to an adult who has reached the age of eligibility stipulated for program or service. For example, the Nunavut home and community care program refers to clients aged 55+ as seniors, although age is not a requirement for service.

For the purpose of this report, an adult is aged 19+, and the term “senior” is used instead of “Elder” because care needs change with age and chronic disease progression rather than with community status. The term “Elder” is used when referring to an individual who does have the role and status that are not linked to age.

### Documents Reviewed

1. Recommendations for Continuing Care Services in Nunavut, January 2005
2. Home and Community Care Program in Nunavut Evaluation Report, March 2012
3. Nunavut Home & Community Care 2003 – 2013, April 2015
4. Government of Northwest Territories Department of Health and Social Services Continuing Care Review, November 2013
5. Chronic Disease Summary: Nunavut (Fiscal Years 2004 – 2012)

### Source of statistics

The Nunavut Bureau of Statistics publishes population estimates by age group, region and community. The Bureau provided population estimates in increments of 5 year age groups for Nunavummiut aged 45 to 80+ for 2020, 2025, 2030, and 2035 by region and by community. These estimates were prepared in December, 2014.

## Community Engagement

Obtaining the input of Nunavummiut is vital to any assessment of need for programs and services, however the geography of Nunavut presents challenges to community engagement. Efforts were made to facilitate input from Elders and other key informants in each community.

GROUP	WHO WAS APPROACHED	RESPONSE
Individuals identified by hamlet officials as being Elders in the community	Letter from the Minister to every Mayor, followed by emails and phone calls to every hamlet office to arrange a teleconference with a group of Elders.	Arctic Bay, Hall Beach, Sanikiluaq, Kugaaruk, and Iqaluit.
Home and community care program clients	Some Home Care nurses were provided with a survey and asked to discuss the questions with their clients.	One response received.
Nunavummi Disabilities Makinnasuaqtiit Society	Executive Director	Interview conducted
Continuing Care Centres	Managers	No response
Elders Homes	Managers	Two responses
Qikiqtani General Hospital	Nurse Manager of the inpatient unit	Interview conducted
Baffin Region Rehabilitation Services	Manager	Provided input on behalf of the team
Supervisors of Community Health Programs (SCHP), also known as nurses-in-charge (NIC) in some communities.	All NICs asked to provide input by email or phone conversation	Sanikiluaq, Arctic Bay, Hall Beach, Qikiqtarjuaq, Kugaaruk, Whale Cove, Resolute, Rankin Inlet, Pond Inlet, Kimmirut, Grise Fiord, Baker Lake, and Arviat.
Elder re: Inuit experience with dementia	Roy Inglangasuk	Telephone interview conducted

GROUP	WHO WAS APPROACHED	RESPONSE
Family Services	Deputy Adult Guardian and Family Services Specialist who leads the Seniors' file.	Interviews conducted
Department of Culture and Heritage	Director for Elders and Youth	Interview conducted
Department of Justice	Public Trustee	Interview conducted
Nunavut Housing Corporation	Senior policy officials	Provided comments and data

## Elders

Mayors and Senior Administration Officers (SAO) in five communities arranged gatherings of Elders for a teleconference with the project lead. In each participating community the hamlet staff member who is responsible for interpretation provided the service. Generally, three or four Elders plus the SAO were present to discuss long-term care for their community. In Iqaluit, a group of Elders and an interpreter met in person with the project lead.

Participating communities were: Arctic Bay, Hall Beach, Sanikiluaq, Kugaaruk, and Iqaluit.

Although the topic of residential long-term care was raised by the interviewer at each community consultation, the Elders focused on other topics instead. The following issues were identified by Elders in Nunavut as being important to them - seniors 4plex housing, family visits to loved ones residing in long-term care centres, Elders gatherings, ability to get out on the land, and transportation. The comments below are a consolidation of the discussions with Elders in five communities. Due to the fact that the conversations were interpreted, these comments are not direct quotes.

### **Seniors 4 plex**

Elders stated that they need a good view of land/water. Right now when they look out the window at home they see only sky. They asked to make sure the houses do not have long walkways or high steps and do not put young families with seniors because the young families are loud and disruptive when they fight and drink alcohol. Elders stated that they want to face the sea rather than the land because they are used to living on the beach. If a senior's room is too small there are increased respiratory problems.

### **Family visits**

Elders in two communities discussed at length the situation of an individual who was placed in a Continuing Care Centre. The Elders want family visits once or twice a year for this individual and others in the same situation. The resident who was the main subject of the discussion is nonverbal, so telehealth family visits would not be ideal.

### **Ability to get out on the land**

Elders stated that they were nomadic and still want to get on the land, so consider an accessible van for seniors to go on the land; the health centre driver can be responsible.

No taxi service and cannot get onto the land.

### **Transportation**

Elders stated they want to activate the Elders Committee to work on transportation.

Elders stated that there is no taxi service to go to gatherings and get groceries.

## **Miscellaneous**

An Elder stated that some communities do not have a bank so seniors must go to Iqaluit to get direct deposit account for their pensions. The bank forms are only in English.

An Elder stated that public housing units for seniors do not have enough space. There are no ramps for wheelchairs and walkers in public housing units.

An Elder who had recently completed a lengthy caregiving journey emphasized need for caregiver support and education.

## **Health Care Professionals and Government Stakeholders**

The following themes were explored with health care professionals and government stakeholders. The comments are not direct quotes.

### **How are seniors cared for currently?**

The most often cited reply to this question was family and home care. Additional comments were that very little home care is available so two seniors are being looked after by community members but the medications are being stolen, and in another situation, family look after the senior, who is being exploited financially.

One informant stated that there is no home care in the community due to difficulties hiring home care workers.

### **What is the prevalence of chronic illnesses in the community?**

COPD (chronic obstructive pulmonary disease), Type II diabetes, and arthritis were mentioned most frequently. Hypertension, stroke and lung cancer were also mentioned. Dementia was spoken of twice.

### **Availability of housing for seniors**

Comments:

- The local housing authority builds ramps.

- The community has two duplexes that are accessible by ramp.
- There is one designated house for the elderly or disabled.
- There is a seniors 4plex with one bedroom and a smaller room for the caregiver but families move in and cause overcrowding.

### **Available programs to support seniors**

Comments:

- There is an Elders gathering place that is not much used by Elders anymore but the informant was unsure why it fell into disuse.
- The Elders Committee owns a little cabin on the land so Elders can have day trips.
- The home care team runs an Elders lunch at the Wellness Centre and the driver from the Community Health Centre takes Elders to gatherings.

### **Suggestions for supportive living arrangements**

Comments:

- An Elders' complex staffed 24/7.
- An Elders' complex, keeping in mind that it would be difficult to staff.
- This is a traditional community so seniors will not live in a congregate setting unless they can bring families with them.
- Could designate a family member to give care and receive room and board in exchange.
- Increase home care hours.

### **Suggestions for other senior supportive activities**

Comments:

- Create an adult day program to alleviate isolation.
- Establish programming in a seniors 4plex.

- Establish day programs for tea and games.
- A subsidized taxi service is needed.
- Transportation to health appointments is needed.
- Ensure supports are available for elderly Nunavummiut who are experiencing financial abuse.

## Needs Assessment Limitations

The needs assessment did not include site visits in any communities other than Iqaluit (due to a lack of budget for travel).

Nunavut Tunngavik Incorporated (NTI) was invited to participate in the steering committee guiding the needs assessment, however NTI did not respond to the invitation. In addition, the Qikiqtani Inuit Association, Kivalliq Inuit Association, and the Kitikmeot Inuit Association were each invited to provide comments, however none of the organizations responded.

As a result, the needs assessment is largely based on comments from health system professionals and may be biased toward a medical model of continuing care services without adequately reflecting Inuit values and cultural preferences.

## DISCUSSION OF NEEDS

*"Families are the main living environment of Inuit" ALIANAIT Inuit Mental Wellness Action Plan p. 27*

Nunavummiut care for their frail elderly, chronically ill, or disabled family members as best they can in often crowded homes. Home care support is provided where available. However, the caregiving journey can be lengthy and demanding, particularly in cases of dementia, incontinence, or reduced mobility. At some point, it may no longer be feasible to provide care at home. When this happens, the individual is placed on the waiting list for residential long-term care. Increasingly, the person is sent to the Qikiqtani General Hospital or out of territory.

### Housing

Anecdotal evidence indicates that concerns for safety from elder abuse, financial exploitation, and/or extreme isolation are driving many referrals for residential long-term care, rather than care need. Conversely, there are known situations in which a senior requires care in a residential facility but the individual and/or the family refuse to consent to the placement for reasons that include the fear of losing public housing for the entire family. In some cases the Public Guardian becomes involved. The issues of elder abuse and the guardianship process are significant and require immediate attention but are beyond the scope of this report.

### Home and Community Care

During the community engagement process for this needs assessment it became clear that the provision of home and community care services is inconsistent across the territory. There is at least one community in which no home care is available due to the inability to recruit home care staff. In other communities, home care workers are unable to provide care in certain homes due to fear for their own safety, with the result that the individual in need is not getting the appropriate care. The current home care program is not configured to provide care in the evenings and on weekends, except in rare circumstances, such as palliative care.

In some hamlets, however, the home and continuing care (HCC) program is widely praised and highly regarded as the staff strives to care for community members.

In one community the HCC program organizes lunch for seniors in addition to providing service in the home.

The importance of a strong HCC program and diligent service delivery to the quality of life in Nunavut's remote communities cannot be over-emphasized. Creativity and collaboration among home care staff and health care clinicians in the community and staff at the Department of Health were cited as the critical success factors for one particular home care situation. In this example, an individual experienced a catastrophic medical event but recovered sufficiently to return home. The care needs were extensive and beyond the capability of the home care staff at the time. There were not enough family members who were able to cope with the care needs due to employment and child rearing demands. The community health centre staff, home care staff, and the family devised a plan in which a family member from another community agreed to become the primary caregiver. With the support of the health team the family member was educated in caregiving tasks and received a small wage to pay for groceries. The local community pitched in as well, by providing a small cabin for the caregiver's accommodation. The care recipient and family were able to stay together in the home community and receive quality care.

## Single Entry Access (SEA)

Prior to 2014, each Elders Home and Continuing Care Centre in Nunavut maintained an independent waiting list for placement. A centralized intake system did not exist so it was difficult to determine the overall territory-wide need. There is no information regarding individuals who were on the list but were placed in care or are now deceased.

## Demand for Residential Long-term Care

### **Waiting List**

As of December 31, 2014 there were insufficient residential long-term care spaces to meet the needs of Nunavummiut. At that time there were 32 individuals on the waiting list.

Three individuals on the list have been living in out-of territory facilities for several years so it is possible that repatriation to Nunavut is not in their best interest.

Four other patients have been living in out-of-territory facilities and have expressed an interest in being repatriated to Nunavut.

Four people on the waiting list have been offered placement in the territory within the last two years but refused to leave their home communities at the time that placement was offered.

### **Waiting List Analysis – Care Needs**

The care needs of Nunavummiut on the waiting list as of December 31, 2014 are as follows:

<b>LEVEL OF CARE</b>	<b># WAITING FOR PLACEMENT</b>
Not stated	12
One, two, or three	4
Four or five	15
Palliative	1
<b>TOTAL</b>	<b>32</b>

Nineteen individuals waiting for placement are receiving care at home from family and the HCC program, seven are in out-of-territory facilities, two are in adult group homes in the territory, two are in the Pairijait Tigumivik Centre (Iqaluit), one is in the Kivalliq Regional Health Centre (Rankin Inlet) inpatient unit, and one is in the Qikiqtani General Hospital.

The ages of individuals on the waiting list range from 27 to 100. The majority are over the age of 60.

Removal from the waiting list occurs upon the death of a resident in a care facility or the death of the individual on the list while still waiting for placement. It is important to note that being placed out-of-territory does not mean an individual is removed from the Nunavut waiting list. The individual is eligible for repatriation.

### **Waiting List Analysis – Days on the list**

Analysis of the wait times for placement, as of 31 December 2014, shows that three individuals were referred to the waiting list in 2010, three were referred in 2011, six were referred in 2012, five were referred in 2013 and 11 were referred in 2014. In other words, some Nunavummiut have been on the waiting list for over 1,000 days.

Average wait times in Canadian jurisdictions vary from 34 days in Saskatchewan to 150 days in Nova Scotia.

It is of interest that the number of referrals to the Nunavut waiting list doubled in 2014 as compared to 2013 and 2012. This could be a result of increased need or increased awareness of the centralized intake system or a combination of both factors.

### **Length of Stay in the Continuing Care Centres**

At the time of writing this report, data regarding the length of stay in the two Continuing Care Centres (CCCs) is not centrally collected. Such information could be useful for calculating future need. There has been minimal turnover in beds at the CCCs since they opened in 2009 and 2010. Most of the current residents are younger than 60, and have lived in the CCC for more than three years. The younger population of residents is significantly different than most other Canadian jurisdictions where less than 10% are younger than 60.

At the time the two CCCs opened in 2009 and 2010, adults aged 55 and older were eligible for placement, but there were not enough Nunavummiut to fill the beds. The age eligibility was reduced to 19. As a result, several younger patients were repatriated from out-of-territory placements, and adults were moved from the Naja Isabelle facility to free up spaces for children.

Based on the age of current residents at the CCCs it can be argued that the bed-turnover rate will continue to be inadequate to meet demand for placement. Additions continue to be made to the waiting list. The lack of capacity in the Continuing Care system has recently resulted in seniors with high care needs due to dementia-related illness staying in the Qikiqtani General Hospital (QGH) for lengthy periods, despite the fact that they do not need acute medical care, they require an alternate level of care (ALC). This is known colloquially as “bed-blocking” and is a significant issue in southern jurisdictions. The fact that it is now happening in Nunavut is a sign of comparable pressure on the system.

### **Average Long-term Care Bed Capacity in Canada**

The Canadian average in 2008/2009 was 46 residential long-term care beds of all levels of care in operation per 1,000 elderly aged 65 and older, according to a report by the Canadian Institute for Health Information (CIHI) titled Health Care in Canada,

## 2011: A Focus on Seniors and Aging.<sup>10</sup>

In the Northwest Territories, in 2013, there were 160 residential long-term care beds in operation for a population of 4,616 citizens aged 60+, which is a rate of 34.7 beds per 1,000 elderly aged 60+.

In Nunavut, in 2014, there are 44 residential long-term care beds combined in the Elders Homes and Continuing Care Centres for a population of 1,060 Nunavummiut aged 65+. At first glance this compares favourably to the Canadian average number of beds per capita, however a point of concern must be noted. The residents of the Continuing Care Centres in Nunavut are significantly younger than the residents of long-term care facilities in other jurisdictions, so the current beds will not be available to the system as often they are elsewhere. In addition, the Canadian average is not ideal, as evidenced by waiting times of up to 150 days before placement.

JURISDICTION	# OF LONG-TERM CARE BEDS PER 1,000 SENIORS
Canada	Average 46 per 1,000 aged 65+
Northwest Territories	34 per 1,000 aged 60+
Nunavut	44 per 1,000 aged 65+

### Estimating future residential long-term care bed requirements

There is no Canadian standard method for estimating residential long-term care requirements. The most widely used method was developed by the Manitoba Centre for Health Policy (MCHP) in 2002 to estimate residential long-term care bed requirements forward to 2020. The method is fully described in a report titled Estimating Personal Care Home Bed Requirements by the Manitoba Centre for Health Policy, December 2002.<sup>11</sup> It was determined that 110 beds per 1,000 population aged 75+ is a reasonable goal, based on a trend toward aging in place in the community longer and the elderly staying healthier longer. In 2012 the Manitoba Centre for Health Policy reviewed the 110/1000 ratio and found it continued to be valid for estimating bed requirements to 2020.<sup>12</sup> British Columbia,

10 [https://secure.cihi.ca/free\\_products/HCIC\\_2011\\_seniors\\_report\\_en.pdf](https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf)

11 <http://mchp-appserv.cpe.umanitoba.ca/reference/pch2020.pdf>

12 [http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP\\_pch\\_days\\_report\\_WEB.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf)

Alberta, Quebec, and Prince Edward Island also use this ratio for planning purposes.

Applying the Manitoba ratio, and assuming a similar health status for this age group as for Manitoba's residents, Nunavut would need a total of 148 residential long-term care beds for all adults in the system by 2035.

Another method to estimate future residential long-term care bed requirements is based on historic use and demand. All residential long-term care facilities in Nunavut for both the adult and child populations are consistently fully occupied. At any given time there are approximately 30 adults on the waiting list for residential long-term care. Currently there are 44 beds for adults in the system, with an additional 7 beds in the Kitikmeot Regional Health Centre expected to be operational in 2015, bringing the total complement to 51 beds. The new beds will reduce the waiting list but new referrals can be expected.

In the short term, based on recent use, and assuming no changes to the current utilization pattern, the waiting list can be cleared if at least 25 beds are added to the system as soon as possible, bringing the total complement to 76 beds.

Assuming the total complement of 76 beds is an adequate approximation of current utilization, it can be argued that the ratio of adults in Nunavut requiring residential long-term care is 1 bed for every 102 adults. Note that this ratio was calculated using the population of Nunavummiut aged 45+ because that closely approximates the age range of the current residents and individuals on the waiting list. In the next 20 years, based on the recent use ratio, the total complement of residential long-term care beds should be 129 in 2035. This constitutes an additional 53 beds once the short-term needs are met.

To summarize, the current waiting list can be cleared if at least 25 beds are added to the system as soon as possible. In addition to those 25 beds, there is an estimated need for 72 more beds by 2035 if the Manitoba ratio is applied. An estimated additional 53 beds will be needed if the historic use ratio is applied.

### **Predictors of Future Demand in Nunavut**

The causes of transition among the levels of care in the continuum of care include: frailty due to age, dementia-related wandering and/or challenging behaviours, a broken hip due to a fall, and incontinence.

Chronic disease such as COPD (chronic obstructive pulmonary disease), hypertension, diabetes, and arthritis also contribute to the need for transition along the continuum to residential long-term care.

## Frailty due to Age

As defined by the Medical Council of Canada, “Frailty is a term that applies to some older adults who have varying degrees of weight loss and/or malnutrition, cognitive impairment, multiple medical comorbidities, decreased mobility, and/or psychosocial stressors, leading to decreased function (e.g., activities of daily living)”.<sup>13</sup>

“Frailty is a strong predictor of several negative outcomes including disabilities, institutionalization, and mortality”, emphasis added ().<sup>14</sup>

Frailty is an emerging issue. The medical community is grappling with agreement on a standard definition of frailty due to age. The few studies completed to date indicate that individuals aged 80+ are at most risk.

As of 1 July 2014, the number of Nunavummiut aged 80+ was estimated to be less than 150, however this will double over the next 10 years and double again in the 10 years after that. In other words, the number of 80+ Nunavummiut is expected to quadruple in the next 20 years. This age demographic could be a predictor of demand.

80+	2020	2025	2030	2035
Qikiqtaaluk	87	157	270	372
Kivalliq	64	73	102	138
Kitikmeot	59	59	81	112
<b>NUNAVUT</b>	<b>209</b>	<b>289</b>	<b>453</b>	<b>623</b>

Data provided by the Nunavut Bureau of Statistics, December 2014.

13 [http://apps.mcc.ca/Objectives\\_Online/objectives.pl?lang=english&role=expert&id=31-1](http://apps.mcc.ca/Objectives_Online/objectives.pl?lang=english&role=expert&id=31-1)

14 [http://consultgerirn.org/topics/frailty\\_and\\_its\\_implications\\_for\\_care\\_new/want\\_to\\_know\\_more](http://consultgerirn.org/topics/frailty_and_its_implications_for_care_new/want_to_know_more)

## **Dementia**

Dementia is a condition that affects memory, thinking, behaviour, and the ability to perform everyday activities .<sup>15</sup>

There are many types of dementia; Alzheimer disease is the most common.

Dementia is progressive and can be roughly divided into three stages for the purpose of this report:

1. Mild dementia means the person is slightly forgetful and has some mood changes;
2. Moderate dementia means the person is very forgetful, gets lost, needs support to live at home, may display inappropriate behaviour or aggression;
3. Severe dementia means the person is unaware of time or place, does not recognize family, has difficulty swallowing, may be confined to wheelchair or bed, may display escalated aggression (kicking, biting).

There are several risk factors for dementia, including age, diabetes, stroke, high blood pressure, alcoholism and obesity. Dementia is a major cause of disability for elders.<sup>16</sup>

Dementia falls within the mental health portfolio because it is classified as a mental disorder in the DSM (Diagnostic and Statistical Manual of Mental Disorders).

Dementia is a degenerative, progressive condition so the affected individual's care needs can fall anywhere within the range of levels of care. Initially, levels 2 and 3 care may be sufficient but challenges with behaviour and/or communication often result in transition to requiring higher levels of care. Individuals in the end stage of dementia often require total care due to catastrophic loss of mobility, cognition, and ability to communicate.

As of January 2015, there are Nunavummiut living with dementia in Elders Homes and in the Continuing Care Centres, but coordinated assessment, case management, and training standards for dementia care do not exist in the territory. Attempts to place Nunavummiut with dementia when care needs intensify are done in reaction to a crisis rather than as a planned transition.

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15 <http://www.alz.co.uk/WHO-dementia-report>

16 <http://www.alz.co.uk/WHO-dementia-report>

As of 31 December 2014, there were six referrals to residential long-term care due to dementia. Of these, three patients were exhibiting symptoms such as wandering or challenging behaviours that are causing the case manager to recommend immediate placement out of territory due to lack of services in Nunavut.

Elderly individuals who are admitted to a hospital as the result of a medical event and also exhibit behavioural symptoms usually associated with dementia are medically stabilized and then often moved to ALC beds. If they lack community supports they stay in the ALC beds in the hospital to wait for placement in a residential long-term care facility. In the last six months of 2014 there was usually one ALC patient in the QGH. In 2013/2014 an ALC patient stayed in the QGH for over 360 days. Lacking adequate staff resources, appropriate training, and ALC protocols, the hospital administration managed challenging behaviours by posting security on the patient 24 hours per day, 7 days per week. This was a prohibitive cost to the system and caused great distress to the patient and family, and staff at the QGH.

The epidemiologists on staff in the Department of Health were consulted in attempts to obtain statistics regarding the incidence and prevalence of dementia in the territory. Currently there is no Canadian standard case definition for dementia. Data about each community health centre visit by a Nunavut Health Card holder is gathered using ICD-10 codes (International Classification of Diseases). Although there are ICD-10 codes for dementia and related symptoms, these are not used in practice.

Since data on the prevalence of dementia in Nunavut is not collected, it is necessary to extrapolate from Canadian data. In Canada, 1.5% of the population (all ages) has been diagnosed with a form of dementia; this is expected to grow to 3% in the next 20 years. The risk that a person will have dementia doubles every 5 years after the age of 65.

	2020	2025	2030	2035
Qikiqtaaluk	1125	1525	1905	2273
Kivalliq	451	578	781	1009
Kitikmeot	370	474	606	743
<b>NUNAVUT</b>	<b>1,946</b>	<b>2,577</b>	<b>3,292</b>	<b>4,025</b>

Data prepared by the Nunavut Bureau of Statistics, December, 2014.

Due to a lack of age standardized prevalence rates, it is necessary to extrapolate the rate of dementia based on the Canadian rate applied to the population aged 65+ rather than the entire population. Accordingly, 1.5% of Nunavummiut currently aged over 65, (approximately 20 individuals) may have dementia. In 20 years, as the prevalence rate increases to 3% and the number of Nunavummiut aged 65+ increases, there could be as many as 120 Nunavummiut living with dementia. In other words, there could be a 600% increase in dementia in the next 20 years.

## Administration, Policy, and Planning

### **Territorial Lead Continuing Care**

In 2005 an Interdepartmental Continuing Care Task Force led by the Department of Health and Social Services completed a needs analysis and developed a Continuing Care Plan. Cabinet approved the Continuing Care Plan containing nine recommendations. As of December 2014, only two of the nine have been fully implemented and one has been partially implemented. It can be argued that the failure to create a position for a Territorial Lead with the responsibility to move forward with the Continuing Care Plan upon its completion was a barrier to fully implementing all of the recommendations that had been accepted by Cabinet.

A business case was submitted in the fall of 2014 to request funding for an indeterminate position for Territorial Lead located at Health Headquarters to provide for consistent, proactive system planning and program design, project management, and evaluation of the Continuing Care System in Nunavut. In 2015 the position was approved.

## RECOMMENDATIONS

Recommendations to address the pressure on the Continuing Care system can be divided into the following themes - consolidate the continuum of care, support aging in place, and increase capacity for residential long-term care.

### Consolidate the Continuing Care system

#### **Transfer responsibility for Elders Homes and Naja Isabelle Home to Health**

In order to streamline policy, planning, and service delivery within the Continuing Care system, transfer responsibility for the Elders Homes and the Children's Medical Care Home to the Department of Health from the Department of Family Services.

#### **Establish a Community of Practice**

Enable the managers of all the facilities, including the Elders Homes and the Naja Isabelle, to convene regularly to discuss issues of common interest and support each other.

#### **Investigate Standard Assessment Tools**

Standard assessment, case planning, case management, and referral should be a seamless process throughout the territory. This is a complex issue that needs further exploration. Nunavut does not use a tool that is common to other jurisdictions, such as RAI, to assess level of need for home care and residential long-term care. RAI, or some other commonly used tool, will help support case management and decision-making for out-of-territory placements. Further, using a tool that is common to other jurisdictions helps policymakers and planners develop systems of comparable quality and efficiency and allows for cross-jurisdictional comparison.

It is recommended that implementation of a standard assessment tool, such as the RAI tool, across the territory be investigated.

#### **Develop a Single Entry Access (SEA) Workshop**

Information about the newly-developed central intake and waiting list process has not been disseminated to all of the professional staff in the communities who may be impacted. Consider creating a short (1 hour) workshop to be delivered

by Telehealth for home care professionals, physicians, and other health care professionals to explain the Single Entry Access process and answer questions.

### **Establish Alternate Level of Care (ALC) Policies**

It is imperative that directives, policies and processes for ALC beds be developed at QGH as soon as possible so that patients receive appropriate care, social support and leisure programming while waiting for placement in residential long-term care.

### **Arrange an Eldercare Solutions Summit**

Gather health care professionals, Elders, family caregivers, and hamlet officials together regionally to discuss elder care in general, share best practices and brainstorm solutions.

### **Improve Seniors File Coordination**

Frameworks, strategies, policies, programs, and services concerning seniors are developed and delivered by various departments in the Government of Nunavut. This activity is uncoordinated, so it will potentially result in gaps or costly overlaps in service, mis-matched strategies, and duplicated work. Policies and programs that tangentially affect seniors are not reviewed using a seniors' lens to determine efficiencies and impact on the lives of seniors. Further work in long-term care planning and strategy development would benefit from a coordinated approach to seniors' issues within the Government of Nunavut.

## **Support Aging in Place**

### **Examine the impact of Nunavut Housing Corporation policies**

Anecdotal evidence suggests that fear of losing access to public housing is a significant factor in the care choices being made by chronically ill or disabled seniors and their families, and preventing or delaying acceptance of placement in a residential long-term care facility. Anecdotal evidence further suggests that overcrowded housing, food insecurity, and determination to remain in the community of choice are resulting in poor quality of life for some chronically ill or disabled adults.

It is recommended that a working group be created with the Nunavut Housing Corporation to examine the impact of housing policies that may be acting as a barrier to receiving care.

### **Strengthen the delivery of the Home and Community Care (HCC) Program**

The 2012 Home and Community Care Evaluation Report contained recommendations that have not yet been implemented. This report should be revisited with an eye to implementing the recommendations.

Policies and directives are needed to ensure that delivery of the HCC program is strengthened in every community. Increasing home care hours to provide service during evenings and weekends is recommended.

### **Investigate the possibility of programming in Seniors 4plexes**

Almost every hamlet has a seniors 4plex, which is a single building with four discrete apartments that is meant to be accessible for seniors. It is recommended that Health work with the Nunavut Housing Corporation and the local housing authorities to investigate the options for programming in existing seniors 4plexes.

### **Provide family caregiver support**

Begin family caregiver support groups, particularly for dementia-related illness, collaborating with the Community Wellness workers and mental health staff in the hamlets.

Explore options for providing income support to a family member who is the primary caregiver.

### **Consider creating a palliative care framework**

Consider developing a palliative care framework for Nunavut.

### **Improve data collection**

There is a need for better data collection for planning purposes, including but not limited to, the number of dementia diagnoses, length of time on waiting list, utilization of respite beds, and utilization of palliative care services.

Work with health centre and HCC program staff to stress importance of completing the forms already in use.

## Increase capacity of residential long-term care

### **Build a secured dementia care unit**

It is strongly recommended that a secured dementia care unit be created in Nunavut.

Individuals with dementia who are at risk for elopement and/or exhibit serious challenging behaviours cannot be safely cared for in the existing residential long-term care facilities in Nunavut. A secured unit devoted to dementia care is required. It is not feasible to mix residents who do not require a secured unit with those who do. As a result, the timely solution for Nunavummiut living with dementia who require placement in a secured unit is to find appropriate placements out of territory. Being placed out of territory is not the first choice for most Nunavummiut and their families due to the Inuit history with residential schools and tuberculosis sanitariums, and because they might live the rest of their lives far away from friends and family, with limited access to country food and conversation in their native language.

Nonetheless, as of December 31, 2014, to address the pressing need for safe, appropriate care, steps were being taken to find out-of-territory facilities willing to accept Nunavummiut residents. The discharge planner at QGH is working with the Community Care Access Centre (CCAC) to attempt to gain access to the central intake system for publicly funded beds in Ottawa and the Territorial Lead for Long-term Care Planning is working with OHSNI (Ontario Health Services Network Inc.) to find suitable private residential long-term care placement in Ottawa.

Due to the movement of baby boomers through the life course and inadequate government planning, each Canadian province and territory has insufficient capacity to meet the residential long-term care needs of their health card holders. As a result, access to beds by non-residents is difficult to obtain and expensive.

### **Re-purpose existing infrastructure**

To begin reducing the waiting list and to add capacity as quickly as possible, the Department of Health is planning to re-purpose a section of the Kitikmeot Regional

Health Centre in Cambridge Bay from acute inpatient care to residential long-term care.

The health centre has a vacant inpatient unit on the upper floor. Staff housing challenges have historically acted as a barrier to making the inpatient acute care unit operational. The housing challenge is mitigated by a different staffing mix required for residential long-term care than for acute inpatient care.

The unit currently has three double rooms, a single room, and a palliative care suite. Re-purposing the unit will add seven beds to the Continuing Care system.

It is strongly recommended that the Department of Health continue to seek opportunities to re-purpose existing infrastructure in order to increase capacity in a timely manner. For example, the hamlet council in Taloyoak has expressed an interest in re-purposing the old health centre for residential long-term care when the new one is operational.

### **Invest in Continuing Care Centre(s)**

During the period of 2015 – 2035 demand on residential long-term care will necessitate adding more capacity to the system. There are no plans to build new Continuing Care Centres in Nunavut at this time. Consideration is being given to adding long-term care beds to new health centres in Cape Dorset and Qikiqtarjuaq. Construction is planned to start in Cape Dorset in 2017 and construction will start in Qikiqtarjuaq in 2019.

The work required for capital planning and choice of location(s) for new Continuing Care Centre(s) should begin immediately. Opportunities to implement economies of scale should be rigorously investigated.

### **Provide specialized dementia care training**

Training in dementia care, especially in responsive behaviours, is vital for all facility staff, QGH staff, and HCC program staff.

## Conclusion

In Nunavut, Continuing Care programs and services are provided to adults and children with chronic illness, physical disability or cognitive impairment, according to assessed need. As of December 2014, the programs and services consist of:

- the Home and Community Care Program;
- two Continuing Care Centres;
- three Elders Homes and a facility for children with significant disability;
- beds as needed in the Qikiqtani General Hospital; and
- placement in residential long-term care out-of-territory (OOT).

The Continuing Care system in Nunavut is under pressure just like every other Canadian jurisdiction. The current capacity is insufficient to meet demand. Nunavummiut care for their frail elderly, chronically ill, or disabled family members as best they can in often crowded homes. Home care support is provided where available. However, the caregiving journey can be lengthy and demanding. When it becomes infeasible to receive care at home, the individual is placed on the waiting list for residential long-term care. Increasingly, the person is sent to the Qikiqtani General Hospital or out of territory.

## Appendix A: Prioritization Criteria for Admission of Long-term Care Residents to Facilities providing Level 4-5 Care

Prioritization criteria for admission of Nunavummiut holding a Nunavut Health Care Card to continuing care facilities providing level 4-5 care, taking into account gender:

### Priority 1

Crisis Applicants: Person requiring immediate admission as a result of a crisis arising from the person's condition or circumstances; the absence of an available caregiver(s) who is able to provide required care without risk of harm to the person requiring care or to themselves; and the absence of community-based supports to provide the necessary support to meet the person's care needs in order for them to remain at home safely in their community.

Person occupying a bed in another facility that is temporarily or permanently closing.

Person occupying a bed at the Qikiqtani General Hospital or other acute care bed, and the absence of community-based supports to provide the necessary support, within the program's guidelines, to meet the person's care needs in order for them to remain at home safely in their community.

### Priority 2

Spousal Reunification: Spouses/partners who are determined eligible as a result of their care needs and wish to reside together in the same facility.

Cultural Reasons: Language or dialect preference by a resident that cannot be offered at another site.

Person who will likely require admission to a continuing care facility in the near future (next three (3) months):

- Should there be a change in the person's condition/circumstances, they will require immediate admission as a result of a crisis; or
- Where attending to the person's care needs is jeopardizing the health and well-being of the person's caregiver.

Person residing in a continuing care facility and is waiting to move to their preferred continuing care site.

### **Priority 3**

Person awaiting continuing care placement, however admission is not required in the short term (next three months):

- As the person's condition is not expected to deteriorate or to put the person at risk of physical or emotional harm to self or others;
- As the person's caregiver(s) is able to continue to provide the same level of care without risk of harm to the person requiring care or to themselves;
- As community-based programs and supports, such as home care, can provide the necessary support within the program's guidelines to meet the person's care needs in the interim.

Person who is already residing in a facility, which provides level 4-5 care, that is not their preferred continuing care site and who decides that they would prefer to move to another continuing care facility.