



TABLED DOCUMENT 453-18(2) TABLED ON SEPTEMBER 26, 2017

# Continuing Care Services Action Plan

2017/18 – 2021/22



September 2017





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# Minister's Message

As the Minister of Health and Social Services and the Minister Responsible for Seniors, I am very proud to present the Government of the Northwest Territories' *Continuing Care Services Action Plan*. At its core, this Action Plan will serve to support seniors and elders to age in place while ensuring that supports are available for those who can no longer live in their own homes.

This government values the importance of the wisdom, knowledge, and experience that seniors and elders bring to our communities. Seniors and elders provide the foundation for the rich cultural heritage and traditional knowledge that defines the unique character of the Northwest Territories. Enhanced home and community care services will ensure that seniors and elders remain in their homes as long as possible, allowing them to maintain their respected place within the community. At the same time, it is essential that we care for our elders who can no longer remain in their homes by making available high quality long term care services. Whether in their homes or through long term care, this government is committed to providing our seniors and elders with the most responsive, culturally safe and efficient health care possible.

This *Continuing Care Services Action Plan* builds on the priorities established within the 2014 strategic framework *Our Elders: Our Communities*. We have also drawn upon best practices in developing the targeted actions to



meet our goals. The *Continuing Care Services Action Plan* directly supports both the current mandate of the GNWT and the Department of Health and Social Services strategic plan by enhancing home and community care services, palliative care services and long term care services. We are looking forward to implementing the *Continuing Care Services Action Plan*, which will guide the work required to ensure that seniors and elders are given the best opportunity to age in their place of choice, and help us meet our vision of *Best Health, Best Care, for a Better Future*.

# Introduction

This *Continuing Care Services Action Plan* guides the work required over the next five years to support seniors and elders in the Northwest Territories to age in place, while optimizing their health, wellness and quality of life. This vision includes increasing opportunities for seniors and elders to lead active and independent lives, strengthening home and community care services and caregiver supports, improving long term care services, and enhancing palliative care. Running as a common thread throughout all activities described in this action plan is the final objective of employing high quality, culturally safe, and sustainable best practices in all areas of Continuing Care service delivery.

The *Continuing Care Services Action Plan* aims to address the relevant goals and commitments set forth by three guiding documents: the strategic framework *Our Elders: Our Communities*; the Department of Health and Social Services' strategic plan *Caring for Our People*; and the *Mandate of the Government of the Northwest Territories – 2016-2019*. The majority of the action plan's activities directly support the areas for future action identified within *Our Elders: Our Communities*. That strategic framework also established the seven guiding principles which directed the development of this action plan: Choice, Respect and Dignity, Equity, Awareness, Access, Safety, and Empowerment.

Successful implementation of this action plan will require strong partnerships and integration across all regions of the Northwest Territories. The Department of Health and Social Services is dedicated to collaborating with our partners – the Northwest Territories Health and Social

Services Authority, Hay River Health and Social Services Authority and Tlicho Community Services Agency – to ensure that the activities established in this plan are integrated across the territory. Many of the activities detailed in this action plan will further require partnerships and collaboration between other GNWT departments, local community governments, and non-governmental organizations. We will be working with our partners to ensure there is appropriate monitoring and reporting on the progress of all action items within the plan, including regular reporting on the status of mandate commitments.

The *Continuing Care Services Action Plan* contributes to the larger efforts of the Department of Health and Social Services to realize the Department's vision of *Best Health, Best Care, for a Better Future*. This plan will be implemented alongside, and in the context of other important initiatives such as the *Child and Youth Mental Wellness Action Plan*, and the forthcoming *Disability Action Plan*, *Mental Health Action Plan*, and the *Addictions Recovery Action Plan*. The *Continuing Care Services Action Plan* represents the work required to fulfill the role that Continuing Care Services provides within the greater continuum of essential health and social services for residents of our territory.





# Our Approach

To support the commitments set forth by *Our Elders: Our Communities* (OEOC), the *GNWT Mandate*, and the *HSS Strategic Plan*, this action plan works towards the goal set by the *Caring for Our People* departmental strategic plan of “reducing gaps and barriers to provide equitable access to safe, culturally respectful, and responsive programs and services”. The *Continuing Care Services Action Plan* includes five objectives that are centred around: optimizing healthy aging; home and community care services; long term care; palliative care; and sustainable best practices and culturally safe care.

Objective Area	Informed By and Links To:
<p>Optimize healthy aging by increasing opportunities and improving environments</p>	<ul style="list-style-type: none"> <li>• OEOC Priority 1 – Healthy and Active Aging</li> <li>• OEOC Priority 5 – Elder Responsive Communities</li> <li>• <i>Caring for Our People</i> 2017-20 HSS Strategic Plan – Priority 5</li> </ul>
<p>Improve home and community care services and caregiver supports</p>	<ul style="list-style-type: none"> <li>• OEOC Priority 2 – Home and Community Care Services</li> <li>• OEOC Priority 4 – Caregiver Supports</li> <li>• 2016-19 GNWT Mandate, Community Wellness and Safety 4.2.1</li> <li>• <i>Caring for Our People</i> 2017-20 HSS Strategic Plan – Priority 5</li> </ul>
<p>Provide equitable access and high quality long term care</p>	<ul style="list-style-type: none"> <li>• 2016-19 GNWT Mandate, Community Wellness and Safety 4.2.1</li> <li>• <i>Caring for Our People</i> 2017-20 HSS Strategic Plan – Priority 5</li> </ul>
<p>Enhance palliative care services</p>	<ul style="list-style-type: none"> <li>• 2016-19 GNWT Mandate, Community Wellness and Safety 4.2.1</li> <li>• <i>Caring for Our People</i> 2017-20 HSS Strategic Plan – Priority 5</li> </ul>
<p>Employ sustainable best practices to provide culturally safe, high quality Continuing Care services</p>	<ul style="list-style-type: none"> <li>• OEOC Priority 3 – Integrated and Coordinated Service Delivery</li> <li>• OEOC Priority 6 – Accessible and Current Information</li> <li>• OEOC Priority 7 – Sustainable Best Practices</li> <li>• <i>Caring for Our People</i> 2017-20 HSS Strategic Plan – Priority 5</li> </ul>

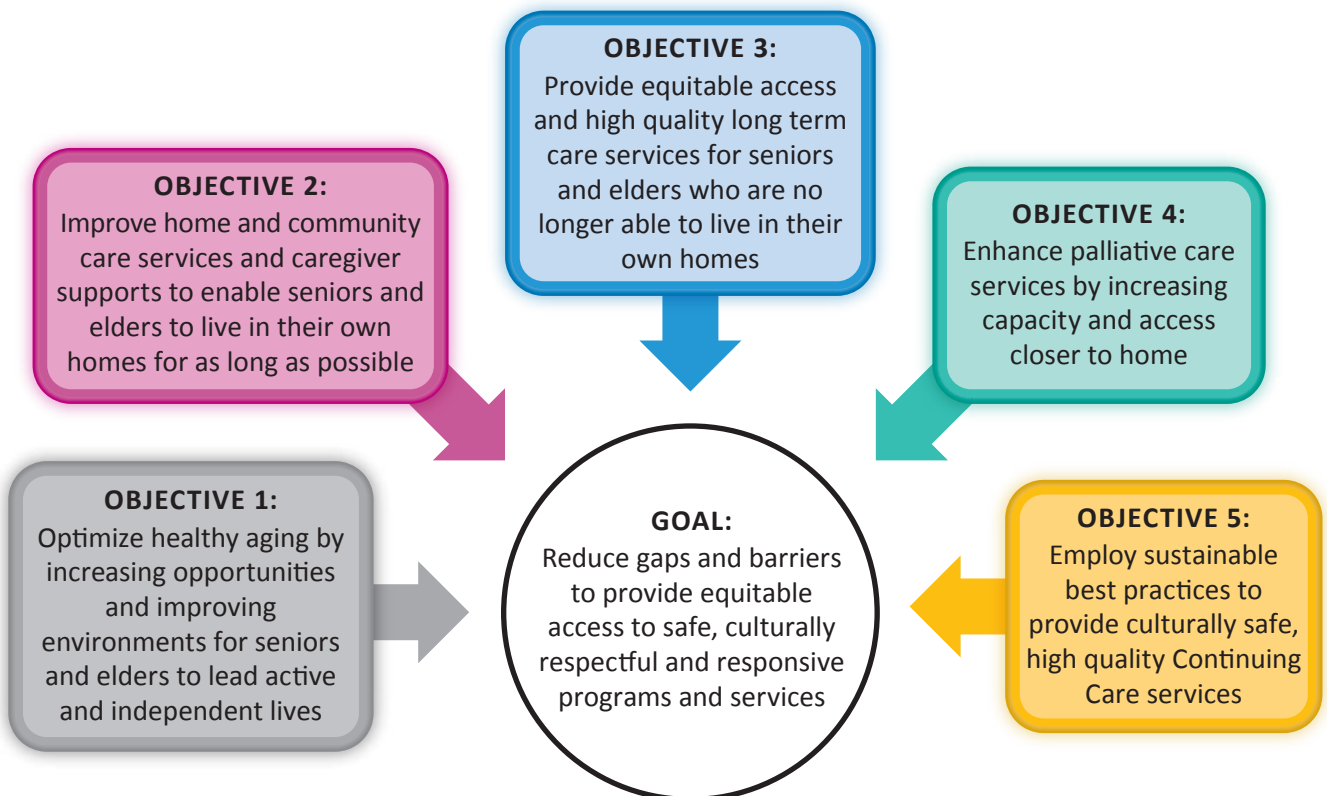
# Plan at a Glance

## Vision:

Support NWT seniors and elders to age in place, and optimize their health, wellness and quality of life.

## Guiding Principles:

- Choice
- Respect and Dignity
- Equity
- Awareness
- Access
- Safety
- Empowerment





# Objective 1

Objective 1: Optimize healthy aging by increasing opportunities and improving environments for seniors and elders to lead active and independent lives			
Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Injury Prevention</b></p> <ul style="list-style-type: none"> <li>Continue to partner with the NWT Recreation and Parks Association (NWTRPA) to support the delivery of the Functional Fitness for Falls Prevention certification program. (2017/18 – 2021/22)</li> <li>Improve Continuing Care policies and practices to support injury prevention. (2017/18 – 2019/20)</li> </ul>	Decreased falls risk and create safer Continuing Care environments for seniors and elders.	Seniors and elders experience fewer falls and other injuries.
MACA	<p><b>Active Living</b></p> <ul style="list-style-type: none"> <li>Work with Municipal and Community Affairs (MACA), NWT Association of Communities (NWTAC) and the NWT Seniors Society (NWTSS) to offer active living programs and events to seniors and elders. (2017/18 – 2021-22)</li> <li>Building on our partnerships with MACA, and NWTRPA, we will work toward a longer-term, strategic, and comprehensive approach to expanding Elders in Motion training and delivery. (2017/18 – 2021-22)</li> </ul>	More seniors and elders are engaged in active living programs at the community level.	A more active and healthy seniors and elders population.
HSS	<p><b>Elder Abuse</b></p> <ul style="list-style-type: none"> <li>In partnership with the NWTSS, finalize a standard set of elder abuse screening tools, protocols and intervention procedures for use by health care providers. (2017/18 – 2021-22)</li> <li>Continue to partner with the NWTSS to support public awareness about elder abuse in the NWT. (2017/18 – 2021-22)</li> </ul>	Increased awareness of elder abuse and timely and appropriate intervention to elder abuse.	Decreased rate of elder abuse in the NWT.

# Objective 1

Objective 1: Optimize healthy aging by increasing opportunities and improving environments for seniors and elders to lead active and independent lives			
Lead	Activities and Timelines	Outputs	Outcomes
NWTHC	<p><b>Supportive Housing</b></p> <ul style="list-style-type: none"> <li>Develop approaches to supportive housing for seniors and elders, and persons with disabilities in collaboration with NWT Housing Corporation. (2017/18 – 2021-22)</li> <li>Ensure space for adult day programs is included in new seniors and elders housing facilities. (2017/18 – 2021-22)</li> </ul>	Increased accessibility and availability of well-designed supportive housing for seniors and persons with disabilities.	More seniors and persons with disabilities living in supportive housing as required, with access to adult day programs.
MACA	<p><b>Community Services to Support Independent Living</b></p> <ul style="list-style-type: none"> <li>Partner with MACA, and the NWTAC to support local municipalities to improve community-based services to enable seniors and elders to maintain their homes and live as independently as possible (i.e. accessible transportation, snow clearing, shopping and errand services). (2017/18 – 2021-22)</li> <li>Work with the NWTAC to encourage and support communities to use the <i>Built Environment Guide</i> and the <i>Healthy Communities Toolkit</i>. (2017/18 – 2021-22)</li> </ul>	Seniors and elders have access to community services that will support them to live longer in their own homes.	Seniors and elders are able to live independently in their own homes longer.



**Objective 1: Optimize healthy aging by increasing opportunities and improving environments for seniors and elders to lead active and independent lives**

Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Adult Day Programs</b></p> <ul style="list-style-type: none"> <li>Continue to expand Adult Day Programs throughout the territory in collaboration with local municipalities. (2017/18 – 2021-22)</li> <li>Develop and pilot a high intensity day programming model for community-dwelling seniors and elders at risk of Long Term Care admission. (2017/18 – 2018/19)</li> </ul>	Adult day programs are available to seniors and elders in pilot program communities.	Seniors and elders attending adult day programs are able to live in their own homes longer.
HSS	<p><b>Alzheimer’s Champions</b></p> <ul style="list-style-type: none"> <li>Partner with the Alzheimer’s Society of Alberta and the Northwest Territories to identify and train Alzheimer’s Champions in the NWT. (2017/18 – 2020/21)</li> </ul>	Increased community awareness and advocacy for Alzheimer’s disease and dementia.	NWT residents living with Alzheimer’s disease and dementia are better understood and supported by other community members.



## Objective 2



### Objective 2: Improve home and community care services and caregiver supports to enable seniors and elders to live in their own homes for as long as possible

Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Home and Community Care Review</b></p> <ul style="list-style-type: none"> <li>Conduct a comprehensive territorial review of home and community care (HCC) services by region and community. (2017/18 – 2019/20)</li> <li>Define the core basket of HCC services. (2017/18 – 2019/20)</li> <li>Develop a community staffing standard by population for HCC. (2017/18 – 2019/20)</li> </ul>	Better understanding of strengths and gaps in HCC service; more equitable and adequate territorial HCC service delivery.	Seniors, elders and other HCC clients throughout the territory have access to equitable and adequate levels of HCC service.
HSS	<p><b>Skilled Home and Community Care Staff</b></p> <ul style="list-style-type: none"> <li>Develop and implement standardized HCC orientation procedures. (2017/18 – 2018/19)</li> <li>Standardize HCC job descriptions throughout the NWT, meeting NWT Continuing Care Standard 5.2.2. (2017/18 – 2018/19)</li> <li>Increase the number of Home Support Workers with Personal Support Worker certification in partnership with Aurora College. (2017/18 – 2018/19)</li> <li>Provide training to Registered Nurses and Licensed Practical Nurses working in HCC for advanced skills certification relevant to HCC practice (i.e. geriatric care, foot care, wound care, rural and remote nursing, etc.). (2017/18 – 2019/20)</li> </ul>	A more skilled HCC workforce throughout the NWT.	Seniors, elders and other HCC clients receive higher quality services.
HSS	<p><b>Access to Clinical Supports for Health Professionals</b></p> <ul style="list-style-type: none"> <li>Improve access to geriatric, rehabilitation (physiotherapy, occupational therapy, speech-language pathology and audiology), and chronic disease management resources and supports to increase the capacity of care providers. (2018/19 – 2021/22)<sup>1</sup></li> </ul>	HCC professionals are better supported in providing clinical care.	Seniors, elders and other HCC clients receive higher quality services.

<sup>1</sup>Also referenced in Objective 3, under “Skilled Long Term Care Workforce” topic

**Objective 2: Improve home and community care services and caregiver supports to enable seniors and elders to live in their own homes for as long as possible**

Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Paid Family/Community Caregiver Program</b></p> <ul style="list-style-type: none"> <li>Develop and pilot a Paid Family/Community Caregiver Program as an option for seniors, elders and persons with disabilities to self-manage their care. (2017/18 – 2019/20)</li> </ul>	An options paper and a pilot Paid Family/Community Caregiver program in select communities.	Seniors, elders and persons with disabilities have access to self-managed care.
HSS	<p><b>Family/Community Caregiver Supports</b></p> <ul style="list-style-type: none"> <li>Conduct a territorial Family/Community Caregiver needs assessment. (2017/18 – 2019/20)</li> <li>Implement caregiver supports based on inter-jurisdictional and best practice research that are relevant to the remote, northern NWT context. (2018/19)</li> <li>Increase hours of home support respite services (in-home short-term respite) for family caregivers. (2017/18 – 2021/22)</li> <li>Develop and implement a support program for caregivers living with frail seniors/elders or persons with dementia. (2017/18 – 2019/20)</li> </ul>	Family and community caregivers are better supported to care for their loved ones at home.	Reduced family/community caregiver burden and burnout, resulting in seniors and elders being able to live in their own homes longer.
HSS	<p><b>Family/Community Caregiver Information</b></p> <ul style="list-style-type: none"> <li>Increase access to culturally appropriate information for family and community caregivers in the NWT. (2018/19)</li> <li>Establish an online webpage as a centralized access point for information, training and resources for caregivers. (2018/19)</li> <li>Evaluate and revise the NWT Caregivers Guide. (2018/19)</li> </ul>	Family and community caregivers have access to the most current information and are better supported to care for their loved ones at home.	Seniors and elders receive higher quality care from family and other community caregivers.

## Objective 3

Objective 3: Provide equitable access and high quality long term care services for seniors and elders who are no longer able to live in their own homes			
Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Skilled Long Term Care Workforce</b></p> <ul style="list-style-type: none"> <li>Develop and implement standardized long term care (LTC) orientation procedures. (2017/18 – 2018/19)</li> <li>Standardize LTC job descriptions throughout the NWT, meeting NWT Continuing Care Standard 5.2.2. (2017/18 – 2018/19)</li> <li>Increase the number of Resident Care Aides with Personal Support Worker certification in partnership with Aurora College. (2017/18 – 2018/19)</li> <li>Provide training to Registered Nurses and Licensed Practical Nurses for advanced skills certification relevant to LTC practice (i.e. geriatric care, dementia care, responsive behaviours, palliative care, etc.). (2017/18 – 2018/19)</li> <li>Improve access to geriatric, rehabilitation (physiotherapy, occupational therapy, speech-language pathology and audiology), and chronic disease management resources and supports to increase the capacity of care providers. (2018/19 – 2021/22)<sup>2</sup></li> </ul>	The NWT LTC workforce is more highly skilled and better supported.	Seniors and elders living in LTC receive higher quality services.
HSS	<p><b>Improved Long Term Care Service Delivery</b></p> <ul style="list-style-type: none"> <li>Continue to promote Supportive Pathways along with skills based training, such as PIECES, to enable staff to consistently apply a person-centred approach that fosters respectful, compassionate care in providing dementia care and managing responsive behaviours. (2017/18 – 2020/21)</li> </ul>	Standardized approaches to LTC service delivery.	

<sup>2</sup> Also referenced in Objective 3, under “Skilled Long Term Care Workforce” topic





**Objective 3: Provide equitable access and high quality long term care services for seniors and elders who are no longer able to live in their own homes**

Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Improved Long Term Care Operations</b></p> <ul style="list-style-type: none"> <li>• Implement Inter-RAI to validate assessed need for LTC placement throughout the NWT.</li> <li>• Continue to monitor LTC bed utilization and territorial waitlist data to develop validated bed demand projections. (2017/18 – 2021/22)</li> <li>• Based on documented projected need, plan to increase LTC beds throughout the territory to meet the expected future demand. (2017/18 – 2021/22)</li> <li>• Propose alternate financing options for efficient, effective and sustainable operation of long term care, including adjusting the LTC room and board rates according to an individual’s ability to pay. (2017/18 – 2021/22)</li> </ul>	LTC assessment and operational decisions are informed by consistent, evidence-based processes.	Seniors and elders have equitable access to LTC services when they are required.
HSS	<p><b>Restorative Care</b></p> <ul style="list-style-type: none"> <li>• Establish a restorative care model for short-term stays in LTC facilities for patients who no longer need inpatient hospitalization but require further recovery prior to safely returning to their homes. (2017/18 – 2020/21).</li> </ul>	A restorative care model is implemented in the NWT.	Shorter hospitalizations and faster return to the home community or region for seniors, elders and other NWT residents.
HSS	<p><b>Long Term Care Regulatory Framework</b></p> <ul style="list-style-type: none"> <li>• Develop and implement an NWT LTC Regulatory Framework. (2017/18 – 2021/22)</li> </ul>	LTC facilities in the NWT are regulated by law.	More consistent LTC service delivery with higher levels of accountability for service providers.

## Objective 4

Objective 4: Enhance palliative care services by increasing capacity and access closer to home			
Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Standardized Approach to Care</b></p> <ul style="list-style-type: none"> <li>Implement the NWT Palliative Approach to Care service model in collaboration with the NWT Seniors Society (NWTSS). (2017/18 – 2021/22)</li> <li>Develop a mandatory standardized Advanced Care Planning and Goals of Care process for use with all clients with a palliative diagnosis. (2017/18 – 2021/22)</li> <li>Standardize for palliative care:               <ul style="list-style-type: none"> <li>Care pathways</li> <li>Clinical practice guidelines</li> <li>Clinical decision-making support tools (2017/18 – 2021/22)</li> </ul> </li> </ul>	Consistent, equitable palliative care services available throughout the territory.	NWT residents experience a higher quality of palliative care services when needed, in or closer to their homes and home communities.
HSS	<p><b>Physical Resources</b></p> <ul style="list-style-type: none"> <li>Implement a standardized formulary with stock drugs for palliative symptom management. (2017/18 – 2021/22)</li> <li>Develop an adequate palliative care equipment and supplies bank for loan to clients with a palliative diagnosis. (2017/18 – 2021/22)</li> </ul>	NWT residents who require palliative care have access to the medications and equipment they need.	
HSS	<p><b>Skilled and Supported Workforce</b></p> <ul style="list-style-type: none"> <li>Develop a resource inventory of NWT health professionals with palliative care training. (2018/19 – 2021/22)</li> <li>Implement a Palliative Care Clinical Support Network to support NWT health care providers: 24/7 availability of expert consultation and support on palliative and end of life care. (2018/19 – 2021/22)</li> <li>Continue to support palliative and end-of-life care training initiatives. (2017/18 – 2021/22)</li> </ul>	NWT health professionals who provide palliative care have improved knowledge and skills, and are better supported.	

**Objective 4: Enhance palliative care services by increasing capacity and access closer to home**

Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Culturally Safe Palliative Care</b></p> <ul style="list-style-type: none"> <li>• Ensure that information on culturally safe end-of-life practices, specific to the cultural context of the NWT is readily available to both health care providers and clients. (2017/18 – 2021/22)</li> <li>• Support Continuing Care staff to participate in cultural awareness training. (2017/18 – 2021/22)</li> <li>• Adapt Canadian tools for discussing personal directives as necessary in consultation with traditional palliative care experts. (2017/18 – 2021/22)</li> <li>• Validate relevance and accuracy of content in “<i>Talking About End of Life Care</i>” Primary Provider Guides with local elders and in collaboration with the NWT Seniors’ Society; revise if necessary and redistribute. (2017/18 – 2021/22)</li> <li>• Contextually and culturally adapt advance care planning templates. (2017/18 – 2021/22)</li> </ul>	Palliative care information, and tools are available in culturally relevant formats, and services provided are culturally safe.	NWT residents who require palliative care receive culturally safe services.



# Objective 5

Objective 5: Employ sustainable best practices to provide culturally safe, high quality Continuing Care services			
Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>Culturally Safe, Person/Family Centred Care</b></p> <ul style="list-style-type: none"> <li>Integrate a culturally safe, person/family centred approach to care across all Continuing Care service areas. (2017/18 - 2019/20)</li> <li>Provide training in culturally safe, person/family centred care to Continuing Care supervisors and frontline staff. (2018/19 - 2019/20)</li> </ul>	Continuing Care services are provided using a culturally safe, person/family centred approach.	Continuing Care clients receive culturally safe care.
HSS	<p><b>Improved Continuing Care Core Processes</b></p> <ul style="list-style-type: none"> <li>Develop territorial policies and procedures for referral, admission, assessment, treatment and discharge planning. (2017/18 - 2021/22)</li> <li>Establish standardized reporting of sentinel events across all streams of Continuing Care services. (2017/18 - 2021-22)</li> </ul>	Enhanced and consistent Continuing Care core procedures.	Continuing Care clients receive safer, higher quality and more consistent services.



**Objective 5: Employ sustainable best practices to provide culturally safe, high quality Continuing Care services**

Lead	Activities and Timelines	Outputs	Outcomes
HSS	<p><b>InterRAI Assessment System</b></p> <ul style="list-style-type: none"> <li>• Implement InterRAI throughout the NWT across all Continuing Care programs, facilities and admissions processes:               <ul style="list-style-type: none"> <li>◦ Implement the InterRAI Long-Term Care Facilities Assessment System</li> <li>◦ Implement the InterRAI Home Care Assessment System (2018/19 – 2021/22)</li> </ul> </li> <li>• Provide InterRAI staff training. (2018/19 – 2021/22)</li> <li>• Employ InterRAI to strengthen integration and communication between care teams. (2020/21 – 2021/22)</li> <li>• Support use of InterRAI to identify client care needs and strengthen referral pathways. (2020/21 – 2021/22)</li> <li>• Support use of InterRAI to collect, aggregate and communicate quality outcome indicators in collaboration with the Canadian Institute for Health Information. (2020/21 – 2021/22)</li> </ul>	Evidence-based, seamless comprehensive assessment system across all Continuing Care and palliative care services.	More equitable access and improved continuity of care for Continuing Care clients, with smoother transitions between levels of care.
HSS	<p><b>Medical Assistance in Dying</b></p> <ul style="list-style-type: none"> <li>• Provide training to ensure that all Continuing Care staff are aware of the processes, forms and protocols to follow when a client requests information or access to Medical Assistance in Dying services. (2017/18)</li> </ul>	Continuing Care staff are trained to respond with accurate information and approved processes to requests regarding Medical Assistance in Dying.	Continuing Care clients have access to accurate information and approved processes to Medical Assistance in Dying when they request it.





If you would like this information in another official language, call us.

English

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Si vous voulez ces informations en français, contactez-nous.

French

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Kīspin ki nitawih̄tīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.

Cree

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Tłjchq yatı k'èè. Dı wegodi newq dè, gots'ō gonede.

Tłjchq

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ʔerih̄t'ís Dēne Sų́íné yatı t'a huts'elkēr xa beyáyatı theʔą ʔat'e, nuwe ts'ēn yóftı.

Chipewyan

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Edı gondı dehghá got'je zhatıé k'èè edat'éh enahddhę nıde naxets'é edahıı.

South Slavey

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K'áhshó got'jne xədə k'é hederı ʔedjht'é yerııwę nıde dúle.

North Slavey

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Jii gwandak izhii ginjik vat'atr'ijáhch'uu zhit yinothtan jı', diıts'at ginohkhıı.

Gwich'in

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Uvanittuaq ilitchurisukupku Inuvialuktun, ququagluta.

Inuvialuktun

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Inuktitut

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Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.

Inuinnaqtun

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1-855-846-9601





