



Health Innovation Portal: Archive of Innovative Practices

Theme: Aboriginal Health

January 2014



Health Council of Canada
Conseil canadien de la santé



Selected Search Output Table (December 16, 2013)

1. Saskatoon Primary Health Bus

Implementation Year: Tuesday, December 9, 2008 - 15:45	Location: Saskatchewan	Practice Website: http://www.saskatoonhealthregion.ca/your_health/ps_primary_health_health_bus.htm
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SNAPSHOT:

This innovative practice improves access to care in low-income neighbourhoods. The practice was launched in Saskatoon, Saskatchewan, and involves nurse practitioners and paramedics.

CONTACT INFORMATION:

Sheila Achilles, Director Primary Health and Chronic Disease Management Primary Health St. Paul's Hospital 1702-20th Street West Saskatoon, SK S7M 0Z9 Telephone: (306) 655-5806

2. Aboriginal Health Access Centres

Implementation Year: Saturday, December 9, 1995 - 14:30	Location: Ontario	Practice Website:
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SNAPSHOT:

This innovative practice improves the health and well-being of Aboriginal communities. Between 1995 and 2000, 10 Aboriginal Health Access Centres (AHACs) were established in Ontario. AHACs involve traditional healers; Western primary care providers; and cultural, health promotion, and community development workers.

CONTACT INFORMATION:

Name: Imran Ali Organization: Ontario Ministry of Health and Long-Term Care, Negotiations Branch Telephone: 416-327-8237

3. Taima Tuberculosis (TB): Increasing Awareness and Screening of Tuberculosis in Nunavut

Implementation Year: Sunday, November 27, 2011 - 10:30	Location: Nunavut	Practice Website: http://taimatb.tungavik.com/
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SNAPSHOT:

This innovative practice addresses the disproportionately high incidence rate of tuberculosis (TB) in Nunavut. The practice was launched in Iqaluit, Nunavut, and involved a public health team of registered nurses and Inuktitut-speaking community TB champions.

CONTACT INFORMATION:

Name: Deborah Van Dyk RN, MScN Title: Project Coordinator, Taima TB Organization: Ottawa Hospital Research Institute Email address: dvandyk@ohri.ca Telephone number: (867) 222-5026 Information last updated on: August 23, 2013

4. Mental Health Liaison

Implementation Year: Friday, November 26, 2004 - 14:00	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1017161
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SNAPSHOT:

This innovative practice improves the level of coordination and accessibility of mental health care services in a rural setting in Alberta by providing a direct link among physicians, nurses, and patients. In 2004, the mental health liaison was added as a new position to the Access and Early Intervention Program of Mental Health Services in the community of Rocky Mountain House, Alberta. There are now 27 mental health liaison positions throughout the central region of the province.

CONTACT INFORMATION:

Name: Gloria Bruggencate **Title:** Instructor **Organization:** Mental Health Services **Email address:** gbruggencate@dthr.ab.ca **Telephone number:** 403-783-7907

5. Community Liaison Discharge Planning, First Nations Health Programs, Whitehorse General Hospital

Implementation Year: Tuesday, November 26, 2002 - 11:00	Location: Yukon	Practice Website:
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SNAPSHOT:

This innovative practice addresses the complex needs of First Nations, Inuit, and Métis patients who are discharged from hospital to rural and remote communities in the Yukon. The practice was established as a component of the First Nations Health Programs at Whitehorse General Hospital in 2002, and involves a community liaison discharge planner.

CONTACT INFORMATION:

Name: Laura Salmon **Title:** Director, First Nations Health Programs **Organization:** Yukon Hospital Corporation **Email address:** laura.salmon@wgh.yk.ca **Telephone number:** 1 (867) 393 8756 **Information last updated on:** September 16, 2013

6. On-line Elder care education for community-based health care providers—Saint Elizabeth's @YourSide Colleague First Nations Elder Care Course

Implementation Year: Tuesday, November 26, 2013 - 11:00	Location: National	Practice Website: http://saintelizabeth.com/FNIM/Home.aspx
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SNAPSHOT:

This innovative practice provides affordable, accessible, and culturally appropriate training for community health providers. The course was launched in January 2013 and is available on-line to providers across the country. It involves First Nation health care providers, Elders, and specialists.

CONTACT INFORMATION:

Name: Tracy Scott **Title:** Program Lead **Organization:** Saint Elizabeth First Nations, Inuit and Métis Program **Email address:** tscott@saintelizabeth.com **Telephone number:** 204.253.3560 **Information last updated on:** October 2, 2013

7. Traditional Healing, Medicines, Foods and Supports Program (THMFS) and Aging at Home Elder Care Continuum, Sioux Lookout Meno Ya Win Health Centre (SLMHC)

Implementation Year: Friday, November 26, 2004 - 10:45	Location: Ontario	Practice Website:
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SNAPSHOT:

This innovative practice is improving the health and well-being of Elders in remote and isolated communities in northwestern Ontario through the delivery of culturally safe care and the development of a continuum of linked community-based and institutional services. Initiated by Sioux Lookout Meno Ya Win Health Centre (SLMHC), the practice is rooted in a collaborative strategy among First Nations leadership and communities, the LHIN, provincial and federal governments, health organizations, providers, and clients.

CONTACT INFORMATION:

Name: Heather Fukushima **Title:** Director, Long-Term Care and Service Development and Traditional Program **Organization:** Sioux Lookout Meno Ya Win Health Centre **Email address:** hfukushima@slmhc.on.ca **Telephone number:** (807) 737-2700 **Information last updated on:** June 26, 2013



8. Integrated services for elders on-reserve—Siksika Nation Health Services

Implementation Year: Thursday, November 26, 2009 - 10:30	Location: Alberta	Practice Website: http://www.siksikahealth.com/index.html
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SNAPSHOT:

This innovative practice addresses the need for an integrated continuum of care and housing options for elders on-reserve. The practice was established in 2009 and involves care provided through teams, partnerships, agreements, and investments in technology.

CONTACT INFORMATION:

Name: Cheryl Sorenson **Title:** Team Leader for Siksika Home Care / Siksika Elders Lodge **Organization:** Siksika Health Services **Email address:** cheryls@siksikahealth.com **Telephone number:** 403 734-5621 **Information last updated on:** September 25, 2013

9. Supporting Aboriginal Seniors at Home (SASH), Southwest Ontario Aboriginal Health Access Centre

Implementation Year: Friday, November 26, 2010 - 10:15	Location: Ontario	Practice Website:
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SNAPSHOT:

This innovative practice provides culturally safe care to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. In doing so, the practice addresses disparities between the life expectancy and the incidence of chronic disease for Aboriginal and non-Aboriginal seniors. It was launched in Ontario at an Aboriginal Health Access Centre, and involved a nurse practitioner, a senior's health advocate, and a patient navigator.

CONTACT INFORMATION:

Name: Barb Chrysler **Title:** Manager, Primary Care **Organization:** Southwest Ontario Aboriginal Health Access Centre **Email address:** bchrysler@soahac.on.ca **Telephone number:** (519) 289 0352 **Information last updated on:** September 23, 2013

10. Supporting Métis seniors and families—Métis Nation of Ontario (MNO) community centres

Implementation Year: Friday, November 26, 1993 - 10:15	Location: Ontario	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need to support Métis senior citizens who are at risk of falling through the cracks of a complex health system. The first community centres were established in the mid-1990s, with the remaining centres developing since that time. Programming involves partnerships with different ministries, Aboriginal groups and the volunteer sector. Care delivery involves interdisciplinary health staff, community centre workers and volunteers.

CONTACT INFORMATION:

Name: Wenda Watteyne, **Title:** Director of Healing and Wellness **Organization:** Métis Nation Ontario **Email address:** wendaw@metisnation.org **Telephone number:** 613.798.1488 **Information last updated on:** October 23, 2013

11. Kahnawake Home and Community Care Services; Culturally Competence Case Management

Implementation Year: Wednesday, November 26, 2003 - 10:00	Location: Quebec	Practice Website: http://www.kscs.ca/taxonomy/term/5/all
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SNAPSHOT:

This innovative practice addresses the need to provide a better continuum of care for First Nations seniors and others in their home community of Kahnawake (population 9,500). It provides services in clients' homes and involves a 10-member home care nursing team, an 18-member home health aide team, a seven-member hospital-based Day Program team, an Adult and Elders Service Counsellor, two Day Program Animators, two Elders Case Workers, administrative staff, a kitchen team, a maintenance and security team, and the program's manager.

CONTACT INFORMATION:



Name: Mike Horne Title: Program Manager, Kahnawake Home and Community Care Services Organization: Kahnawake Shakotii'a'takehnhas Community Services Email address: mikeh@kscskahnawake.ca Telephone number: (450) 632 5499 ext: 115 Information last updated on: July 17, 2013

12. Adapting the Non-Insured Health Benefits (NIHB) program to meet the needs of First Nations elders – Policy Tools, Pharmaceutical Medication and Rural/Remote Travel.

Implementation Year: Saturday, November 26, 2011 - 10:00	Location: New Brunswick, Newfoundland & Labrador, Nova Scotia, Prince Edward Island	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need for improvement in FNIHB's programs and services in the Atlantic region, to better meet the needs of Elders and improve their health and wellbeing. The Strategic Plan for Atlantic First Nations Elder Care was launched in January 2011. FNIHB Atlantic works collaboratively with the Mi'kmaq Maliseet Atlantic Board to implement the plan.

CONTACT INFORMATION:

Name: Louise Cholock Title: Director, NIHB Organization: Health Canada, First Nations and Inuit Health Branch, Atlantic Region Email address: Louise.Cholock@hc-sc.gc.ca Telephone number: (902) 426-2519 Information last updated on: October 7, 2013

13. Saskatchewan First Nations Aboriginal Diabetes Initiative Action Plan

Implementation Year: Thursday, November 26, 2009 - 10:00	Location: Saskatchewan	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need to reduce the incidence and effects of type 2 diabetes in First Nations people. The practice was launched in all 78 First Nations in Saskatchewan, involving representatives of these communities and of Health Canada.

CONTACT INFORMATION:

Name: Barbara MacDonald, RN, BSN, CDE Title: Community Health Services Nurse Consultant Organization: Primary Care and Clinical Services, First Nations and Inuit Health, SK Region, Health Canada Email address: barbara.macdonald@hc-sc.gc.ca Telephone number: (306) 780 5747 Information last updated on: July 15, 2013

14. Community health aides help with nursing shortages, continuity of care, and cultural safety

Implementation Year: Monday, November 26, 2007 - 10:00	Location: Newfoundland & Labrador	Practice Website: http://www.nunatsiavut.com/index.php?option=com_content&view=frontpage&Itemid=1&lang=en
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SNAPSHOT:

This innovative practice addresses concerns about the recruitment and retention of nurses, and about the continuity and cultural safety of care for Inuit seniors.

CONTACT INFORMATION:

Name: Tina Buckle Title: Community Health Nursing Coordinator Organization: Nunatsiavut Government, Dept. of Health and Social Development Email address: tina_buckle@nunatsiavut.com Telephone number: (709) 896-9750 ext 232 Information last updated on: September 30, 2013

15. Culturally Competent Collaborative Practice Model for Chronic Disease Management

Implementation Year: Friday, November 26, 2010 - 09:45	Location: Saskatchewan	Practice Website:
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SNAPSHOT:



This innovative practice aims to improve quality of life and health care delivery for First Nations people with chronic disease, through better linkages between provincial and on-reserve services and enhanced service delivery on-reserve. Launched in 2010, this practice included collaboration among Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program) and three First Nations communities including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation.

CONTACT INFORMATION:

Name: Sandy Hassler **Title:** Collaborative Practice Coordinator (retired) **Organization:** n/a **Email address:** s.hassler@sasktel.net **Telephone number:** 306 736-9099 **Information last updated on:** October 10, 2013

16. Bringing chronic disease self-management to rural and remote regions in Rocher-Percé

Implementation Year: Saturday, November 26, 2011 - 09:45	Location: Quebec	Practice Website: http://interestsante.ca/participation-au-4e-rendez-vous-de-la-gestion-des-maladies-chroniques.php
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SNAPSHOT:

This innovative practice improves the effectiveness of chronic disease management in rural remote regions. Established in 2011 and funded for two years, this practice involved an interprofessional team of nurses, dietitians, and kinesiologists who worked collaboratively with physicians.

CONTACT INFORMATION:

Name: Tim Sutton **Title:** Kinesiologist **Organization:** The Centre de santé et des services sociaux du Rocher-Percé **Email address:** tim.sutton.pabok@SSSS.gouv.qc.ca **Telephone number:** 418-680-3307 **Information last updated on:** September 25, 2013

17. Youth caring for elders and preventing elder abuse—Carcross /Tagish First Nation Health and Wellness Department

Implementation Year: Saturday, November 26, 2011 - 09:45	Location: Yukon	Practice Website: http://www.ctfn.ca/
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SNAPSHOT:

This innovative practice addresses the need to build family, community, and provider capacity to care for elders and enable them to stay safely and longer in their homes. Implemented in 2011, a remote Yukon community took a strategic approach to making youth more responsible, reducing elder abuse, and strengthening the home care program.

CONTACT INFORMATION:

Name: Roberta Shepherd **Title:** Outreach Program Manager **Organization:** Carcross/Tagish First Nation **Email address:** roberta.shepherd@ctfn.ca **Telephone number:** 867 821-4251 Ex 8232 **Information last updated on:** September 25, 2013

18. Home care program for everyone, on- or off-reserve, Bella Coola

Implementation Year: Monday, November 26, 2007 - 09:30	Location: British Columbia	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need for equal access to integrated home and community care for Aboriginal seniors on-reserve. The practice was launched in Bella Coola and involves an interprofessional team of federal home care workers, provincial home care workers, and band-employed workers.

CONTACT INFORMATION:

Name: Glenda Phillips **Title:** Manager, Home & Community Support **Organization:** Bella Coola General Hospital **Email address:** glenda.phillips@vch.ca **Telephone number:** 250-799-5311 **Information last updated on:** September 30, 2013

19. Aboriginal Care Coordinator Registered Nurse, Case Management, Royal Alexandra Hospital, Alberta Health Services



Implementation Year: Monday, November 26, 2007 - 09:30	Location: Alberta	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need for coordinated care in a hospital environment (from intake through discharge) for First Nations and Métis people. It was launched at Royal Alexandra Hospital in 2007 and serves First Nations and Métis patients living in Central and Northern Alberta. The practice involves an Aboriginal Care Coordinator Registered Nurse (RN) working collaboratively with interprofessional teams.

CONTACT INFORMATION:

Name: Brenda Crook, BA (Psych), RN, BN, CCHN (C) **Title:** Aboriginal Care Coordinator, Care Management, Royal Alexandra Hospital, Edmonton
Organization: Alberta Health Services **Email address:** brenda.crook@albertahealthservices.ca **Telephone number:** (780) 735 6935 **Information last updated on:** October 1, 2013

20. Telehealth Services, Primary Care, Carrier Sekani Family Services

Implementation Year: Sunday, November 25, 2012 - 19:00	Location: British Columbia	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need to enhance access to primary care and continuity of care in remote First Nations communities in North Central British Columbia through use of telehealth. The practice was launched at Carrier Sekani Family Services in January 2012 and involved a primary care physician, a family nurse practitioner, and medical staff at nursing centres and health centres in eight First Nations in Carrier and Sekani Territory.

CONTACT INFORMATION:

Name: Ginny Burns **Title:** Family Nurse Practitioner and Clinical Support **Organization:** Carrier Sekani Family Services Primary Care **Email address:** ginnyy@csfs.org **Telephone number:** (250) 567 7561 **Information last updated on:** September 27, 2013

21. The importance of culture to care – Continuing Care and Independent Living Program – Tlilcho Community Service Agency

Implementation Year: Wednesday, November 25, 2009 - 18:45	Location: Northwest Territories	Practice Website: http://www.tlilcho.ca/organization/tlilcho-community-services-agency
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SNAPSHOT:

This innovative practice aims to address the need for integrating culture and holistic programming into home and continuing care, to better meet the needs of elders. A new managerial role of Continuing Care and Independent Living was created to work with coordinators in all program areas.

CONTACT INFORMATION:

Name: Nora Wedzin **Title:** Manager, Continuing Care and Independent Living **Organization:** Tlilcho Community Service Agency (TCSA) **Email address:** nwedzin@tlilcho.net **Telephone number:** 867-392-6161 **Information last updated on:** October 2, 2013

22. Saanich First Nations Adult Care Society

Implementation Year: Sunday, November 25, 2007 - 18:45	Location: British Columbia	Practice Website:
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SNAPSHOT:

This innovative practice addresses gaps in care for Elders and disabled people in First Nations communities on Vancouver Island in British Columbia. The Saanich First Nations Adult Care Society provides care in clients' homes, and currently involves two home care nurses and five home support workers.

CONTACT INFORMATION:

Name: Audrey Sampson **Title:** Coordinator **Organization:** Saanich First Nations Adult Care Society **Email address:** coord.sfnacs@shaw.ca **Telephone**



number: (250) 544 1627 Information last updated on: October 1, 2013

23. Pond Inlet Elder Education and Awareness Program

Implementation Year: Tuesday, November 25, 2003 - 18:30	Location: Nunavut	Practice Website:
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SNAPSHOT:

This innovative practice addresses the isolation, health knowledge levels, and self-management skills of Inuit Elders in a rural and remote community in Nunavut. The practice was established in 2003 in a community centre and involved a home and community care nurse, home and community care workers, and a community health representative.

CONTACT INFORMATION:

Name: Sherry Parks **Title:** Home Care Nurse **Organization:** Government of Nunavut **Email address:** Sparks@gov.nu.ca **Telephone number:** 1 (867) 899 7506 **Information last updated on:** October 2, 2013.

24. Shared Caregiving in the Community—Peter Ballantyne Cree Nation (PCBN)

Implementation Year: Tuesday, November 25, 2008 - 18:15	Location: Saskatchewan	Practice Website: http://www.peterballantyne.ca/index.html
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SNAPSHOT:

This innovative practice addresses the need for home and continuing care for seniors living on-reserve. The PBCN Health System developed a structured home and community care program in 1999, enhancing it in 2008 by pooling community resources and bringing together an interprofessional team, families, and community services

CONTACT INFORMATION:

Name: Bonita Beatty **Title:** Assistant Professor, Department of Native Studies, Co-Director Graduate Studies, International Centre **Organization:** University of Saskatchewan **Email address:** bonita.beatty@usask.ca **Telephone number:** (306) 291-2562 **Information last updated on:** September 25, 2013

25. Building bridges between First Nations health care providers and the mainstream health care system, Mamaweswen North Shore Tribal Council (NSTC)

Implementation Year: Sunday, November 25, 2007 - 18:15	Location: Ontario	Practice Website:
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SNAPSHOT:

This innovative practice improves communication and continuity in care for seniors who are discharged from the hospital back to their First Nations community. Launched in 2007, two First Nation System Navigator/Discharge Planning Nurses (DPN) from First Nations communities work in collaboration with hospitals, CCAC, clients, families, and the Mamaweswen North Shore Tribal Council (NSTC) communities.

CONTACT INFORMATION:

Name: Edith Mercieca **Title:** Community Support Services Manager **Organization:** Mamaweswen, North Shore Tribal Council **Email address:** edith.mercieca@nmninoeyaa.ca **Telephone number:** 705-844-2021 x 308 **Information last updated on:** October 3, 2013

26. Keewaytinook Okimakanak (KO) Telemedicine: Improving care for and reducing isolation of Elders

Implementation Year: Wednesday, November 25, 2009 - 18:00	Location: Ontario	Practice Website: http://telemedicine.knet.ca/?q=node/2559
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SNAPSHOT:



This innovative practice provides a continuum of care in remote areas of northwestern Ontario and connects Elders to their families and communities. KO Telemedicine (KOTM) has continued to grow over the past 20 years, and in 2009 the in-home camera service was expanded to home care. The cornerstones of the service are the 26 community telemedicine coordinators who work in collaboration with off-site interprofessional health practitioners and the Ontario Telemedicine Network (OTN).

CONTACT INFORMATION:

Name: Heather Coulson **Title:** Program Development Coordinator **Organization:** KO Telemedicine **Email address:** heathercoulson@knet.ca **Telephone number:** 807 737 1135 ext 1580 **Information last updated on:** September 16, 2013

27. Improving Home Care Services to First Nations and Métis People, Aboriginal Home Care Program

Implementation Year: Wednesday, November 25, 2009 - 18:00	Location: Saskatchewan	Practice Website:
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SNAPSHOT:

This innovative practice improves access to home care services for First Nations and Métis people in the North Central area of Regina. The practice was launched in 2009 in a primary health care facility in the Regina Qu'Appelle Health Region (RQHR) and involved members of RQHR's home care team (community liaison worker, case manager, nurses, continuing care aides, scheduler, and administrative staff), First Nations and Métis knowledge keepers, and other health care providers.

CONTACT INFORMATION:

Name: Dawn McNeil **Title:** Executive Director, Home Care & Palliative Care **Organization:** Regina Qu'Appelle Health Region **Email address:** dawn.mcneil@rqhealth.ca **Telephone number:** (306) 766-7210

28. Quality Improvement Policy Framework for First Nations

Implementation Year: Wednesday, November 7, 2012 - 11:30	Location: National	Practice Website:
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SNAPSHOT:

This innovative practice provides policy tools to help guide continuous quality improvement in government health care policy and program development. The practice was launched by Health Canada's First Nations and Inuit Health Branch (FNIHB) in 2012 to establish a national system of culturally relevant accreditation for on-reserve First Nations and Inuit health and treatment services in Canada and is being implemented by a small group of staff and an external training consultant.

CONTACT INFORMATION:

Name: Jennifer Greene **Title:** Manager, Quality Improvement and Accreditation Program **Organization:** First Nations and Inuit Health Branch, Health Canada, Government of Canada **Email address:** jennifer.greene@hc-sc.gc.ca **Telephone number:** (613) 954-2295

29. Drop the Pop

Implementation Year: Friday, November 5, 2004 - 14:30	Location: Northwest Territories, Nunavut, Yukon	Practice Website: www.dropthepopnwt.ca
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SNAPSHOT:

This innovative practice addresses the issue of childhood obesity and other nutrition-related health issues as part of a jurisdictional health promotion strategy. The practice was launched in 2004 in Nunavut, starting with 14 schools and involved a government lead, community partners, and administrators/teachers leading individual school efforts.

CONTACT INFORMATION:

Name: Title: Population Health Division, Health Promotion **Organization:** Government of Northwest Territories, Department of Health and Social Services **Email address:** healthpromotion@gov.nt.ca **Telephone number:** Information last updated on: July 29, 2013

30. Social Work through Hip Hop (BluePrint For Life): Promoting physical and mental health in youth



Implementation Year: Saturday, October 7, 2006 - 11:15	Location: National	Practice Website: www.blueprintforlife.ca
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SNAPSHOT:

This innovative practice addresses the issue of compromised physical and mental health in youth, especially those living in Canada's North and inner cities. This practice was first launched in Nunavut in 2006 and involves hip hop artists and facilitators with social work training, as well as community members to support the event and follow-up activities.

CONTACT INFORMATION:

Name: Stephen Leafloor **Title:** CEO **Organization:** BluePrintForLife **Email address:** Steve@BluePrintForLife.ca **Telephone number:** 613 592 2220

31. Nuka: The Customer-Owner Model

Implementation Year: Tuesday, February 3, 1998 - 00:15	Location: International	Practice Website: https://www.scf.cc/nuka/
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SNAPSHOT:

This innovative practice aims to provide customer-owned, community centered, team-based models of care to Alaska's native population.

CONTACT INFORMATION:

Name: Dr. Douglas Eby, M.D. **Title:** Vice President of Medical Services **Organization:** Southcentral Foundation **Email address:** deby@scf.cc **Telephone number:** (907) 729-4345

32. First Nations Health Authority

Implementation Year: Friday, February 3, 2012 - 00:00	Location: British Columbia	Practice Website: http://www.fnhc.ca
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SNAPSHOT:

This innovative practice transfers all service delivery to improve the health and well-being of First Nations peoples, to eliminate gaps in health between First Nations people and other British Columbians, and to provide a role for meaningful involvement of First Nations in decision-making regarding the health of their peoples. Launched in 2012, the First Nations Health Authority will design and deliver all federally funded health programs and services for British Columbia.

CONTACT INFORMATION:

Name: Davis McKenzie **Title:** Director, Communications and Public Relations **Organization:** First Nations Health Authority **Email address:** dmckenzie@fnhc.ca **Telephone number:** 604-913-2080 ext: 243

33. Health Service Delivery Models in Remote and Isolated First Nations Communities

Implementation Year: Monday, February 8, 2010 - 10:00	Location: National	Practice Website:
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SNAPSHOT:

This innovative practice focuses on issues that lead to program fragmentation and that affect continuity of care in remote and isolated communities within the multi-jurisdictional First Nations health service environment. In August 2010, Health Canada and the Assembly of First Nations initiated a two-year research project, Health Service Delivery Models in Remote and Isolated First Nation Communities, to identify a path towards transforming health service delivery in remote and isolated First Nations communities.

CONTACT INFORMATION:

Name: Debra Gillis **Title:** Executive Director, Primary Care, First Nations and Inuit Health Branch **Organization:** Health Canada **Email address:** debra.gillis@hc-sc.gc.ca **Telephone number:** 613-957-6359



34. Clinique Minowé

Implementation Year: Tuesday, February 12, 2008 - 00:15	Location: Quebec	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need for an appropriate model of care for the provision of integrated health and social services for Aboriginal people living in urban centres. In December 2008, with support from Health Canada's Aboriginal Health Transition Fund, the partners began work on a project to develop a new urban-based health and social services model. Their goal was to establish a model that would introduce new mechanisms for collaboration and partnership, would be based on knowledge and understanding of Aboriginal people's health and social service needs.

CONTACT INFORMATION:

Inquiries about Clinique Minowé should be directed to Edith Cloutier, Executive Director, Val-d'Or Native Friendship Centre (edith.cloutier@caavd.ca). Additional information on Clinique Minowé is available online at http://caavd.ca/admin/editor/asset/CliniqueMinowe_ANGw_2fev.pdf

35. WRHA Framework for Action: Cultural Proficiency & Diversity

Implementation Year: Tuesday, February 1, 2011 - 00:15	Location: Manitoba	Practice Website:
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SNAPSHOT:

This innovative practice emphasizes the need to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. Developed in the Winnipeg Regional Health Authority in 2011, The Framework for Action is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the interests and experiences of a diverse population and authentically engaging and collaborating with community.

CONTACT INFORMATION:

Additional information on WRHA's Aboriginal Health Programs is available at <http://wrha.mb.ca/aboriginalhealth/index.php>. WRHA's Framework for Action: Cultural Proficiency & Diversity can be found at http://www.wrha.mb.ca/community/commdev/files/WRHA_cpd_framework_final.pdf.

36. St. John's Friendship Centre

Implementation Year: Tuesday, February 3, 2004 - 00:30	Location: Newfoundland & Labrador	Practice Website:
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SNAPSHOT:

This innovative practice supports First Nations, Inuit, and Métis people who travel to St. John's for medical care. Launched in 2004, the Friendship Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

CONTACT INFORMATION:

Additional information on St. John's Friendship Centre is available at <http://www.sjncf.com>.

37. Provincial Health Services Authority's (PHSA) Aboriginal Health Program

Implementation Year: Friday, February 3, 2006 - 00:30	Location: British Columbia	Practice Website:
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SNAPSHOT:

This innovative practice delivers a facilitated online training program that acts as an educational bridge to transform attitudes, behaviours, and practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 Transformative Change Accord (more information



on the Accord can be found here) signed by the Province of British Columbia and the First Nations Leadership Council.

CONTACT INFORMATION:

Additional information about the PHSA Indigenous Cultural Competency Training Program is available online at www.culturalcompetency.ca, or from Cheryl Ward, Provincial Lead for Indigenous Cultural Competency Training (cward-02@phsa.ca).

38. Interior Health Authority (IHA)

Implementation Year: Wednesday, February 3, 2010 - 00:30	Location: British Columbia	Practice Website:
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SNAPSHOT:

This innovative practice addresses the need to make changes to the way a health region plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population. The Interior Health Authority (IHA) in British Columbia has developed and implemented the Aboriginal Health & Wellness Strategy, 2010–2014, which recognizes that the gap between the health status of Aboriginal people and other residents.

CONTACT INFORMATION:

Additional information on IHA's Aboriginal Health Program and the Aboriginal Health & Wellness Strategy, 2010–2014 can be found at www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/default.aspx.

39. All Nations' Healing Hospital (ANHH)

Implementation Year: Friday, February 3, 2006 - 00:30	Location: Saskatchewan	Practice Website:
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SNAPSHOT:

This innovative practice offers a model for collaboration in health service delivery, straddling cultural and jurisdictional boundaries to offer a full range of services to all community members in Fort Qu'Appelle and the surrounding region, which lies within the traditional territories of the 35 Treaty 4 First Nations. The All Nations' Healing Hospital (ANHH) has drawn national and international attention, is unique in its approach to service delivery, governance, and funding.

CONTACT INFORMATION:

Additional information about ANHH is available online (<http://www.fortquappelle.com/anh.html>) or from Gail Boehme, Director of ANHH & Health Services, File Hills Qu'Appelle Tribal Council (gboehme@fhqtc.com).

40. Regina Qu'Appelle Health Region's (RQHR) Aboriginal Home Care Program

Implementation Year: Friday, February 3, 2006 - 00:30	Location: Saskatchewan	Practice Website: http://www.healthcouncilcanada.ca/rpt_det.php?id=437
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SNAPSHOT:

This innovative practice aims to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. Launched in the Regina Qu'Appelle Health Region's (RQHR), the program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

CONTACT INFORMATION:

Additional information about this program is available online at http://www.rqhealth.ca/programs/comm_hlth_services/homecare/homecare.shtml.

41. Aboriginal Support Workers, Southern Regional Health Authority

Implementation Year: Friday, February 3, 2012 - 00:45	Location: Manitoba	Practice Website:
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SNAPSHOT:

This innovative practice has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve. Launched in Manitoba's Southern Regional Health Authority in 2012, Aboriginal Health Services have adapted their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people.

CONTACT INFORMATION:

For additional information on the Aboriginal Support Workers and Aboriginal Health Services at Southern Regional Health Authority, please feel free to connect with the office of Southern RHA's Regional Director of Aboriginal Health at (204) 239 2304 or dharris@rha-central.mb.ca.



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Saskatoon Primary Health Bus

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	

Snapshot: This innovative practice improves access to care in low-income neighbourhoods. The practice was launched in Saskatoon, Saskatchewan, and involves nurse practitioners and paramedics.

Practice Description:

A 2006 study examining health disparities by neighbourhood in Saskatoon showed that low-income neighbourhoods have a higher than average use of health care, higher burdens of illness (including mental disorders, diabetes, chronic obstructive pulmonary disease, coronary artery disease, chlamydia, gonorrhoea, hepatitis C), higher rates of teen births, and greater likelihood of low birth weights. Primary health care managers in Saskatoon Health Region recognized that residents of these neighbourhoods (primarily First Nations people, Métis, immigrants, and refugees) could not access primary care easily. To address this concern, they converted a recreational vehicle to serve as a mobile clinic with a fully equipped examination room. The Health Bus, which is staffed by nurse practitioners and paramedics, operates daily to provide primary care services to patients at various locations that are convenient to the residents. Services include blood pressure and blood sugar checks, diagnosis and treatment of common illness and injuries, testing for sexually transmitted infections, provision of free condoms, pregnancy testing, suturing and suture removal, wound care, management of chronic conditions, disease prevention, health education, advocacy, and referral. A community advisory committee helps guide Health Bus operations.

Impact:

The Saskatoon Health Region has tracked program utilization and demographic information of users. During the 2011/12 calendar year, 2,777 patients visited the bus (Saskatoon Health Region, 2012). The majority of visits were for integumentary or ENT conditions. The service was most heavily used by women and by people in the 0–9 and 20–59 age groups.

This innovative practice has been implemented since 2008 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health. Early evidence suggests mobile clinics improve screening for chronic conditions (diabetes and hypertension) and coordination of care (Conference Board of Canada, 2012).

An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

The success of the program is dependent on commitment to unique interprofessional primary health care teams; investment of resources for primary health care services to a small number of people; and engagement of community members in discussions of the scope of services and location of the bus.

The Health Bus has not been adapted from another jurisdiction. Three mobile primary care clinics designed to serve patients in rural and northern Manitoba communities who do not have a family physician are scheduled for implementation in 2013.

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Content has been adapted from the following sources and relevant links:

This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

Publications

Canadian Health Services Research Foundation. (2010). Saskatoon Health Bus. In *Casebook of primary healthcare innovations: Picking up the pace*. Ottawa, ON: Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/CasebookOfPrimaryHealthcareInnovations.sflb.ashx

Conference Board of Canada. (October 2012). *Improving primary health care through collaboration: Briefing 1—Current knowledge about interprofessional teams in Canada*. Retrieved from <http://www.wrha.mb.ca/professionals/collaborativecare/files/CBCBriefing12012.pdf>

Saskatoon Health Region. (2012). *Primary Health Bus report (2011–2012): Events of Distinction 2011–2012*.

External Source: http://www.saskatoonhealthregion.ca/your_health/ps_primary_health_health_bus.htm



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Aboriginal Health Access Centres

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

Snapshot: This innovative practice improves the health and well-being of Aboriginal communities. Between 1995 and 2000, 10 Aboriginal Health Access Centres (AHACs) were established in Ontario. AHACs involve traditional healers; Western primary care providers; and cultural, health promotion, and community development workers.

Practice Description:

AHACs are community-led primary health care organizations that provide traditional healing, primary care, cultural programs, community development initiatives, and social support services to First Nations, Métis, and Inuit communities, both on- and off-reserve, in urban, rural, and northern communities. Primary care providers include physicians, nurse practitioners, and varying complements of other health care providers such as dietitians and chiropractors. In addition to general primary care services, AHACs provide targeted programs such as diabetes education and smoking cessation. The core attributes of AHACs are that they are culturally congruent, interprofessional, community-governed, community- and family-oriented, and inclusive of the social determinants of health. All AHACs provide services in English as well as at least one other First Nations language (Ojibwe, Oji-Cree, Mohawk, or Oneida). The major funding for AHACs comes from the Government of Ontario and is flowed through the Ministry of Health and Long-Term Care. AHACs also receive support from other funders, including local health integration networks, for specific programs and initiatives.

Impact:

This innovative practice was first implemented in 1995 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance and has the potential to produce positive outcomes on health. An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

The practice informant did not identify other specific practices that Ontario based AHACs had been adapted from and was unaware whether it has been used as a model elsewhere. The success of this specific program is dependent on sufficient funding (for capital, competitive compensation for providers, etc.), recruitment and retention of primary care providers, and centralized program management of the organization.

Contact Information:

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Telephone: 416-327-8237

Content has been adapted from the following sources and relevant links:

This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

Association of Ontario Health Centres, AHAC Report Working Group. (2010). *Aboriginal health access centres: Our health, our future*. Retrieved from http://www.aohc.org/index.php?ci_id=2989

Ontario Ministry of Community and Social Services. (2010, September). *Ontario's renewed Aboriginal healing and wellness strategy*. Retrieved from http://www.mcscs.gov.on.ca/en/mcscs/programs/community/AHWS_renewal_letter.aspx



Ontario Ministry of Health and Long-Term Care. (2010, February). *Aboriginal Health Update: Increased funding for Aboriginal health programs*. Retrieved from http://www.hnhblhin.on.ca/uploadedFiles/Public_Community/Aboriginal_Health_Service_Providers/Aboriginal%20Health%20Update.pdf



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Taima Tuberculosis (TB): Increasing Awareness and Screening of Tuberculosis in Nunavut

LOCATION:	Nunavut	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses the disproportionately high incidence rate of tuberculosis (TB) in Nunavut. The practice was launched in Iqaluit, Nunavut, and involved a public health team of registered nurses and Inuktitut-speaking community TB champions.

PRACTICE DESCRIPTION:

The incidence of active tuberculosis (TB) in Nunavut is disproportionately high. According to the Public Health Agency of Canada, Nunavut's TB rate in 2010 was 304 per 100,000, compared to 4.6 per 100,000 in the rest of Canada. Taima TB—Inuktitut for “Stop TB”—is an innovative public health campaign that aims to reduce the rate of TB infection by targeting residential areas at high risk for TB with door-to-door education, screening, and treatment. The program specifically targets latent TB infections (LTBI), a method that can significantly diminish the number of people who go on to have active TB disease. Taima TB, whose motto is “You may not know you have TB—Get tested, get treated before you get sick,” was piloted in Nunavut's capital, Iqaluit, with a view to enhance the territory's existing preventive efforts in the fight against TB.

The unique features of the Taima TB project include:

- an approach specifically tailored to Inuit culture;
- an awareness campaign using social media strategies, including web-based material, YouTube videos, and a Facebook page;
- introducing and determining the feasibility of a new diagnostic test for LTBI;
- a proactive approach to screening and treatment that targets specific high-risk areas; and
- strong community engagement and active participation at every level and stage of the project.

The project was delivered in two phases. Phase I involved raising community-wide awareness of TB, and included a focus group, a local media campaign, a community feast, and a YouTube challenge. Phase II was a six-month door-to-door education, screening, and treatment campaign targeting households in residential areas at high risk for TB. The project was funded by the Public Health Agency of Canada as part of the National Lung Health Framework Phase II, and the Government of Nunavut.

IMPACT:

Qualitative and quantitative data were collected throughout the pilot project and results were released in a 2012 Progress Report. During Phase I, the general awareness campaign, there was an increase in passive LTBI screening, which refers to individuals who present to public health clinics as walk-ins to get tested for TB. The number of walk-ins increased from an average of 25 per month (over the four years prior to Taima TB) to an average of 50 people per month during the general awareness campaign.

During Phase II, a TB champion and a TB nurse delivered TB education to 444 people in their home. One third were not eligible for screening; the remaining two thirds were screened for LTBI. Approximately one third of those tested positive and were recommended LTBI treatment. Treatment results will be published shortly. In addition to these performance measures, a new blood test for the diagnosis of LTBI was piloted and shown to be feasible in Iqaluit.

Taima TB represents a new approach in the fight against TB, one focused on community-based education and precisely targeted screening and treatment campaigns. It will take further application of a variety of TB control strategies to control TB in Nunavut in the future. The manner in which successful features of Taima TB can be integrated into the local TB program



requires further work and discussion with territorial TB policy-makers.

APPLICABILITY/TRANSFERABILITY:

Taima TB's approach to reducing TB in Nunavut has not been adapted from another jurisdiction. Based on the pilot's success, in 2012 the Taima TB group received a grant from the Canadian Institute of Health Research (CIHR) to facilitate knowledge translation and expand the Taima TB awareness campaign to five other communities in Nunavut that have increased rates of TB. The research team is using the tools developed under the Taima TB project to further empower community members with TB knowledge in both Inuktitut and English. Currently they are engaging with local public health teams to focus TB awareness activities on high school students. Further discussion of the results of Taima TB, including challenges and lessons learned, will be published shortly. Please refer to the Taima TB website for updates.

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Information last updated on: August 23, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Van Dyk, D. (feedback and review). [Taima TB].

Publications:

Alvarez, G.G. (2012, March 12). *Taima TB progress report*. Retrieved from <http://taimatb.tunngavik.com/files/2012/04/Bilingual-PROGRESS-REPORT-TAIMA-TB-Final-Version-March-12-2012.pdf>

Other:

Canadian Institutes of Health Research. (2012, March 22). *Fact sheet—Harper government helps tackle tuberculosis in Nunavut*. Retrieved from <http://www.cihr-irsc.gc.ca/e/45087.html>

Canadian Nurses Association. (2012, June). Bringing the community together to beat TB in Nunavut. *Canadian Nurse*. Retrieved from http://www.canadian-nurse.com/index.php?option=com_content&view=article&id=732%3Abringing-the-community-together-to-beat-tb-in-nunavut&catid=4%3Aperspectives&Itemid=39&lang=en

External Source: <http://taimatb.tunngavik.com/>



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Mental Health Liaison

LOCATION:	Alberta	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice improves the level of coordination and accessibility of mental health care services in a rural setting in Alberta by providing a direct link among physicians, nurses, and patients. In 2004, the mental health liaison was added as a new position to the Access and Early Intervention Program of Mental Health Services in the community of Rocky Mountain House, Alberta. There are now 27 mental health liaison positions throughout the central region of the province.

PRACTICE DESCRIPTION:

Key gaps in health care services identified in Rocky Mountain House and neighbouring Aboriginal communities in Alberta included poor coordination and continuity of mental health services; inadequate quality, accessibility, and awareness of available resources; and low numbers of well-trained mental health professionals. Consequently, the development of a mental health liaison stemmed from the need to improve these service gaps to better meet the needs of the population. This was supported by political will at regional levels and in alignment with the Provincial Mental Health Plan. The position was designed for a nonpsychiatric, rural health care setting and involved a broader scope of practice to include any of the following tasks: direct and indirect client intervention, mental health assessment and consultation, risk assessment, crisis intervention, supportive counselling, brief therapy follow-up, advocacy, staff mentoring, education, psychological first aid, research, mental health prevention and promotion, and more. Actual scope of practice for a given mental health liaison practising in a given community is determined by population needs, mental health managers, and site leaders. Ongoing funding for the continuation of this position has been secured through various arrangements of annualizing innovation grants from the province, reorganizing institutionally managed budgets, and adjusting scopes of practice for vacated positions.

IMPACT:

The introduction of this new position in Rocky Mountain House was first evaluated in 2005 by a questionnaire survey of 116 physicians, hospital staff, and community mental health workers. With a 50% response rate, there was unanimous support that the mental health liaison was serving community needs that were previously unmet. Improvements were noted with respect to the appropriateness of mental health care delivered; support for clients, staff, and physicians; continuity of care through follow-up services; and consistency in the coordination of care. While narrative results were consistently positive, reflecting the general acceptance of this position in this community, it is important to note that the results from the Rocky Mountain House setting are highly personality dependent, and thus the data have limited generalizability.

APPLICABILITY/TRANSFERABILITY:

The initial introduction of the mental health liaison position in Alberta was strongly influenced by similar role development undertaken in rural settings in Australia. Although not formally documented, the mental health liaison role in Rocky Mountain House was expanded to seven additional positions in the first year of introduction, and is now practiced by a total of 27 health providers (predominantly nurses) in the Central Region of Alberta. Communities hosting mental health liaison positions are:

- 1 full-time position: Consort, Castor, Coronation; Drayton Valley; Hanna; Hardisty; Innisfail; Killiam; Lamont; Olds; Ponoka; Rocky Mountain House; Stettler; Sundre; Tofield; Vegreville; Vermilion; and Wainwright, Provost
- 1 part-time position: Sylvan Lake
- 2 full-time positions: Camrose, Lacombe, Westaskiwin
- 2 part-time positions: Red Deer, Three Hills

The initial mental health liaison position in Rocky Mountain House is also linked to the integration of mental health liaisons for the Canadian National Committee for Police (<http://www.pmhl.ca/index.html>), and is responsible for a similar role (mental health consultant) that is still in place in the community of Drumheller. Other similar mental health liaison positions have been



developed independently across Canada, indicating the level of relevance and transferability of this innovative practice.

Based on the 2005 evaluation, important areas to address for the further expansion of the mental health liaison position include:

- support to prevent burnout, given that the responsibilities overlap with those of physicians, nurses, and staff, and that the incumbents try to provide increasingly accessible services, often outside of regular hours;
- divergence between patient expectations and the professional cultures of physicians, nurses, and staff; and
- determining appropriate remuneration.

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Content has been adapted from the following sources and relevant links: Information last updated on: July 31, 2013

Publications:

Brinkman, K., Hunks, D., Bruggencate, G., & Clelland, S. (2009). Evaluation of a new mental health liaison role in a rural health center in Rocky Mountain House, Alberta: A Canadian story. *International Journal of Mental Health Nursing*, 18(1), 42–52. Abstract retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1447-0349.2008.00582.x/abstract>

Personal Communications:

Bruggencate, G. (July 31, 2013).

External Source: <http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1017161>



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Community Liaison Discharge Planning, First Nations Health Programs, Whitehorse General Hospital

LOCATION:	Yukon	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses the complex needs of First Nations, Inuit, and Métis patients who are discharged from hospital to rural and remote communities in the Yukon. The practice was established as a component of the First Nations Health Programs at Whitehorse General Hospital in 2002, and involves a community liaison discharge planner.

PRACTICE DESCRIPTION:

The community liaison discharge planner attends to the complex needs of patients who are in hospital and getting ready for discharge to their home communities. The position focuses on aligning programs and services in patients' home communities to ensure that patients receive the follow-up care they need, and that care transitions are as seamless as possible between hospital and community settings. The practice targets high-risk patients with mental health issues or complex discharge planning needs; seniors constitute a significant proportion of that population.

The community liaison discharge planner is part of the Whitehorse General Hospital's First Nations Health Programs. The discharge planner conducts assessments and complex discharge planning and coordination for First Nations, Inuit, and Métis patients in the hospital, including case management for high-risk patients and their families. The discharge planner is based in the hospital, but must maintain a thorough working knowledge of resources available in communities. The discharge planner works with service providers throughout the Yukon.

The community liaison discharge planner's role differs from usual practice or care. As part of the First Nations Health Programs, the discharge planner brings a holistic approach to their work. Discharge planning starts at admission: the planner tries to anticipate patients' discharge needs and date so that appropriate resources will be in place when patients leave the hospital, and makes sure that patients understand their own care needs and responsibilities before they go. The planner participates in daily discharge planning "huddles," that is, meetings in which the health care team reviews the needs of all patients who will be discharged in the next 24-hour period.

Funding for the community liaison discharge planner position is allocated in the budget for the First Nations Health Programs. The First Nations Health Programs are supported by a transfer from the federal government.

IMPACT:

This innovative practice has been in place since 2002 and does not have a completed evaluation at this time. Personal observations suggest that the practice has the potential for positive outcomes on health.

In a 2009 review of the First Nations Health Programs, patients identified discharge planning practices as a valuable component of the programs, particularly because the practices support safe and coordinated care for patients in the community. The community liaison discharge planner's role is also mentioned in Accreditation Canada's recognition of the Whitehorse General Hospital's First Nations Health Programs as a leading practice.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that WGH Community Liaison Discharge had adapted from and were unaware if the practice was used as a model elsewhere. However, there has been considerable interest in the First Nations



Health Programs as a whole from health care organizations across Canada, and some have adapted aspects of the programs for use in their own program. A challenge that might affect the applicability or transferability of the community liaison discharge planning model to other settings is that it can be difficult to find employees who have the skills and knowledge needed to manage the position's range of responsibilities, for example, from working respectfully and effectively with high-risk patients and their families to maintaining current information on available resources and services throughout the territory.

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Information last updated on: September 16, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Salmon, L. (interview and feedback, July 23, 2013). [Yukon Hospital Corporation].

Publications

Hanson, P.G., Lindsay, L., Parker, K.L., & Taylor, L. (2000). *First Nations programs at Whitehorse General Hospital: Program review, final report.*

Alternative Profiles:

Accreditation Canada. (n.d.). *Leading practice: First Nations health programs, Yukon Hospital Corporation.* Retrieved from <http://www.accreditation.ca/en/LeadingPractice.aspx?id=2844>



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On-line Elder care education for community-based health care providers—Saint Elizabeth’s @YourSide Colleague First Nations Elder Care Course

LOCATION:	National	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice provides affordable, accessible, and culturally appropriate training for community health providers. The course was launched in January 2013 and is available on-line to providers across the country. It involves First Nation health care providers, Elders, and specialists.

PRACTICE DESCRIPTION:

Being able to access culturally relevant health care training and education that does not require travel is a fundamental requirement in meeting First Nations’ realities. There were major challenges in finding affordable, accessible, and culturally appropriate training that met these needs. Receiving an education in the community was not an option for health care providers. Leaving the community for education and training had several negative effects on health care provider and their communities, such as interfering with continuity of care for clients, increasing the burden on the family and community, and draining finances from already exhausted community budgets. These problems were especially common in remote communities. It took community home care staff several years to obtain their personal support worker certificate. These workers left their families, communities, and positions for weeks at a time. If there was a crisis or death in a community they returned home, losing out on training and delaying their education. In addition, many times nurses come to communities without a proper understanding of the importance of culture and protocol, and of building relationships within the community.

The First Nations Elder Care Course (ECC) is one of several on-line professional development programs offered by Saint Elizabeth that is available at no cost to community-based health care providers across Canada. The course provides evidence-based, culturally sensitive education about First Nations history and culture as well as clinical information on health topics related to Elder care, such as falls, medication, nutrition, depression, Alzheimer’s disease, elder abuse, and caring for yourself as a health care provider. The course was designed carefully not to develop a pan-Aboriginal approach and to make sure that people who take the course understand that First Nations communities are very different from one another. Health care providers need to build relationships with the communities to learn more about community-specific cultural practices and protocols. A key message spread throughout the course is the need to understand that every community is unique. It is essential to seek guidance from a community champion to learn about the culture, traditions, and practices in the community.

This program’s unique model involves First Nation health care providers, Elders, and specialists in the development and review phases of the courses. The goal was to ensure that there was comprehensive information to meet community needs, and to develop relationships of mutual trust and respect. Development began with a national survey of health care providers to determine their needs for Elder care information. After the course content was developed, a call was put out for reviewers from communities across the country. Nearly 50 volunteered. In one example, a group of health care providers gathered on three separate occasions to review and provide their feedback. An Elder was present at each gathering and opened the day with a prayer as a customary tradition to start off meetings in a good way. Feedback received from all reviewers was then incorporated into the Elder care course. Saint Elizabeth’s also ran a webinar series on Elder care that included presentations by specialists and Elders.

IMPACT:

Saint Elizabeth regularly evaluates the knowledge exchange initiatives through course utilization statistics and surveys. The course was released in January 2013; at the time of this publication, the course has been available to communities for seven months. Course statistics demonstrate significant knowledge utilization and knowledge uptake: 99 active learners took part in 458 sessions, and 74 pre-tests and 67 post-tests were completed. The course has received an enthusiastic response with new @YourSide Colleague account creations, password resets, and multiple phone calls requesting more information on the course.



Personal accounts and staff discussions indicate that community representatives appreciate that the course provides their staff with understanding and knowledge to provide a safe environment, along with respect and protocols in caring for the Elders. The goal in many communities is to keep Elders in their homes for as long as possible, instead of moving them to a long-term care facility. The online training means that health care providers don't need to leave their communities to develop the knowledge and skills they need to care for Elders. Health care providers are sometimes intimidated by online training, but most of them know how to use Facebook, and once they realize it's just as easy, they are very enthusiastic. Next steps include sending out a knowledge-to-practice survey to all participants to gather data on how the course and our Elder care webinar series have affected health care providers' practice and client care in First Nations, Inuit, and Métis communities.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that @YourSide Colleague First Nation Elder Care Course had adapted from and were unaware if the practice was used as a model elsewhere. Factors that would improve success and transferability/applicability are:

- A national survey of community health care providers identified learning needs.
- Elders guided cultural content throughout the development of the course.
- An advanced practice consultant in gerontology provided clinical content.
- Community reviewers ensured the content was relevant to their unique practice needs.

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Information last updated on: October 2, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Scott, T., & Vermette, M. (interview and feedback, September 9, 2013). [Saint Elizabeth].

External Source: <http://saintelizabeth.com/FNIM/Home.aspx>



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Traditional Healing, Medicines, Foods and Supports Program (THMFS) and Aging at Home Elder Care Continuum, Sioux Lookout Meno Ya Win Health Centre (SLMHC)

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT

This innovative practice is improving the health and well-being of Elders in remote and isolated communities in northwestern Ontario through the delivery of culturally safe care and the development of a continuum of linked community-based and institutional services. Initiated by Sioux Lookout Meno Ya Win Health Centre (SLMHC), the practice is rooted in a collaborative strategy among First Nations leadership and communities, the LHIN, provincial and federal governments, health organizations, providers, and clients.

PRACTICE DESCRIPTION:

SLMHC is a unique model of care in the province with a specific mandate among Ontario's hospitals to care for the First Nations population in a culturally safe manner. SLMHC operates a 60-bed health centre, a 20-bed long-term care/extended care facility, and the Out of the Cold Shelter. *Menoyawin* is an Anishnabe term that connotes health, wellness, and well-being—a state of wholeness in the spiritual, mental, emotional, and physical make-up of the person. SLMHC is recognized as an emerging centre of excellence for culturally integrated care and culturally safe care based on the *menoyawin* model of care.

With its roots in the signing of a historic four-party agreement (1997) by First Nations, the municipality, and the federal and provincial governments, the Traditional Healing, Medicines, Foods and Supports Program (THMFS) began in 2004/2005 with the goal of embedding cultural competency, cross-cultural fluency, and cultural safety into the fabric of the organization to address medical errors and cultural errors that threatened patient safety. The Aging at Home Elder Care Continuum has its roots in this unique model of care.

The goal of the THMFS program is to achieve cultural integration in health services. The program guides fundamental changes in the areas of Odabiidamageg (governance and leadership), Wiichi'iwewin (patient, resident, and client supports), Andaw'iwewin (traditional healing practices), Mashkiki (traditional medicines), and Miichim (traditional foods). Within each of these areas, many initiatives are underway to involve staff throughout the organization and entrench cultural safety in all aspects of program and service delivery.

Concerns about the health, quality of life, and safety of Elders, the high numbers of alternate level of care (ALC) patients, a critical lack of long-term care (LTC) beds for the service area, and long wait lists prompted the SLMHC to bring together multiple partners to commission an environmental scan (2009) with the support of funding from the Aboriginal Health Transition Fund (AHTF). The scan identified pervasive gaps in health care services across the continuum of care, with particular concerns about scarcity of Elder-appropriate services to support them in the community. It also provided an inventory of services and resources available, insight into practices that are working, and recommendations for change.

The scan laid the foundation for an Aging at Home Elder Care Continuum, which continues to develop. Currently, a full basket of services under each of the following areas has been identified: home and community care, patient and family support, support service coordination, respite, community supportive housing, nursing station, northern physician services, regional hospital services, regional long-term care facilities (LTCF), education, and transportation. SLMHC has implemented video-visitation and telephysio through links provided by Keewaytinook Okimakanak (KO) Telememecine and the Ontario Telemedicine Network. The program serves traditional food; incorporates traditional, cultural, medical, and spiritual practices; and provides social and recreational activities, Elders Gathering visits and translation services.



The THMFS program is unique in its comprehensive approach to achieving cultural integration throughout the organization. Many of the tools, such as the Patient Focused Communication Tool and the Cross-cultural Patient Safety framework and model represent leading edge work on the topic. The exclusive focus on planning for Elders is also unique; most local, regional, and provincial health plans do not focus on the elderly. Finally, the collaborative, multi-partner approach with stakeholders committed from across 28 communities to planning an Aging at Home Elder Care Continuum is also different from usual practice.

IMPACT:

Evaluations of the THMFS program based on surveys (board, management, and staff), reviews of SLMHC incident reports, and the Patient-focused Communication Tool are demonstrating improvements. Generally, efforts to create a culturally safe environment are resulting in improved patient safety, decreased medical errors, better processes for addressing patients' issues, and improved satisfaction (clients, board, employees). More specifically,

- Development of a cross-cultural patient safety (CCPS) analytical framework and implementation of a CCPS model is leading to development of cultural safety indicators.
- Phased implementation (over four years) of a cultural competency program (Bimaadiziwin) for staff is improving knowledge and awareness
- A new training and certification program for interpreters has resulted in increased use of the service by providers.
- Increased availability of ceremonial practices and traditional food and medicines is improving patient comfort, satisfaction, and well-being.

Implementation of the THMFS program follows an iterative process and so it continues to develop.

The Aging at Home Elder Care Continuum continues to develop, but positive impacts are notable in many areas. For example, telemedicine reunites families and video-visitation reduces client isolation; the program supports remote family council meetings, facilitated assessment, and placement of residents for LTC, including pre-placement diagnosis and treatment of potential LTCF residents; community Elder care workers and personal support workers have access to training; and stroke survivors have improved access to rehabilitation. With the introduction of ceremonial practices and traditional food, medicines, and social and recreational activities, there are improvements in patients' recovery. Community efforts to collect wood for Elders is helping them stay in their homes, and the Assess and Restore program provides personal support workers, physiotherapy, and occupational therapy, with interpretation, to support discharge back to community or improve quality of life in the LTCF.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that SLMHC had adapted from and were unaware if the practice was used as a model elsewhere. The cultural competency program (Bimaadiziwin) builds on identified best practices but is unique in its design for the SLMHC. SLMHC initiatives are theoretically applicable and transferable to other settings. Important lessons are that (1) leadership, sustained collaboration, a shared long-term vision, mutual support, shared resources, and solid buy-in at the funding/policy level are required, (2) better data about First Nations Elders' health is required to support development of a continuum of linked services, as is more information about practices that are working well in communities, and (3) better coordination between the currently separate federal and provincial programs is a must.

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Information last updated on: June 26, 2013

Content has been adapted from the following sources and relevant links:



Comarty, H. (January 2009). *An introduction to Sioux Lookout Meno Ya Win Health Centre: An emerging centre of excellence for culturally integrated health care in northwestern Ontario*. [Poster Presentation].

Walker, R., St. Pierre-Hansen, N., Cromarty, H., Kelly, L., & Minty B. (2010). Measuring cross-cultural patient safety: Identifying barriers and developing performance indicators. *Healthcare Quarterly*, 13(1), 64–71. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/20104040>.

Walker, R., St. Pierre-Hansen, N., Cromarty, H., Kelly, L., & Minty B. (2010). *Measuring cross-cultural patient safety. Achieving cultural safety in health services: Moving beyond cultural competence*. [Poster Presentation.]

Woolner, F., Timpson, J., Mombourquette, L., & Wood, L. (2009). *Elder care environmental scan in Sioux Lookout zone First Nations*: Prepared for the Sioux Lookout Meno Ya Win Health Centre. Retrieved from http://www.slmhc.on.ca/assets/files/traditional-healing/elder_care_environmental_scan.pdf

Personal Communications:

Cromarty, H. (interview and feedback, June 14, 2013). [Special Advisor for First Nations Health Care, Meno Ya Win Health Centre].

Linkewich, B. (interview and feedback, June 25, 2013). [Vice President of Health Services, Meno Ya Win Health Centre].



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Integrated services for elders on-reserve—Siksika Nation Health Services

LOCATION:	Alberta	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the need for an integrated continuum of care and housing options for elders on-reserve. The practice was established in 2009 and involves care provided through teams, partnerships, agreements, and investments in technology.

PRACTICE DESCRIPTION:

Siksika Health Services is a non-profit, incorporated entity of the Siksika Nation and an accredited First Nations health organization that offers a broad range of health care on-reserve, including a dedicated Elders services area with an Elders Lodge (assisted living) and home care program.

A full continuum of health services and all levels of housing was needed on-reserve. There is still a lack of long-term care facilities. Elders are typically hospitalized (off-reserve) and await long-term care placement for the first available bed, which may be many miles from the community. This leads to isolation and loss of culture.

Given the lack of federal investment in health care on-reserve, it was necessary to find alternative ways to build capacity and provide a full continuum of health services and housing options on-reserve and to address the gap in long-term care. To improve access to services, the leadership entered into a memorandum of understanding (MOU), originally with Calgary Health Regional Authority and then with the province of Alberta (after amalgamation of the regional health authorities). The MOU delineates mutual responsibilities and accountabilities to provide health care services without disturbing Siksika treaty rights to health.

In addition, partnerships were built with a range of organizations. To address the gap in long-term care and support continuing care, Siksika Health Services works closely with the local hospital by participating in weekly discharge planning rounds via telehealth and by attending case conferences to assist the Elders and their families with the transition. To provide palliative care a partnership with the Calgary Rural Primary Care Network (PCN) was arranged. Siksika Health also partners with

- radiologists to provide ultrasound services on-reserve;
- Aboriginal Affairs and Northern Development Canada (AANDC) to provide assisted-living needs
- the Non-insured Health Benefit program for medical travel; and
- the Federal First Nations Inuit Home and Community Care Program (FNIHCC) for home and community care.

Siksika Health Services has invested significantly in information technology and formed partnerships that provide a connection to Alberta's SuperNet, giving health providers better and faster access to telehealth, medical records, digital X-rays, and more. Siksika also boards electronic clinical information systems such as the Electronic Medical Record and the Community Health Immunization Program. A geographic information system (GIS) is used by the Reserve in partnership with emergency medical services and the fire department to know where homes are as well as sacred bundles and artifacts of historical and cultural value.

While MOUs are becoming a practice across the country, Siksika's comprehensive approach to forming agreements and seeking out multiple partnerships to improve all levels of care and support is recognized by government and other Aboriginal communities as being unique and innovative. Siksika has a "history of [creating] partnership[s] to create innovative, leading-edge solutions to complex health challenges" (<http://www.siksikahealth.com/events.html>). The Siksika Nation has been recognized as "one of the largest, most progressive and technologically advanced Health Service facilities anywhere in North America" (<http://www.siksikahealth.com/news.html>).



IMPACT:

Dramatic improvements are made when First Nations reach agreements with the federal and provincial governments and develop partnerships for new health care service delivery models.

Siksika has been very successful in improving access to home care and a continuum of integrated care for First Nations seniors in the Treaty 7 area. For example, this program is helping Elders regain their independence following illness or surgery, and helping them prevent further disability. Elders are supported upon discharge from the hospital and are remaining comfortably and safely in their homes, and have palliative/end-of life care when the time comes.

Siksika Health Services has been accredited since 2007, and it has been a great achievement to continue to retain the accreditation status. Siksika continues to monitor and report on statistics in all of its service areas, demonstrating successes and improvements (<http://www.siksikahealth.com/annual-2012-EXTERNAL.pdf>).

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Siksika had adapted from and were unaware if the practice was used as a model elsewhere. Lessons learned from this specific practice include: MOUs with the provincial government; partnerships with governments, regional health services, and organizations; committed leadership and staff; becoming accredited and maintaining the accreditation status; and investments in information technology, which in turn supports recruitment of health professionals and continuity in care.

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Personal Communications:

Sorenson, C., Kargard, M., & White, T. (interview and email, September 2013). [Siksika Health Services].

Siksika Health Services. (n.d.) *Annual report 2011/2012*. Retrieved from <http://www.siksikahealth.com/annual-2012-EXTERNAL.pdf>

External Source: <http://www.siksikahealth.com/index.html>



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Supporting Aboriginal Seniors at Home (SASH), Southwest Ontario Aboriginal Health Access Centre

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice provides culturally safe care to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. In doing so, the practice addresses disparities between the life expectancy and the incidence of chronic disease for Aboriginal and non-Aboriginal seniors. It was launched in Ontario at an Aboriginal Health Access Centre, and involved a nurse practitioner, a senior’s health advocate, and a patient navigator.

PRACTICE DESCRIPTION:

The Supporting Aboriginal Seniors at Home (SASH) program offers culturally based services designed to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. The program targets First Nations, Inuit, and Métis seniors and their family members. It was established in 2010 and is supported by Aging at Home funding. It was developed in consultation with Aboriginal community members, drawing on models of care that support the delivery of culturally appropriate and culturally safe care.

Staff assigned to the SASH program includes a nurse practitioner, a seniors health advocate, and a patient navigator, as well as a cultural safety trainer and management staff. The nurse practitioner provides primary care and chronic disease management services to seniors at the clinic, in community centres, or in seniors’ homes. The seniors health advocate assists seniors to access community and social services. The patient navigator helps clients find their way through the complex hospital system. The SASH team works with the health care team to develop a client-centred care plan that incorporates traditional healing and culturally safe practices. The cultural safety trainer educates organizations in the region on the provision of culturally safe care, and builds their capacity to work well with Aboriginal patients. Chronic disease management services focus on helping people stabilize, improve, develop better self-management skills, and, in some cases, recover. The team supports clients, caregivers, and families in their interactions with health practitioners, and arranges interpretation and translation services as needed. They connect clients and their families with traditional Aboriginal healers, and counsel clients and their families to ensure that they understand their care plan while in hospital. Team members participate in discharge planning for their clients, helping them transition from hospital settings to home, arranging follow-up care, and connecting them with a comprehensive and holistic range of resources and supports. The team works closely with local organizations and hospitals, and the patient navigators have taken on a community development role, meeting with organizations and bands to better understand service pathways in the region.

The SASH program provides care that is different than what is typically available to Aboriginal seniors. It incorporates a spiritual component in its approach to treatment and wellness, and patients are able to access traditional services. It uses a patient-centred model, and staff members go above and beyond to provide exceptional programming and ensure that patients’ comprehensive needs are taken into account.

IMPACT:

The SASH program was implemented in 2010 and has not completed an evaluation at this time. However, the program is now implementing results-based accountability processes. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. These include increased use of primary care services and reduced use of emergency department services, increased access to appointments with specialists, improved identification and management of chronic disease, and increased movement of people into recovery from addiction. The program is also building the capacity of organizations and practitioners to work well with Aboriginal seniors and provide culturally appropriate and safe care. Linkages between the program and other organizations (in particular, non-Aboriginal organizations) are strengthening.



APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that SASH had adapted from and were unaware if the practice was used as a model elsewhere. Components of the model have been adopted by a local CancerCare program. Lessons learned that might affect the applicability or transferability of the practice include the importance of community development and partnership, and the importance of attending to human resources issues. Staff members must be comfortable working in community settings; comfortable working with networking and promotion activities; and capable of working well with people with mental health issues, addiction issues, and other complicated medical conditions. Staff must also understand the ways of the communities they are working in, and be resourceful about how to address basic needs in areas such as food, housing, and economic security.

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Personal Communications:

Chrysler, B. (interview and feedback, August 7, 2013). [Southwestern Ontario Aboriginal Health Access Centre].



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Supporting Métis seniors and families—Métis Nation of Ontario (MNO) community centres

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT:

This innovative practice addresses the need to support Métis senior citizens who are at risk of falling through the cracks of a complex health system. The first community centres were established in the mid-1990s, with the remaining centres developing since that time. Programming involves partnerships with different ministries, Aboriginal groups and the volunteer sector. Care delivery involves interdisciplinary health staff, community centre workers and volunteers.

PRACTICE DESCRIPTION:

One-third of all Aboriginal people in Canada are Métis. The Métis population is also one of the fastest growing populations in Canada, having doubled in the past 10 years or so. It is also an older population compared to other Aboriginal groups. Many Métis seniors are also experiencing significantly higher rates of chronic disease and other complex conditions compared to non-Métis Ontarians. Because Métis people also fall under a different legislative and regulatory structure than do other Aboriginal groups, they do not have the same access to provincial and federal programming supports available to other Aboriginal Canadians such as the Non-Insured Health Benefits program. Many older Métis also have limited incomes and live in more remote and rural areas, compounding problems of access.

It is for all these reasons that the Métis Nation of Ontario (MNO) developed an innovative, family-centred model of community-based care, founded upon the Métis way of life, and built around the unique needs of the Métis clientele. Situated in 18 historical Métis communities across the province of Ontario, MNO community centres were established to serve as important cultural and service hubs that connect Métis citizens to one another, as well as to essential health services and supports within their local areas. They provide much-needed and very tangible support to Métis senior citizens who are at heightened of falling through the cracks in our complex health care system.

The MNO community centres are especially important in providing Métis seniors with much-needed cultural and social supports, as well as assistance in accessing essential health and medical services. Some of the MNO centres also offer specialist services such as foot care clinics for seniors and other Métis people suffering from diabetes. MNO community centre workers are also very actively involved in outreach with Métis seniors and other MNO citizens in need of assistance, visiting their homes on a regular basis to help with meal preparation, house maintenance, and other tasks of daily living, and to provide important social and cultural support. Through the MNO Medical Transportation Program that has been put in place, Métis seniors can also receive assistance in traveling to and from their medical and other appointments. The MNO's model of community care is founded on a holistic, family-centred, and uniquely Métis approach to health and well-being that has deep roots in the very community-minded Métis culture and way of life.

The MNO service model is unique in the province in both its scope and conceptualization, and has been hailed as a best practice by their governmental partners. MNO works very closely with its provincial government partners and other Aboriginal groups in the development of its programming. MNO receives support through different ministries including the Ministry of Health and Long Term Care's Community Support Services Program, the Ministry of Aboriginal Affairs, and the Ministry of Children and Youth Services, among others. Programs and services are also supported by the MNO's large volunteer base, which includes the MNO Provincial Councils, the MNO Youth Council, and MNO Senators. **IMPACT:**

This innovative practice was first implemented in 1993, with the ongoing development of new community centres since that time. MNO's internal Health Activity Tracking System (H.A.T.S), established for reporting, accountability and evaluation purposes, together with regularly commissioned independent evaluations, indicate that the community centres are having positive impacts on Métis citizen's health and well-being. They are providing critical assistance and support for seniors, particularly those in



more rural and remote areas. They also provide an essential cultural base where Métis seniors can meet with other community members, receive appropriate support and care and link to essential services and programs in the broader community. The centres and their activity within the broader community has also led to an increased awareness of and respect for Métis peoples' culture, unique history, needs and aspirations across the province of Ontario. Most importantly, the MNO centres provide a haven for culturally safe community care for the Métis elders of Ontario.

APPLICABILITY/TRANSFERABILITY

The practice informant did not identify other practices that MNO had adapted from and were unaware if the practice was used as a model elsewhere. However, MNO is regularly approached by provincial ministries to assist in the development and implementation of both Métis and non-Métis Aboriginal policies, programming and services. Two key characteristics of the MNO approach which have contributed to its success are the holistic, needs-driven and culturally-based nature of its community programming and services, and the MNO commitment to collaboration and working closely with government and other Aboriginal partners to address known gaps and to build more effective and integrated care models for Aboriginal populations. Together with committed Métis leadership, the ability to build effective, culturally-based teams with appropriate training for all front line staff and the direct involvement of Métis community members, including seniors and support from a large volunteer base, are among the key factors contributing to success.

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Information last updated on: October 23, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Storm J. Russell and Wenda Watteyne, Métis Nation Ontario (personal and other communications, October, 2013).



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Kahnawake Home and Community Care Services; Culturally Competence Case Management

LOCATION:	Quebec	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT:

This innovative practice addresses the need to provide a better continuum of care for First Nations seniors and others in their home community of Kahnawake (population 9,500). It provides services in clients' homes and involves a 10-member home care nursing team, an 18-member home health aide team, a seven-member hospital-based Day Program team, an Adult and Elders Service Counsellor, two Day Program Animators, two Elders Case Workers, administrative staff, a kitchen team, a maintenance and security team, and the program's manager.

PRACTICE DESCRIPTION:

Kahnawake Home and Community Care Services (KHCCS) strives to provide an enhanced continuum of care to address the health needs of First Nations seniors and other clients living at home in the Mohawk community of Kahnawake in Quebec. The program was implemented in 2000, when Health Canada initiated the Home and Community Care program. The new initiative offered improved funding and less restrictive guidelines, enabling the development of a home care program that met the real-life needs of Kahnawake seniors.

KHCCS connects clients and their families with on-reserve services that include home nursing care, personal care, primary care, tertiary care, palliative care, respite, day programs, and mental health services. It also helps clients to access programs such as income security. The program also oversees the operation of a 25-bed long-term care facility. The program was enhanced in 2005 with the introduction of a case management approach, and the establishment of single window access to services. Incoming clients are assigned to a case manager who completes an initial assessment, identifies resources the client needs, and then makes appropriate referrals. Clients are reassessed at six-month intervals. After each assessment, an interprofessional team develops a strategy to meet any service needs that have changed. The case manager follows clients from intake through discharge planning, ensuring that appropriate resources are in place to support seniors' wellness when they return home or transfer to an alternate level of care.

KHCCS offers First Nations seniors access to home care services (including both home care workers and nurses) 365 days a year, along with access to an unusually comprehensive continuum of on-reserve services. For example, home care nurses work closely with physicians to provide palliative care services, which typically enable seniors to stay at home till the last few days of their life. Home care aides have been delegated responsibility for some aspects of medical care, enabling them to, for example, dispense medications or change bandages. Family members who are primary caregivers can access respite (in the form of day programs for seniors and short-term respite care services) through the home care program. The home care team includes mental health nurses who counsel Elders struggling with issues such as depression, grief, or unresolved trauma. KHCCS can meet the majority of needs their clients might have, and usually can implement services within 24 hours of a request. Staff retention rates are extremely high; 90% of staff members have 10 years of service or more. Most staff members are from the community, and relate well to clients' needs.

IMPACT:

This innovative practice was implemented in 2000. Data on the KHCCS home care program have been included in evaluation data collected by the local hospital, but the KHCCS data cannot be disaggregated. The home care program has, however, been accredited three times since 2006. KHCCS's adoption of a case management approach (in which a comprehensive assessment of client needs ensures that services are not delivered where they are not needed) has enabled the program to maximize efficiency and, at the same time, deliver quality care. This enables cost savings.

APPLICABILITY/TRANSFERABILITY:



The practice informant did not identify other practices that Kahnawake Home and Community Care Services had adapted from and were unaware if the practice was used as a model elsewhere. However, the program has been contacted or visited by representatives of numerous First Nations communities in Quebec, some of which have adapted and implemented aspects of the program. Important lessons learned during the development and implementation of this program include that it is unsafe to assume that what works in one place or time will work everywhere or all the time. Even successful programs must be constantly ready to respond to the changing contexts in which they are delivering services, and the changing needs of the communities they serve. It is also important to think outside the box and be open to unusual ways to accomplish what needs to be done.

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Information last updated on: July 17, 2013

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Personal Communications:

Horne, M. (interview and feedback, July 17, 2013). [Kahnawake Shakotia'takehnhas Community Services].

External Source: <http://www.kscs.ca/taxonomy/term/5/all>



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Adapting the Non-Insured Health Benefits (NIHB) program to meet the needs of First Nations elders – Policy Tools, Pharmaceutical Medication and Rural/Remote Travel.

LOCATION:	New Brunswick, Newfoundland & Labrador, Nova Scotia, Prince Edward Island	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for improvement in FNIHB’s programs and services in the Atlantic region, to better meet the needs of Elders and improve their health and wellbeing. *The Strategic Plan for Atlantic First Nations Elder Care* was launched in January 2011. FNIHB Atlantic works collaboratively with the Mi’kmaq Maliseet Atlantic Board to implement the plan.

PRACTICE DESCRIPTION:

Elders have expressed growing concerns about the programs and services of the FNIHB-Atlantic region. As part of a new *Strategic Action Plan for Atlantic First Nations Elder Care*, FNIHB - Atlantic is working to improve existing programs and services through a co-management (i.e., shared decision-making) committee with the Atlantic First Nations Chiefs, called the Mi’kmaq Maliseet Atlantic Health Board. In 2007, the Board established priorities that included Elder care. The focus of the strategic plan includes identifying and supporting local options to keep First Nations elders in the community for as long as possible, as well as addressing cultural competency, quality of care, and access to family for those who are admitted to long-term care facilities off reserve.

A first priority was to look at policies and requirements associated with the NIHB program; they are established mainly at the national level and cannot be easily changed. The program was reviewed from the perspective of whether the region had any flexibility to make changes for the benefit of elders’ health and well-being.

A “policy lens” tool was created called the Elder Care Assessment Tool (ECAT). The process began with identifying what aspects of the program are within the region’s discretion to design or modify, taking into consideration the elders’ concerns and their health and well-being needs. In a pilot test, the Tool was applied to the medical transportation component of the NIHB program. One of several issues that elders had identified was the requirement for pre-approval to cover the travel costs of “non-medical” escorts - usually a family member or friend - to travel with them to appointments. Prior to the review, all First Nations people required pre-approval for every single appointment. For Elders with complex health needs and multiple doctors, or whose first language is not English, this could mean a lot of paperwork. As a result of applying the Tool, it was learned that while a regional branch of FNIHB could not remove the pre-approval requirement, there was some flexibility to change the procedure for people with chronic health problems or translation needs. Now, they only need to seek pre-approval once a year to have a non-medical escort accompany them to all their appointments. Also, there was a change to the request form so that it was clearer, with easy-to-answer questions, enabling staff to quickly determine whether someone is eligible.

Another area requiring improvement was Elders’ access to prescribed medications. Some medications are covered automatically, but others need to be approved for coverage by the NIHB Drug Exception Centre in Ottawa. A pharmacist is required to call to initiate the review, and then the Drug Exception Centre will send paperwork to the health professional who prescribed the medication. Sometimes there is a breakdown in the process - for example, pharmacists don’t call the Drug Exception Centre to ask for a review, or prescribers don’t fill out the paperwork. The result is that the elder is denied coverage for the medication, and they must pay for it themselves or have their band pay with money from another program.

FNIHB-Atlantic looked at the medications that were rejected for payment to identify the top medications being requested, and learned that most were approved once they were reviewed at the Drug Exception Centre. In those instances where the pharmacist didn’t call, the regional pharmacist in the FNIHB office contacted the pharmacies and reminded them about the



process. The regional pharmacist also sent the results of this work to a pharmacy working group at NIHB headquarters in Ottawa, and this contributed to some drugs being moved to the category where they are covered automatically (called open benefits). The regional pharmacist also created formularies that identified appropriate substitutions for common medications, so that if someone is prescribed a drug that requires a call to the Drug Exception Centre, pharmacists can choose an alternate that is automatically covered by NIHB.

IMPACT:

This innovative practice was implemented in January 2011 and does not have a completed evaluation at this time. A pilot in the NIHB medical transportation component was conducted and the recommendations are in the process of being implemented. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. The ECAT has made a difference: it simplified process and paperwork for non-medical escorts and fewer medications were declined for coverage. Also, it became clear that FNIHB-Atlantic did in fact have flexibility to adjust the procedure for medical transportation, and to think creatively about what else could be done to increase flexibility, while at the same time adhering to national policies. The Tool is still in its infancy, but already FNIHB-Atlantic staff and First Nations partners are developing a strong sense of shared commitment to and responsibility for elders' health. The regional office has committed to completing at least one program review per year. A review of the Aboriginal Diabetes Initiative is underway, other program areas requiring improvement will be identified, and together with quality improvement initiatives taking place within FNIHB nationally, changes to the way the FNIHB Atlantic region works and changes to policies and programs are beginning to be implemented.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that FNIHB Atlantic had adapted from and were unaware if the practice was used as a model elsewhere. However, specific lessons learned from this practice include: partnership and joint working group with First Nations; New Elder Care Assessment Tool used to review policies and procedures; Flexibility for regional office to make changes to procedures while still working within overall national policies.

Problems with FNIHB programs and services have been discussed across the country but no other region appears to be taking this kind of approach to making improvements, making it a unique effort that others across the country are interested in knowing more about. Other than a small contract of \$10,000 for a literature review in the early stages of the plans development, no other resources are attached to the plan or the tool itself.

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Personal Communications:

Boychuk, R. and Cholock, L. (interview and feedback, July 2013). [First Nations Inuit Health Branch-Atlantic Region].



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Saskatchewan First Nations Aboriginal Diabetes Initiative Action Plan

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need to reduce the incidence and effects of type 2 diabetes in First Nations people. The practice was launched in all 78 First Nations in Saskatchewan, involving representatives of these communities and of Health Canada.

PRACTICE DESCRIPTION:

The Saskatchewan First Nations Aboriginal Diabetes Initiative (ADI) Action Plan provides a strategy for diabetes care and management. The goals of the plan are to reduce the incidence and effects of type 2 diabetes in First Nations people and, ultimately, to improve glycemic control and quality of life for people with diabetes. The plan targets seniors and other community members in Saskatchewan First Nations and provides strategies, information, and tools that will allow people with diabetes to manage their health and wellness more effectively.

Initiatives to address the impacts of elevated rates of type 2 diabetes in the First Nations population typically focus on physical activity and nutrition. The Saskatchewan First Nations ADI Action Plan calls for a substantial paradigm shift that moves away from treating sickness (an acute care model) to managing wellness (a chronic care model), and that engages Health Canada in health promotion rather than just the provision of funding. The plan was developed in consultation with First Nations people and draws on the Discovery Learning Model, a model of care developed in Arizona. First Nations communities host three-day in-community training sessions to prepare health care professionals and community health workers to become managers of diabetes. The training transfers knowledge and skills to participants in areas such as diabetes testing and motivational interviewing techniques that focus on patients' needs. The training is not targeted for the general public but rather, trains health workers (a significant proportion of whom are people with diabetes) to deliver education and care on reserve.

The plan meets the distinct needs of First Nations seniors by building knowledge about and understanding of diabetes at a community level, supporting self-management at an individual level, and providing a strength-based model for diabetes care and management. The plan has been developed and implemented in partnership with Saskatchewan First Nations, with guidance and direction from Elders. The ADI Action Plan is not likely to become a permanent program, but it has the potential to generate lasting change. To date, 500 participants representing First Nations and Health Regions throughout the province have completed the training.

The plan is supported by funding from the federal Aboriginal Diabetes Initiative.

IMPACT:

This innovative practice has been implemented since March 2009 and does not have a completed evaluation at this time. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. An informal measure of the plan's success may be the level of uptake in the three-day training sessions, each of which has been overbooked. There have also been reports of changes in the behaviour of providers and health care workers who have participated in the training.

The practice is expected to generate savings both over the short term (for example, improved self-care and management by people with diabetes should generate reductions in hospital visits) and the long term (improved self-care and management by people with diabetes should reduce risks and the incidence of diseases associated with diabetes).

APPLICABILITY/TRANSFERABILITY:

The Saskatchewan First Nations ADI Action Plan incorporates the Discovery Learning Model developed in Arizona, which was modified in collaboration with First Nations communities in Saskatchewan to meet their distinct needs. The practice informant



was unaware whether The First Nations ADI Action Plan had been used as a model for developing similar initiatives, although programs throughout Canada, as well as programs in the United States, have reached out to learn more about the Action Plan. Lessons learned that might affect the applicability or transferability of the program include the importance of looking closely at the context in which you might apply the model, ensuring that you understand it well, and designing a system or plan that fits that context and leads towards the outcomes you are seeking.

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Personal Communications:

MacDonald, B. (interview and feedback, July 15, 2013). [First Nations and Inuit Health, SK Region].

Other:

MacDonald, B., Engel, K., Climenhaga, D., Compton, K., Quewezance, S., & Langley, S. (2013). *Diabetes care and management in Saskatchewan First Nations: A province-wide approach*. [Presentation Notes]. Retrieved from <http://prezi.com/f0fc6g2fi3w3/mho-presentation/>



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Community health aides help with nursing shortages, continuity of care, and cultural safety

LOCATION:	Newfoundland & Labrador	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses concerns about the recruitment and retention of nurses, and about the continuity and cultural safety of care for Inuit seniors.

PRACTICE DESCRIPTION:

A couple of factors prompted the creation of the community health aide position. It was difficult to recruit and retain nurses, and there were concerns about the continuity of care for the residents of Nunatsiavut, a region in Newfoundland and Labrador, especially the seniors receiving service through the Home and Community Care program.

The community health aide model borrows from the past in Labrador and the present in Alaska, where community health aides deliver primary care in remote communities. The new position was created out of necessity and allows Nunatsiavut to deliver culturally safe, cost effective care. For example, where there were two nurses there is now one nurse and one aide, a skill mix that provides continuity of care.

When the Grenfell Mission first came to Labrador, the doctors and nurses hired local women “aides” to assist in all areas of care. The tradition continued, and in 1996, when the Labrador Inuit Association assumed responsibility for nursing in what is now Nunatsiavut, the public health aides came over as well.

The community health aide has an expanded role in public health and in home and community care and is supported by the Nunatsiavut government. In the home and community care program, the community health aides function as the nurses’ “right hands” because they fill so many roles, including supporters, cultural advisors, and planners. They manage the home support workers, go with the nurse on client visits if interpretation is needed, order equipment and supplies, schedule appointments, sterilize equipment, complete month-end reports, and anything else that doesn’t require a nurse to do. The nurse is then able to concentrate on direct client care. The aides also do independent home visiting to support the programs both when a nurse is in town and when the position is vacant.

Just as important, they are the cultural advisors to new nurses. They are trusted in the community, and any new nurse who is accompanied by an aide is accepted. They know everything about the people in the community, including where to find them on any particular day to ensure they come to appointments.

When the community does not have a nurse, the aide functions as the eyes and ears of the community. The aides know when to alert staff to a senior’s condition and when to bring in nursing care. The aides make the appointments and set everything up for the nurses.

From an elder care perspective, the aides can often spend more time with clients than a nurse can, establish and maintain personal connections with clients, and speak the clients’ language. Often, elders are alone in their communities because families have moved away. Community health aides are advocates for elders and support them with a range of issues including elder abuse (which is a big problem), especially financial abuse. They are also familiar with the regional health and long-term care centres in Happy Valley-Goose Bay, so they can describe them to elders and their families, and help them become comfortable with any transitions.

IMPACT:

Evidence of success is based largely on personal accounts, observations, and regular monitoring of seniors’ health and safety at home. Personal observations and testimonials suggest that this program is extremely successful. The community health aide position allows for managing with fewer nurses. For example, in the largest community, instead of having three nurses and one aide, there are two nurses and two aides and it has been possible to maintain programming in a community with no nurse. The



community health aides are a very stable workforce. They live in the community, are committed to the community there is very little turnover. If an aide were to leave, there are people in the communities waiting for these jobs. It is hard to quantify or describe the value they bring, however, essentially, it would not be possible to deliver care without them, and clients would be less willing to receive care.

APPLICABILITY/TRANSFERABILITY:

This innovative practice was adapted from Alaska but the practice informant did not identify any other practice that used this as a model for developing a similar initiative. However, lessons learned from this practice suggest that it is theoretically applicable and transferable to other settings. An important lesson or enabler of success is the fact that Nunatsiavut is self-governing, which allows for flexibility and innovation in developing roles that meet communities' needs. Another enabler is that the aides work in a non-unionized environment. The model is unique in Canada and has not yet spread to other parts of country.

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Personal Communications:

Turner, G., & Buckle, T. (interview and feedback, August 16, 2013). [Nunatsiavut Government]

External Source: http://www.nunatsiavut.com/index.php?option=com_content&view=frontpage&Itemid=1&lang=en



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Culturally Competent Collaborative Practice Model for Chronic Disease Management

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to improve quality of life and health care delivery for First Nations people with chronic disease, through better linkages between provincial and on-reserve services and enhanced service delivery on-reserve. Launched in 2010, this practice included collaboration among Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program) and three First Nations communities including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation.

PRACTICE DESCRIPTION:

In 2010, three partners came together to begin the first ever Kidney Health Education and Targeted Screening Program. The partners were Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program). Three First Nations community partners were asked to participate including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation. This pilot project had the following goals: improved coordination of care of individuals with chronic disease, improved client outcomes, increased access to chronic disease management, increased community capacity and improved self-care management.

Each community had two days of screening where approximately twenty-five people were screened per day. In total, 150 people were screened for chronic disease and educated about ways to keep themselves healthy. Each participant signed a consent form that explained the purpose of the program and what would occur that day and a pre-survey was completed to assess prior knowledge. A health data form was filled out to collect information and record test results, and a copy was also given to the participant in the form of a "kidney report card." Tests were administered including blood pressure, random glucose, A1c, estimated glomerular filtration rate, urinalysis, weight, body mass index, percentage of body fat and waist circumference.

After the tests were completed the participants met with a nurse from the Chronic Kidney Disease program to discuss their results and ask any questions. The nurse provided health advice for optimal kidney function and well-being. Follow-up screening was done in 2011 following the same process.

IMPACT:

There was evidence in the follow-up surveys of the health changes that people were making. They were exercising more, losing weight and decreasing fat and salt consumption, quitting smoking and regularly monitoring their blood glucose and blood pressure and taking their medications. There was also improved coordination and increased access to chronic disease management. Further evaluations are forthcoming.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that the Collaborative Practice Model had adapted from and were unaware if the practice was used as a model elsewhere. However, specific lessons learned from this practice include: repeat screening of clients; regular meetings and foundation for collaboration established to improve coordination of care; client education sessions and engagement of local leadership increased community capacities, and client input contributed to improved self-care management. Challenges that impacted the program included: staff turnover and shortages, heavy workloads prevented staff from dedicating time to the project; and, it was difficult at times to coordinate activities with the Regional Health Authority due to their staff shortages and constraints.

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Personal Communications:

Hassler, Sandra (interview and feedback, June 2013). [Collaborative Practice Project].

Other

Petruka, P. and Bassendowski, S. (April 2013). Innovative Collaborative Practice Models to Managing Home Care Clients. Saskatchewan Region.

Lytle, K. (no date). Strengthening the Bridge: Continuing Prevention of Chronic Disease in Saskatchewan First Nations. The Kidney Foundation of Canada, Saskatchewan Branch.



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Bringing chronic disease self-management to rural and remote regions in Rocher-Percé

LOCATION:	Quebec	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice improves the effectiveness of chronic disease management in rural remote regions. Established in 2011 and funded for two years, this practice involved an interprofessional team of nurses, dietitians, and kinesiologists who worked collaboratively with physicians.

PRACTICE DESCRIPTION:

The population in Rocher-Percé is scattered along a vast coastline, making it a difficult population to service. Approximately 60% of clients are seniors, and chronic diseases are a significant problem given risk factors such as obesity, hypertension, high cholesterol levels, sedentary lifestyle, alcohol abuse, and smoking. Accessing treatment—especially for cardiovascular disease, pulmonary disease, diabetes, and renal disease—is a problem. There is a small team at the health centre (the Centre de santé et des services sociaux du Rocher-Percé) with limited capacity and resources. Specialized resources are far away in Montreal, Quebec City, or Rimouski. The Chandler Hospital emergency department was overloaded, which was costly for the health centre. In addition, programs were not operating efficiently given that there were separate clinics and staff for diabetes, cardiac problems, lung, and renal problems; chronic diseases were not being addressed holistically and staff were not communicating.

An industry representative met with the health centre director to discuss a funding opportunity, in partnership with the Quebec government, for new and innovative chronic disease programs. With the goal of transforming an outdated, siloed, and reactive service delivery model, a proposal based on the internationally recognized Chronic Care Model (www.improvingchroniccare.org) was submitted and accepted. The focus was on bringing services closer to clients in their communities through a partnership and team-based model, and on teaching patients to understand their health, and to take responsibility and control, with team support.

An intensive three-month holistic program was created. Instead of looking at a patient's conditions on an individual basis and developing a different treatment plan for each condition, the interprofessional team (dietitian, registered nurse, and kinesiologist) develops a single treatment plan to address all the conditions effectively. With a referral from the doctor and follow-up communication where the team reports information such as blood pressure and diabetes status, medication and other adjustments are made.

The program includes a healthy lifestyle focus (exercise, good nutrition) and patients are educated (in groups) to better understand their health situation. Patients are seen twice a week at a clinic or at a local gym in their community—similar to a mobile clinic. It's very intensive; for example, staff review daily eating habits with clients, who bring in their food products so labels can be read together. The goal is to make individuals proactive in their treatment so they understand why a particular food is or is not a good choice. Exercise, nutrition, how chronic diseases affect the body, and medication management are all part of the teaching. Clients also receive written information to take away. After the three month program is completed, the team is available for support but not regular care, making staff available to start up a new group.

This kind of intensive follow-up is typically only available in specialized health centres, which are typically far away and difficult to access for patients. It is important for rural and remote regions to offer this kind of program.

IMPACT:

A formal evaluation is due later in 2013. In the interim, positive results are seen from discussions with staff and monitoring of patients. Patients' conditions are improving with reduced use of medication, reduced levels of hypertension, lower cholesterol levels, better-controlled diabetes, weight loss, and a change of lifestyle including less smoking. As a result, fewer specialized services are required including surgery.



Feedback from physicians suggest this program is having positive results as patients are seen less frequently. The program was funded for two years initially, and that ended in January 2013. However, given the success of the program, the health centre decided to permanently integrate the different chronic disease programs into one. As a result, the program continues to operate, since the reallocation of time and money have allowed staff to spend more time with clients.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that CDPM had adapted from and were unaware if the practice was used as a model elsewhere. However, there has been considerable interest in the program. The Government of Quebec is interested in adopting the program across the province. And the Government of Canada, specifically the First Nations and Inuit Home and Community Care (FNIHCC) program, is also interested because they believe it is applicable to rural and remote First Nations and Inuit communities. An important lesson is that an intensive program that empowers clients and focuses on a holistic approach to chronic disease makes a difference. Key components for success included partnerships (in this case with industry, the provincial government, and local gyms), interprofessional team-based care, and an approach that was based on a best practice model.

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Personal Communications:

Sutton, T. (interview and feedback, 2013). [The Centre de santé et des services sociaux du Rocher-Percé].

Publications

Taking charge of health in the territory of Rocher-Percé: An offer of services in chronic disease care adapted to rural and remote regions. (2012, September). Presentation Notes]. Retrieved from <http://interestsante.ca/files/interdisciplinaritegestiondesmaladieschron...>

Improving Chronic Illness Care. (n.d.). *The Chronic Care Model*. Retrieved from www.improvingchroniccare.org

External Source: <http://interestsante.ca/participation-au-4e-rendez-vous-de-la-gestion-des-maladies-chroniques.php>



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Youth caring for elders and preventing elder abuse—Carcross /Tagish First Nation Health and Wellness Department

LOCATION:	Yukon	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need to build family, community, and provider capacity to care for elders and enable them to stay safely and longer in their homes. Implemented in 2011, a remote Yukon community took a strategic approach to making youth more responsible, reducing elder abuse, and strengthening the home care program.

PRACTICE DESCRIPTION:

The main concern that needed to be addressed was the need to build family and community capacity to care for elders in order to more effectively meet elders' needs and relieve some of the workload burden on the home care program. There was a need to reach out to families, support them in taking care of their elders, and address elder abuse.

To break the generational cycle of youth dependence on social assistance and to reduce drug and alcohol abuse, a transitional employment program named the Outreach Program was implemented. Because of the need to build capacity in caring for elders, it was decided that elders' needs would be put first when identifying work opportunities for youth. Youth were assigned an outreach worker and together they developed a case plan to identify goals and aspirations for education and experience. Some examples of the work that the youth do for elders includes collecting, cutting, and stacking wood for elders to heat their homes; making sure the snow is removed from their driveway; maintaining their yards; checking the house for safety issues; doing repairs; putting up handrails; and helping elders with tanning hides. In exchange, the youth were paid well (\$15 an hour) and received a job reference to help get them on track. They learned about responsibility and that *social assistance* is temporary assistance for those in difficult situations, not a way of life.

Different strategies were put into place to address elder abuse. The main type of this abuse was financial abuse by an adult, child, or grandchild. Individuals were spending their temporary financial assistance on alcohol and drugs, and then expecting the elder to feed and shelter them. These individuals were informed that the government and community were aware of the abuse and would not tolerate it. Recipients of temporary financial assistance are now given purchase orders (POs) in the name of an outreach worker, to prevent recipients who suffer from addiction from selling their POs. If necessary, the purchase order is divided in half, so only half of the amount can be spent in the first two weeks of the month, leaving the other half available for the last two weeks. Otherwise, if all of the food was purchased at once, the individual could sell the food for cash.

The Outreach Program was also strengthened through multiple initiatives. Staff worked collaboratively with families to help them better understand and fulfill their responsibilities to elders, and they visited elders in their homes to hear about their concerns and needs. Vehicles were purchased to take elders to their medical appointments and outreach workers accompanied them as advocates, to make sure the elders understood correctly the information they were given. Other traditional activities such as berry picking were also organized. These initiatives are supported by the Carcross/Tagish First Nation government. This community is unique in its approach to try out-of-the-box solutions to address multiple and complex issues in the community.

IMPACT:

This innovative practice does not have a formal evaluation completed at this time. Personal accounts and discussions with staff, family, and elders indicated that the Transitional Employment Program has made a big difference in helping elders remain in their homes. To reduce social isolation, weekly community teas were organized, which brought together First Nations and non-Aboriginal elders; people who've been neighbours for years but never socialized are now becoming friends. The elders are also happier and less frustrated because they can get out in winter, now that their driveways are cleared sooner. They have wood to heat their homes and their homes are safer. The youth are making progress in terms of becoming responsible, and they are able to apply for jobs outside of their community because they have a reference. Monthly interagency meetings are now



bringing together the Health and Wellness Department with other agencies to improve collaboration, and the capacity of home care workers has been strengthened through training activities and improved pay to support retention.

Although it's a relatively new strategy, the purchase orders appear to be working. The outreach workers see that there is food in the homes and the elders are happier. Overall, families are encouraged and supported to take more responsibility for elders' care. Family members have expressed thanks; they appreciate the shared responsibility and feel less stress because they know there is a team of people involved in the well-being of their elders. This gives them the motivation to be involved because it's not so overwhelming.

APPLICABILITY/TRANSFERABILITY:

This innovative practice was adapted from a best practice model from the United States. The Chief, Carcross/Tigish First Nations staff, and a Yukon Government Education representative visited Chelsea Massachusetts to learn about the model and how it enables youth to return to school or work. Factors that would impact success and applicability/transferability are that self-government allows for flexibility to meet community-specific needs. Key components for success include self-government; strong support from the First Nations government for elders, outreach workers, and home care workers; universal agreement that elders' needs are a priority; teamwork; and lots of communication.

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Shepherd, R. (interview and feedback, August 14, 2013). [Carcross/Tagish First Nation].

External Source: <http://www.ctfn.ca/>



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Home care program for everyone, on- or off-reserve, Bella Coola

LOCATION:	British Columbia	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for equal access to integrated home and community care for Aboriginal seniors on-reserve. The practice was launched in Bella Coola and involves an interprofessional team of federal home care workers, provincial home care workers, and band-employed workers.

PRACTICE DESCRIPTION:

Bella Coola is a geographically remote community on the central coast of British Columbia that has limited resources. The community faced several challenges. There was no structured home and community care program or integrated service delivery model between the services available on-reserve and those offered by the province. Complicating the situation were factors such as budget constraints, nursing shortages, lack of nursing supervision, a lack of clarity around staff roles and responsibilities, and differing views about what a home and community care program should look like. Many of the community's youth had left to seek jobs outside this economically depressed community; leaving behind an aging population of seniors who were isolated and without care/support.

A shared vision and model was developed to ensure that First Nations and non-First Nations people, on-reserve and off-reserve, had equal access to care and the option of remaining at home in their community as long as possible. Services are available 365 days a year and there is a fully integrated, culturally safe home and community care program. This program is in a new health centre on-reserve and is used by everyone in the community.

To initiate this work, the first step was to seek approval from the Chief and Council of Nuxalk Nation. Approval was easily obtained because trust had been built over the years with the lead nurse. A community engagement and needs assessment followed, including meetings with the Nuxalk Nation Health Director, Elders, and the RCMP. Meetings were also held between the Chief and Council, Vancouver Coastal Health, the United Church Health Services (an affiliate of Vancouver Coastal Health), and Health Canada's First Nations and Inuit Home and Community Care Program (FNIHCC), which offers home care on-reserve. An agreement was struck that the Nuxalk Nation would deliver services on-reserve and send funding to the home and community care program. Therefore, federal and provincial funding was combined to make a single home care program, where there had been two (the province's program and the federal FNIHCC program) before. The new program was truly a collaborative effort between the United Church Health Services and the Nuxalk Nation Health and Wellness program.

With full community support, integration of all home care programs slowly began in 2007, based on what the clients needed, not whether they lived on- or off-reserve. Everyone in the Bella Coola area uses the on-reserve health centre, whether they are First Nations or not, and whether they live on- or off-reserve. Clinic programs, which are part of the adult day program, include foot care, wound care, blood pressure monitoring, diabetes education and a bath program. The interRAI home care assessment is used to develop a care plan. Also available is an interprofessional palliative care program.

The health centre is a hub for primary health care, telehealth, pharmacy, mental health and addictions, public health, social services, and an administrative office to support patient travel. Doctors and practitioners in the home care program meet weekly to review clients. There are also connections to specialists outside the community. For example, for wound care, Pixalere, a complete wound care management system is used. The Librestream camera system is used for a virtual connection to highly skilled teams, and there is a connection to BC's health information network and medication database, Medinet.

There is no new money for this program. Funding streams were pooled to work around budget restraints, expand capacity, and provide flexibility. This practice, which creates equal access to care through pooled funding; integrated on- and off-reserve programs; and having federal, provincial, and band employed staff all working together in interprofessional teams with clear roles and responsibilities, is unique and very different from usual practice.

IMPACT:



At this time, a formal evaluation of this practice has not been completed. Personal accounts and regular monitoring of clients suggest that the quality of care is improving. Before integration, the on-reserve seniors didn't have access to the same broad range of services. Some benefits of these services include fewer emergency department visits, fewer hospital admissions, and fewer alternate level of care (ALC) clients at Bella Coola General Hospital. People have been transitioned back home after having lived in the hospital for more than a year. There is also reduced patient travel. And, due to improved foot care, no one has had an amputation in years. There is also an effort to hire local health professionals; after they leave for training and education..

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Bella Coola had adapted from and were unaware if the practice was used as a model elsewhere. Currently, neighbouring communities are interested in developing the same integrated program and sharing ideas. Important lessons learned are: it only takes one person to identify a gap and champion change; Chief and Council must be consulted first—their support is crucial; the federal government, province, regional health authority, and band were willing to explore a different model; staff were hired and developed from within the community; taking a shared care approach with the whole community working together is effective; and the use of technology and assessment tools improves client care.

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Personal Communications:

Phillips, G. (interview and feedback, August 2013). [Bella Coola General Hospital]



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Aboriginal Care Coordinator Registered Nurse, Case Management, Royal Alexandra Hospital, Alberta Health Services

LOCATION:	Alberta	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for coordinated care in a hospital environment (from intake through discharge) for First Nations and Métis people. It was launched at Royal Alexandra Hospital in 2007 and serves First Nations and Métis patients living in Central and Northern Alberta. The practice involves an Aboriginal Care Coordinator Registered Nurse (RN) working collaboratively with interprofessional teams.

PRACTICE DESCRIPTION:

This practice was developed in response to First Nations and Métis patients' need for coordinated care in hospital environments, from intake through any alternate levels of care provided in provincial and federal health care systems or discharge to the community. The practice, which is based in Royal Alexandra Hospital, is led by an Aboriginal Care Coordinator RN and targets First Nations and Métis people in acute care settings in the health region. Funding to support the practice comes through the budget assigned for care management.

When the Aboriginal Care Coordinator RN position was established in 2007, its responsibilities focused on discharge planning, providing navigation supports for both patients and community health providers, and liaising between the hospital and providers in patients' communities to ensure that patients' needs were met when they left the hospital. In 2008, the hospital introduced a care management model, and the focus of the Aboriginal Care Coordinator RN's work shifted to include supporting First Nations and Métis patients' access to care and potential alternate levels of care in acute and community settings. The Aboriginal Care Coordinator RN works with interprofessional teams (which, in addition to doctors, may include unit-specific RNs, social workers, physical and occupational therapists, dietitians, respiratory therapists, pharmacists, nurse practitioners, pastoral care providers, and Aboriginal cultural helpers) to coordinate patients' care and their discharge to a variety of alternate levels of care or to a home or community setting. Even as patients' care needs change, the Aboriginal Care Coordinator RN follows them through the system and connects the hospital with the patients' community context.

This practice differs from the usual care available to First Nations and Métis in several ways:

- **Patient Driven:** The Aboriginal Care Coordinator RN works in an interprofessional team that is led by the patient. The Coordinator RN works to understand the needs of the First Nations and Métis seniors who are their patients, and then collaborates with other team members to identify how to make the best use of available resources to meet those needs, support the patient's wellness, and ensure that the patient maintain as much control over their care as possible.
- **Care Management Model:** The care management model used in this practice considers the needs of First Nations and Métis seniors in the acute care setting of the hospital and other settings they may move to after they are discharged. Patients are assessed using tools that include interRAI and McMaster Case Management to ensure that their needs are well understood by the Aboriginal Care Coordinator RN and other members of the interprofessional team. With that understanding in hand, the team explores how they can best meet the patient's care needs.
- **Community and Family Linkages:** The Aboriginal Care Coordinator RN has built relationships with service providers in the home communities of the First Nations and Métis seniors they serve. These relationships have given the Aboriginal Care Coordinator RN a practical understanding of the resources available in these communities. Community resources vary widely, and when a First Nations or Métis senior is discharged to a community setting, the Aboriginal Care Coordinator RN works with the patient, family members, and providers to identify how they can work together to meet the senior's care needs and ensure that appropriate resources are in place.



- **Cultural Safety:** This practice incorporates a holistic approach to the care of First Nations and Métis seniors and supports patients' need for quality care that is culturally relevant and culturally safe both in and outside of the hospital setting. The Aboriginal Care Coordinator RN recognizes that patients' care needs cannot be fully understood without also understanding the contexts of their families and communities, and the effect that social determinants of health might have on their ability to care for their own wellness.

IMPACT:

This innovative practice was implemented in 2007 and does not have a completed evaluation at this time. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health, particularly with respect to improved quality of care for First Nations and Métis seniors, reduced length of hospital stays, and improved access to appropriate after care. These positive outcomes, in turn, should reduce the likelihood of seniors being readmitted.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that the Aboriginal Care Coordinator RN had adapted from and were unaware if the practice was used as a model elsewhere. However, this initiative is theoretically applicable and transferable to other settings, and health educators and service delivery organizations in Alberta and other provinces have expressed interest in the model. Important lessons learned during the development and implementation of this model include that (1) the patient must be in the lead in the care team; and (2) the Aboriginal Care Coordinator RN's commitment to initiate and develop relationships with patients' families and community providers and actively engage them in the patients' care are crucial to the practice's success.

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Information last updated on: October 1, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Crook, B. (interview, July 30, 2013). [Alberta Health Services].



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Telehealth Services, Primary Care, Carrier Sekani Family Services

LOCATION:	British Columbia	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses the need to enhance access to primary care and continuity of care in remote First Nations communities in North Central British Columbia through use of telehealth. The practice was launched at Carrier Sekani Family Services in January 2012 and involved a primary care physician, a family nurse practitioner, and medical staff at nursing centres and health centres in eight First Nations in Carrier and Sekani Territory.

PRACTICE DESCRIPTION:

Carrier Sekani Family Services (CSFS) introduced telehealth into its primary care services as a way to enhance access to care in eight remote First Nations communities it serves. Prior to the introduction of this technology, seniors in these communities relied on the services of fly-in physicians. With no access to physician care between these community visits, individuals typically access primary care services from nurses who rotate through the communities. Anticipated outcomes of introducing telehealth included (1) reduced need for medical transfers, (2) enhanced ability to meet chronic care guidelines, and (3) enhanced ability to provide continuity of care and access to evidence-based care. Funding to support telehealth is drawn from the CSFS budget.

CSFS introduced telehealth in 2012, piloting it in the most remote community it serves. Telehealth enabled nurses and patients in the community to access (as needed) CSFS's nurse practitioner and primary care physician. Within six months, CSFS brought telehealth into a second community; today, nursing staff in eight communities are using telehealth. The nurse practitioner and primary care physician continue to travel to the communities, but the physician's practice has shifted to focus on telehealth appointments with patients. At scheduled clinics in the communities, the nurse practitioner can facilitate physical examinations needed to complete patients' virtual visits with the physicians. CSFS's telehealth practice has been established as a permanent program and continues to grow. The program now includes access to mental health services. CSFS has recently received funding for three additional nurse practitioner positions, which will further enhance patients' access to care and the utility of the telehealth practice.

Seniors, other patients, and nursing staff have embraced telehealth. Telehealth has meant that all medical staff in CSFS's system of nursing stations now have access to the same information. Each Monday morning, nursing staff in all eight communities and the nurse practitioner meet via telehealth, a practice that offers valuable peer support to nursing staff.

CSFS telehealth-assisted primary health care services provide more access to care than was previously available to First Nations seniors in the region. The practice has increased continuity of care and changed the way in which care is provided. Seniors and their families are able to establish relationships with their physician, and the practice supports collaborative care. Ordinarily, in nursing stations, care focuses on treatment. Telehealth positions CSFS to shift the focus of in-community services towards maintenance and preventive care. Telehealth has also proven to be an invaluable resource in the provision of in-community palliative care, enabling CSFS's physician, nurse practitioner, and nursing staff to meet with patients and their families and ensure that the best possible care is in place.

IMPACT:

While an evaluation has not been completed at this time, a survey of nursing staff at the pilot site is underway. Personal testimonials from patients and other observations suggest that the practice has the potential for positive outcomes on health. For example, the number of medical transfers from communities where the telehealth practice is now being used has declined to about half of what it was before the technology was introduced. Reductions in medical transfers and travel are generating savings.

APPLICABILITY/TRANSFERABILITY:



The practice informant did not identify other practices that Sekani had adapted from and were unaware if the practice was used as a model elsewhere. Although, at the time of this report, the practice had only been in place for a relatively short time, other health organizations in British Columbia have shown interest in the model. Lessons learned from this practice suggest that it is theoretically applicable and transferable to other settings:

Although, at the time of this report, the practice had only been in place for a relatively short time, other health organizations in British Columbia have shown interest in the model.

- The telehealth program was championed by CSFS's primary care physician, whose passion, knowledge, and dedication to the practice have been invaluable.
- Staff education is key, particularly in communities served by rotating visiting nurses.
- For the practice to succeed, medical practitioners and nurses in the communities must be willing to collaborate with the program's nurse practitioner and physician. To minimize fear or resistance from community service providers, CSFS's nurse practitioner has worked to establish personal relationships, visiting the communities when the practice is introduced or when equipment or programming changes occur, making it clear that the technology will enhance—not replace—the relationships between care providers and patients.
- Challenges encountered in the development and implementation of this practice have included having limited access to adequate bandwidth and Internet service in some communities and limited access to dedicated funding.

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Information last updated on: September 27, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Burns, G. (interview and feedback, July 23, 2013). [Carrier Sekani Family Services].

Pawlovich, J. (interview and feedback, July 23, 2013). [Carrier Sekani Family Services].



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The importance of culture to care – Continuing Care and Independent Living Program – Tlicho Community Service Agency

LOCATION:	Northwest Territories	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to address the need for integrating culture and holistic programming into home and continuing care, to better meet the needs of elders. A new managerial role of Continuing Care and Independent Living was created to work with coordinators in all program areas.

PRACTICE DESCRIPTION:

Culture is a critical part of the effectiveness of all health and social service programs. Culture includes stories, legends, rituals, celebrations and practices, taboos, songs, drum dances, child rearing practices, hunting practices, roles and responsibilities, expectations of leaders, forms of punishment, teaching methods, how to relate to outsiders—every aspect of how to live one’s life. As part of the transition to self-government (in 2005) a Tlicho Cosmology Project was developed to help initiate discussion about what culture means for the Tlicho people and to apply this knowledge to modern organizations and programs.

Cosmology was successfully integrated into a variety of program areas and there was interest in trialing it in the home and continuing care program to enhance the cultural component. There was also a need for new staff roles and training to put Cosmology into practice but also to expand staff skills and enhance programming.

Continuing Care and Independent Living is a program of the Tlicho Community Services Agency (TCSA), which provides the management, administration and delivery of three program areas including education, health care, and social services, in the four Tlicho communities. The TCSA is the only authority that combines the functions of a health authority and an education council in the Northwest Territories; it is therefore unique in its holistic approach to the delivery of programs.

The Continuing Care and Independent living program includes Continuing Care, Home Care, an Elders’ Day program, Elder’s Recreational Activity program, Independent Assisted Living, Medical Social Work, Adult Foster Home, and Meals on Wheels. A new position called Manager of Continuing Care & Independent Living was created to integrate social work, clinical practice and a cultural component into a medical model of care, and work with coordinators in all of the program areas to apply Cosmology in the programming. In addition, the TSCA worked with Health Canada to develop and approve a Traditional Food and Diet Policy that basically says Elders have the expertise to determine when an animal is safe to eat. Another position called Elder’s Day Coordinator was established to oversee Elders spending time on the land and in traditional activities such as snaring rabbits, berry picking and caribou hunting, and to arrange to bring youth and elders together for games and drumming.

Another key area has been the hiring and training of local Tlicho staff. All staff in the LTC and Continuing Care and Independent living program are Tlicho, which means elders can communicate with staff. Additional training was provided to allow the Personal Support Workers to give injections. They became Residential Care Aid Workers and have been valuable as a back-up to the nurses given the lack of 24-hour nursing service. This has allowed elders to remain in their community. Last year, another program was initiated to train students as Personal Support Workers for eight months in the community by bringing a trainer from one of the colleges to the community. The program is supported by the Tlicho government. Nineteen students are graduating this spring. Hiring local people has positive impacts on retention. The Government also funds the Tlicho CART (Community Action Research Team), a collaborative project with university-based researchers that conducts “research-to-action” projects to find solutions to health problems and then translate this information into teaching materials for providers. The materials integrate the knowledge of the Tlicho values and beliefs.

IMPACT:

This innovative practice does not have a completed evaluation at this time. Personal testimonials and observations suggest that



this practice has the potential for positive outcomes on health. A community consultation was held to receive feedback on these initiatives and it was very positive. Elders enjoy the community activities; the program keeps them healthy, happy and more independent. Hiring and training local people has had very positive impacts on retention, capacity to fill gaps in care has improved, and the wait list for long term care has shortened to only 1 or 2 people because people are able to remain in their homes longer. The cultural component is now embedded in programs and services and new ideas are forthcoming. For example, plans for expanding long term care, with additional staffing and a long-term initiative that involves the Tlicho Government, the Government of the NWT and the federal Minister of Aboriginal Affairs negotiating changes to the Intergovernmental Services Agreement (ISA) for self- government as it relates to education, health and social programs in the communities. The lessons learned from the Cosmology Project will have a central place in this effort to ensure that programs will closely reflect the culture, language, and way of life of the Tlicho people in years to come.

APPLICABILITY/TRANSFERABILITY

The practice informant did not identify other practices that Continuing Care and Independent Living Program had adapted from and were unaware if the practice was used as a model elsewhere. Factors that would impact the success and applicability/transferability of the practice are: self-government allows for flexible development of programs to meet community needs; committed First Nations leadership provides guidance; Cosmology provides a holistic framework that guides the development of programs and services; CART, this collaborative research project brings best practice research and programs to the community and integrates them with the traditions and values of the Tlicho people; support from the leadership is important to training front-line workers to provide injections; and hiring and training local staff improves retention.

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Information last updated on: October 2, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Wedzin, N. (interview and feedback, August 14, 2013). [Tlicho Community Service Agency].

External Source: <http://www.tlicho.ca/organization/tlicho-community-services-agency>



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Saanich First Nations Adult Care Society

LOCATION:	British Columbia	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses gaps in care for Elders and disabled people in First Nations communities on Vancouver Island in British Columbia. The Saanich First Nations Adult Care Society provides care in clients' homes, and currently involves two home care nurses and five home support workers.

PRACTICE DESCRIPTION:

The Saanich First Nations Adult Care Society was developed in response to gaps in care to Elders and disabled people in four First Nations communities on the Saanich Peninsula of Vancouver Island. The organization was started by volunteers, who were determined to improve services for their community members. Over a two-year period, the volunteers completed a needs assessment in the four First Nations on the Saanich Peninsula, and learned that community members were being discharged from hospitals with inadequate follow-up. Community members who initially were not sick enough to be in hospital but not well enough to be at home could not access the care they needed to stay out of hospital. There was a clear need for home care services, and the organization used data from the needs assessment to support a funding application to the Closer to Home program. When funding for a pilot project was secured in 1995, the Society began delivering services.

The Saanich First Nations Adult Care Society is a permanent program, supported by funding from the Vancouver Island Health Authority. Its practices differ from usual practice or care available to First Nations seniors. Clients may be referred to the Society by family members, medical practitioners, social workers and others. Home care nurses visit clients in their homes, complete initial assessments, follow-up when clients are discharged from a hospital, provide referrals to other services, accompany clients to medical appointments, advocate for patients, and incorporate what they learn from other medical practitioners into their own care plans for the client. Home support workers assist clients with personal care, cooking, housecleaning, errands, and other tasks. All services are provided to clients at no charge.

The nurses and home support workers have developed close relationships with their clients, and the clients trust them. The home support workers are certified, and provide culturally competent care. They typically come from local communities and know the history of the communities, families, and clients they serve. Nursing staff are not from the communities, but have developed connections there and are deeply committed to their practice. They are respectful and supportive with their clients, working flexible hours so that they can provide clients with the care they need. As a not-for-profit organization with well-developed infrastructure, the Society has generated trust and confidence in funders. It has been able to assert its identity as an Aboriginal organization, but also remains independent of any band or chief and council.

IMPACT:

The Society has not completed an evaluation at this time. Personal testimonials and observations also suggest that the organization's practices have the potential for positive outcomes on health.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Saanich had adapted from and were unaware if the practice was used as a model elsewhere. . A factor that might impact applicability or transferability of this practice is that a strong connection to community enhances service provider's ability to offer quality care.

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Information last updated on: October 1, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Sampson, A. (interview and feedback, July 15, 2013). [Saanich First Nations Adult Care Society].

Sampson, C. (interview and feedback, July 15, 2013). [Saanich First Nations Adult Care Society].



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Pond Inlet Elder Education and Awareness Program

LOCATION:	Nunavut	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses the isolation, health knowledge levels, and self-management skills of Inuit Elders in a rural and remote community in Nunavut. The practice was established in 2003 in a community centre and involved a home and community care nurse, home and community care workers, and a community health representative.

PRACTICE DESCRIPTION:

The Pond Inlet Elder Education and Awareness Program was developed to reduce Inuit Elders' isolation, and increase their health knowledge and self-management skills. The goal was to create an ongoing opportunity for Elders to get out of their homes, socialize, and learn about a variety of health topics, including but not limited to self-management.

The program provides regularly scheduled "teas" for Elders, held at a community centre in Pond Inlet. The teas offer community Elders a chance to join in cooking activities, share country food, and take part in education and awareness sessions with community health professionals and guest speakers. The program targets all Pond Inlet Elders, but Elders with diabetes can access additional care and counselling to support self-management of their disease through the program. Home and community care workers assist with the program development and implementation, home and community care nurses contribute clinical expertise and care, and community health representatives deliver health promotion sessions on a wide range of topics, such as nutrition, physical activity, and tobacco cessation.

The Pond Inlet Elder Education and Awareness Program was established in 2003 and is now a permanent component of the home and community care program. The program is different from the usual practice and care provided to Inuit Elders. It is community-designed and delivered to address the unique needs of Elders residing in a rural and remote Nunavut community. Health programs for Nunavut seniors are often brought to the North, but this program was developed in Pond Inlet for the people of Pond Inlet. The activities provided through the program are multifaceted, and the program has a lot of support and buy-in from the community.

Program funding is through the Government of Nunavut's Health Portfolio Contribution Agreement and currently supported by the Chronic Disease and Injury Prevention Community Funding.

IMPACT:

This innovative practice has been implemented since 2003, and does not have a completed evaluation at this time. Personal testimonials and observations suggest this practice has the potential for positive outcomes on health. The practice reduces the burden placed on home care workers and on the Health Centre, as clients are able to see the home care nurse at each regularly scheduled Elders' Tea.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Pond Inlet had adapted from and were unaware if the practice was used as a model elsewhere.

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Information last updated on: October 2, 2013.

Content has been adapted from the following sources and relevant links:

Personal Communications:

Budgell, J. (questionnaire and feedback, August 19, 2013). [Department of Health, Government of Nunavut].



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Shared Caregiving in the Community—Peter Ballantyne Cree Nation (PCBN)

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for home and continuing care for seniors living on-reserve. The PBCN Health System developed a structured home and community care program in 1999, enhancing it in 2008 by pooling community resources and bringing together an interprofessional team, families, and community services.

PRACTICE DESCRIPTION:

The Peter Ballantyne Cree Nation (PBCN) consists of over 8,500 Woodland Cree members residing in eight largely isolated communities in northeastern Saskatchewan. Elder care is a growing priority. An increasing number of seniors require higher levels of specialized medical care that are primarily offered in urban centres. There is also a lack of community-based long-term, palliative, respite, and after-hours care services to manage chronic issues. The situation is made more complicated and serious by jurisdictional disagreements over authority and financial resourcing, and by fragmentation caused by the lack of coordination among the federal government, provincial government, and regional health authorities when it comes to providing services on- and off-reserve. Elders travelling between their home communities and urban areas are especially vulnerable because there are few service links or communication between northern and southern services.

In 1999, the PBCN Health System developed a structured home- and community-care program based on needs identified by elders and families. While this provided an excellent foundation for improved culturally responsive services, additional networks, resources, and planning were needed to support the diverse needs of the elderly. A community health plan indicated the need for a holistic community focus on elder care in alignment with PBCN's vision of health care, which is to strengthen the individuals, families, and communities through a holistic approach. A home and community care service and delivery plan helped identify short- and long-term strategies to enhance the federal First Nations Inuit Home and Community Care (FNIHCC) program. Several changes were implemented:

- Community resources were pooled for some services, plans for serving the elderly were coordinated using all services that were in the community, and primary community-based health care became a key focus.
- When seniors could not come to the clinic, home care staff provided transportation, offered at-home nursing and home help, and whenever possible in emergent cases, a doctor provided bedside care.
- When elders have to leave their communities for care, community health providers help the caregivers, families, and patients bridge the north-south divide and assist with transition into urban health care settings. They help coordinate medical health information. Home care nurse assessors advocate for, and work with, the elderly and their families to arrange long-term care or hospital care in conjunction with the home care manager located in Prince Albert, which is the main urban setting for the PBCN. Trained, Cree-speaking local home care aides, home living assistants, and elder coordinators are available to help the elderly navigate the medical system and provide translation, transportation, and other support services.
 - PCBN Health works with local agencies to ensure elders have wood to heat their homes or to assist with propane costs, and to ensure social needs are met to reduce isolation. An elder worker helps to provide transportation and organizes traditional and social activities such as grocery shopping outings to the nearest town or blueberry picking. The home living assistance provides support through doing small maintenance repairs to elders' homes, shovelling their snow, chopping wood, or bringing them fresh traditional food such as fish and moose. Some elders also receive Meals on Wheels from the program a couple of times per week.

Working together at the community level and coordinating the community and urban health providers is the crux of the shared caregiving approach and it is a unique approach to the delivery of care for elderly individuals on-reserve. PCBN received



national recognition at the National Research Conference on Urban Aboriginal Peoples, and the practice has been written about in journal articles.

IMPACT:

From 2008 to 2010, PBCN Health did a small study on the PCBN elderly care programs and services to explore how they could better facilitate the respect and dignity of elders during chronic and/or end-of-life care in the communities. Results showed that the shared caregiving model helped to enhance the FNIHCC program. More seniors in their late 80s are able to stay at home rather than being forced to urban facilities. The multilevel programs offered in the health centres, including home care, helped to promote independence and provide services that allowed the elderly to remain at home longer. Although some elders had to leave the community for long-term care or hospital care, the efforts to link services through coordination and advocacy between rural communities and urban health care were successful in making sure vulnerable elders didn't fall through the cracks.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Peter Ballantyne had adapted from and were unaware if the practice was used as a model elsewhere.

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Information last updated on: September 25, 2013

Content has been adapted from the following sources and relevant links:

Beatty, B. & Weber-Beeds, A. (2012). Mitho-Pimatisiwin for the elderly: The strength of a shared-caregiving approach in Aboriginal health. In D. Newhouse, K. FitzMaurice, T. McGuire-Adams, & D. Jetté (Eds.), *Well-being in the urban Aboriginal community*. Toronto, ON: Thompson Education.

Beatty, B.B. & Berdahl, L. (2011). Health care and Aboriginal seniors in urban Canada: Helping a neglected class. *International Indigenous Policy Journal*, 2(1). Retrieved from <http://ir.lib.uwo.ca/iipj/vol2/iss1/10>

Personal Communications:

Beatty, B. (interview and feedback, April and September 2013). [University of Saskatchewan].

External Source: <http://www.peterballantyne.ca/index.html>



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Building bridges between First Nations health care providers and the mainstream health care system, Mamaweswen North Shore Tribal Council (NSTC)

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice improves communication and continuity in care for seniors who are discharged from the hospital back to their First Nations community. Launched in 2007, two First Nation System Navigator/Discharge Planning Nurses (DPN) from First Nations communities work in collaboration with hospitals, CCAC, clients, families, and the Mamaweswen North Shore Tribal Council (NSTC) communities.

PRACTICE DESCRIPTION:

At one time, there was a gap in communication flow when seniors were discharged home from the hospital back to their First Nations community. There were no referrals made to community services to ensure follow-up care. Clients would return home after the hospital stay, and community support services were not aware of the hospitalization or the need for follow-up care and assessment, homemaking services, assistive devices, and general support that would enable individuals to live independently.

A partnership was formed between the North Shore Tribal Council (NSTC), the Indian Friendship Centre, and the Métis Nation of Ontario in Sault Ste. Marie, to provide collaborative, integrated care and a client-centred case management approach to the senior population. Two First Nation System Navigator/Discharge Planning Nurses (DPNs) were put in place to be part of the discharge teams at the hospitals in the region.

Now, when seniors are admitted into the hospital, they are encouraged to self-identify as First Nations, Aboriginal, or Métis so they can be referred to the service. If they accepted the DPN's involvement, there is access to the chart and they become part of the discharge team's case load. The nurse works in collaboration with hospital staff, the Community Care Access Centre (CCAC), the client, the family, and the NSTC community to assist in the client's transition back home. Some of the DPN's roles include: visiting the client at the bedside to assess needs, attending rounds and being a part of developing discharge plans, keeping the client and their family informed about discharge information, helping clients understand their illness and how the discharge plan will help, advising the First Nations community support services of the discharge date and ensuring services will be in place, and providing follow-up home visits to ensure that appointments with health care providers are in place and kept.

This program was made possible by provincial funding. The Tribal Council already had a comprehensive primary care program as well as a community support services program for Elders, but the DPNs are a much-needed enhancement to the services. A proposal was submitted to the local health integration network (LHIN) under the province's Aging at Home strategy. A requirement for applying for the provincial funding was to partner with other organizations. The Tribal Council invited both the Indian Friendship Centre and the Metis Nation in Sault Ste. Marie to be part of the provincial proposal.

There is a very good working relationship with the LHIN, and regular meetings are held. When the LHIN began, representatives met with the Chief and Council and discussed programs and funding that could be accessed through LHINs. The Chiefs approved working with the LHIN and they addressed the fiduciary responsibilities of the federal government at a different level. This way, politics were separated from the service delivery in order to work together to bring in these services for the seniors.

IMPACT:

It's evident through personal accounts, observations, staff discussions, and monitoring of clients that follow-up care for seniors after discharge has improved and that this is having positive outcomes on health. The staff is informed of when individuals are in hospital and when they are going home; thus, they are able to put services in place for the seniors' continued care at home.



They are also more informed about what additional off-reserve services are available to wrap around their care if required. It has also been an education for the hospital and the CCAC to realize the level of service that is provided in the First Nations communities. Having DPNs on the discharge planning team has helped break down barriers and improve understanding, communication, and trust between hospitals and communities.

No evaluation exists at this time, but next steps are to track whether efforts are reducing hospital admissions; look at seniors housing options for the communities; and look at services with various levels of care to wrap around the individual's assessed needs, in order to keep these seniors at home longer and avoid moving them into long-term care.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that North Shore Tribal Council had adapted from and were unaware if the practice was used as a model elsewhere. Lessons learned from this specific practice that would affect applicability/transferability are that politics can be separated from service delivery, committed leadership is critical, and building partnerships between First Nations and Métis and between on-reserve and urban communities is critical for the provision of hospital discharge services to both First Nations and Métis seniors within the catchment area.

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Information last updated on: October 3, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Mercieca, E. (interview and feedback, September 9, 2013). [Mamaweswen, North Shore Tribal Council].



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Keewaytinook Okimakanak (KO) Telemedicine: Improving care for and reducing isolation of Elders

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice provides a continuum of care in remote areas of northwestern Ontario and connects Elders to their families and communities. KO Telemedicine (KOTM) has continued to grow over the past 20 years, and in 2009 the in-home camera service was expanded to home care. The cornerstones of the service are the 26 community telemedicine coordinators who work in collaboration with off-site interprofessional health practitioners and the Ontario Telemedicine Network (OTN).

PRACTICE DESCRIPTION:

The catchment area for KOTM includes communities in northwestern Ontario that are geographically isolated and culturally distinct, and whose members have less access to health care services and lower health status compared to other Ontarians. Most are fly-in communities without road access, which makes it more challenging and expensive to travel for health care. Certain communities are so remote that sometimes clients cannot travel to nursing stations to access telemedicine. There is also the issue of isolation of Elders from community events and from their families.

KOTM uses information technology to link health care providers and patients onscreen. It improves access to a range of health care services and professionals, and is especially valuable for follow-up care. This not-for-profit organization, affiliated with the Ontario Telemedicine Network (OTN), is operated by First Nations. It serves 26 communities in the Sioux Lookout Zone of northwestern Ontario.

KOTM is as much about the people as the technology. The cornerstones of the service are the 26 community telemedicine coordinators (CTCs). They are the eyes and ears on what's happening in the community and are supported by off-site health providers. Their roles are flexible, making them a great resource. They often help with a range of tasks including translation, providing appointment reminders to clients, and technical assistance.

KOTM is provided at designated telehealth sites, such as nursing stations and health centres, but it can also be done in a person's home through remote video and a hand-held camera. This in-home service started addressing home care needs in 2009, and with changes in technology the service expanded in 2011/12 from four base communities to 22. A CTC takes a camera into a client's home and moves it around according to a health care provider's direction. This allows the health provider to assess the safety of the environment or to see the patient up close. For example, telestration allows for zooming in to assess a skin condition such as dermatitis or the condition of a wound. It also allows physiotherapists and occupational therapists to assess the need for assistive devices such as handrails, leg braces, walkers, and wheelchairs. A virtual social worker might also be involved to help explain situations to the family or discuss the mental and emotional impact related to the illness or condition. In-home cameras also allow service providers to link together. For example, a home care nurse can be in the home virtually to support a personal care worker with a dressing change, or to provide advice on how to turn the patient. In-home cameras are being used for palliative care as well. Together with phone calls between the visiting nurse and the palliative nurse in Thunder Bay, a client can receive quality of care and have a peaceful death at home.

KOTM also plays a huge role in reducing isolation for Elders. Monthly Elders' Gatherings are hosted by telemedicine so that Elders can have visits with family in other communities. A medical van picks up the Elders and brings them to a telemedicine site. There they meet with one another, family, and friends and also hear about educational health and wellness topics. These visits are highly anticipated by clients, since they provide a way of connecting with their loved ones socially.

While telemedicine for the delivery of care exists across the country, KOTM is the only First Nations-operated organization of its kind. The recently expanded in-home camera to support home care is affiliated with OTN's Telehomecare Expansion Project.



KO Telemedicine has won awards from the Canadian Society of Telehealth for its work and has been recognized as the best First Nations practice in telemedicine in the country and the world.

IMPACT:

The success of delivering care virtually through telemedicine is well established by the OTN. There are reduced costs and travel for patients and providers, together with improved access and quality of care. The results of a recent evaluation of KOTM and a retrospective of the home care program are forthcoming. Through personal accounts, observations, and monitoring of patients, KOTM contributes to improved health outcomes for on-reserve populations. It helps close health status gaps for remote First Nations communities, and it has substantially improved access and community-based choice of health service providers. It has also demonstrated how culturally safe and competent health services can be delivered by First Nations across large geographic and culturally diverse territories. In this way, communities' capacities are being built and strengthened while providing health workers with the resources they need to do their jobs effectively. Discussions with Elders indicate that they are very accepting of telemedicine because travel is more challenging physically. Conversations with families also tell how telehealth has made a difference in reducing the burden for them in caring for their Elders. It also reduces isolation, which improves overall health and well-being. Overall, providers and clients are very satisfied.

APPLICABILITY/TRANSFERABILITY:

Telemedicine exists throughout Canada, and services are delivered to many remote First Nations communities through the OTN. The practice informant did not identify other practices that KOTM, as a First Nations operated organization had adapted from and were unaware if the practice was used as a model elsewhere.

Key components for success include:

- the vision held by Elders;
- committed First Nations leadership and community involvement;
- funding and partnerships to enable growth and development of the services;
- maintaining security and privacy through continued monitoring and policy;
- maintaining community telemedicine coordinators and a strong supportive community team; and
- providers who realize the importance of the service for elder care and who are willing to use the technology.

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Personal Communications:

Coulson, H. (interview and feedback, 2013). [KO Telemedicine].



PUBLICATIONS

Ontario Telemedicine Network. (n.d.). *Embarking on the journey for virtual care: 2012/13 annual report*. Retrieved from <http://otn.ca/sites/default/files/otn-annual-report-2012-13.pdf>

Keewaytinook Okimakanak Telemedicine. (n.d.). *KO Telemedicine*. Retrieved from <http://www.telemedicine.knet.ca/files/KOTM%20Brochure.pdf>

External Source: <http://telemedicine.knet.ca/?q=node/2559>



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Improving Home Care Services to First Nations and Métis People, Aboriginal Home Care Program

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT:

This innovative practice improves access to home care services for First Nations and Métis people in the North Central area of Regina. The practice was launched in 2009 in a primary health care facility in the Regina Qu'Appelle Health Region (RQHR) and involved members of RQHR's home care team (community liaison worker, case manager, nurses, continuing care aides, scheduler, and administrative staff), First Nations and Métis knowledge keepers, and, other health care providers.

PRACTICE DESCRIPTION:

The Aboriginal Home Care Program developed out of the RQHR Home Care Program when it became known that in an area of Regina where First Nations and Métis people make up a significant portion of the population, the Home Care Program was receiving very few referrals for this population. To understand why this was happening and how they could improve services for this community, RQHR established a working group. This group included managers, community members, and Elders. RQHR drew on the working group's recommendations and guidance to develop the Aboriginal Home Care program. The program began as an AHTF pilot project, but was so successful that it is now an ongoing project, sustained through reallocation of RQHR home care funds.

The Aboriginal Home Care program focuses on the distinct needs of First Nations and Métis people in an urban setting, and is significantly different from usual practice or care as follows:

- The Aboriginal Home Care program uses a holistic approach that integrates both traditional Indigenous and mainstream understandings of health and wellness. A holistic assessment tool is used as an adjunct to the comprehensive MDS-HC tool to identify client needs, and interprofessional teams attend to clients' emotional, physical, and spiritual needs. The program works closely with the Eagle Moon Health Office, which focuses on improving service delivery for First Nations and Métis people in RQHR, offering both clients and staff access to First Nations and Métis knowledge keepers.
- Client care is self-directed, based on the client's expressed needs and self-identified priorities. Home care nurses and workers are able to take time during client appointments to interact and build relationships with their clients. This provides a unique opportunity for staff to learn about and understand clients' needs.
 - Program staff include a community liaison worker who does community outreach. At the time of writing, this position was filled by an Aboriginal person who follows traditional ways, listens well, and is known and trusted in the community. The community liaison worker has helped clients gain more trust in the health care system, and build the courage and capacity to take increased responsibility for their health.
 - The program strives for consistency in the home care team. Applicants' affinity to work with this population and recognition of the need to establish trust and positive relationships with community members are considered in the hiring process. Team members participate in cultural and skills development training, which has strengthened the team and made it more cohesive.
 - A scheduler who is dedicated to First Nations and Métis home care referrals is an integral part of the Aboriginal Home Care team. Flexible scheduling has also been introduced, making it easier for staff to accommodate clients' availability and needs.
 - Referral pathways have been clarified, a change that has increased the efficiency of service delivery. Referrals are also supported by a comprehensive service directory that has been distributed to service providers and to the public.



- The program draws on the expertise of First Nations and Métis community members. A Steering Committee, with representation from community members, Elders, managers, and the program's Executive Director, provides ongoing guidance and advice to the program.
- The program's offices were relocated to a primary health care facility near the community it serves.

IMPACT:

Key findings from a 2012 evaluation demonstrate that (1) First Nations and Métis clients' access to services has increased significantly since the Aboriginal Home Care Program was introduced, (2) the number of case-managed clients has increased 100%, and (3) First Nations and Métis clients are now more involved with self-care and have improved their own health management and (4) Clients' increased ability to manage their own health results in fewer trips to the emergency department and less use of hospital services.

Additionally, personal accounts and informal observations suggest that First Nations and Métis clients perceive home care team members as genuinely caring and sensitive, and feel more comfortable and trusting in their interactions with home care team members. These outcomes are expected to generate savings in costs associated with service delivery.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that FNIM had adapted from and were unaware if the practice was used as a model elsewhere.

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Content has been adapted from the following sources and relevant links:

Personal Communications:

Lloyd, D. (interview and feedback, August 21, 2013). [Regina Qu'Appelle Health Region].

McNeil, D. (questionnaire and feedback, August 21, 2013). [Regina Qu'Appelle Health Region].

Cavers, S. (questionnaire and feedback, August 21, 2013). [Regina Qu'Appelle Health Reg



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Quality Improvement Policy Framework for First Nations

LOCATION:	National	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:		FRAMEWORK CATEGORY:	

SNAPSHOT: This innovative practice provides policy tools to help guide continuous quality improvement in government health care policy and program development. The practice was launched by Health Canada's First Nations and Inuit Health Branch (FNIHB) in 2012 to establish a national system of culturally relevant accreditation for on-reserve First Nations and Inuit health and treatment services in Canada and is being implemented by a small group of staff and an external training consultant.

PRACTICE DESCRIPTION:

FNIHB's Quality Improvement Policy Framework (QIPF) builds on the branch's vision and activities to establish a national system of culturally relevant accreditation for on-reserve First Nations and Inuit health and treatment services in Canada. The QIPF provides a common understanding of what quality means to FNIHB through an integrated, branch-level approach for use by headquarters and regional staff. The intent is for quality improvement to be embedded throughout all aspects of FNIHB programming. Specifically, the framework aims to:

- demonstrate leadership and commitment to improving the quality of First Nations and Inuit health services;
- better align quality improvement activities and efforts across FNIHB; and
- achieve quality and value in services and programs through coordinated, continuous quality improvement.

The framework elements include a vision, purpose, guiding principles, and six dimensions of quality:

- accessible
- client-centred
- culturally competent
- effective
- efficient
- safe

It is anticipated that full implementation will be achieved in 2017, approximately five years after the launch date. Implementation is being driven by the Model for Improvement and includes the use of plan-do-study-act cycles. Seven key factors have been identified to help guide implementation activities: strong leadership, clear quality improvement plans, effective communication of quality improvement activities, motivation and the will to improve, performance measurement and evaluation, appropriate implementation support, and celebration and recognition of success.

Throughout the implementation phase, a Quality Improvement and Accreditation Unit will coordinate the necessary training and assistance required to help program teams learn how to develop and implement quality improvement plans. This unit will also launch a user guide and approach key influencers, such as the FNIHB's change management group, to help promote the framework. In the first year of implementation, voluntary early adopters were sought, including primary care policy staff and staff from other program areas. In the second year, training will be provided by an external expert and by FNIHB staff.

IMPACT:

FNIHB's Quality Improvement Policy Framework was implemented in the fall of 2012 and does not have an evaluation at this time.



APPLICABILITY/TRANSFERABILITY:

The foundation of the policy framework is based on an extensive review of quality improvement initiatives and approaches in Canada (e.g., provincial health quality councils) and internationally, such as in the United Kingdom, the United States, and Sweden. Additional research on Aboriginal health-specific quality improvement looked at models in Australia, New Zealand and the US. This initiative is theoretically applicable and transferable to other settings seeking to begin quality improvement initiatives.

Several lessons learned may help others apply this practice to other settings:

- When developing the framework, including government staff from a variety of departments at the working level will help align the content of the emerging framework with related initiatives (such as accreditation policy frameworks and quality improvement tools at the service delivery level).
- Consulting with external experts to review the framework can help to improve credibility in the Canadian context.
- Implementation requires time, change management, and training of staff.
- It is important to anticipate the limited availability of resources that are required to implement a quality improvement framework during times of federal economic restraint.

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Content has been adapted from the following sources and relevant links:

Other:

Health Canada, FHNIB. (2012, August 20). Response to the Health Council of Canada's Health Care Quality Improvement Survey of Federal/Provincial/Territorial Governments.

Health Canada, FNIHB. (review, August 26, 2013). [Health Canada, FNIHB, Assistant Deputy Minister's Office]

Greene, J. (interview, July 19, 2013). [Health Canada, First Nations & Inuit Health Branch].

Publications

Health Canada. (2009). *First Nations and Inuit Health Services Accreditation Policy Framework*. Retrieved from <http://www.hc-sc.gc.ca/fniah-spnia/services/accred-agrem/acc-agr-eng.php>

Health Canada. (2011). *Building quality healthcare*. Ottawa, ON: Government of Canada.

Health Canada, FNIHB. (2012). *Quality Improvement Policy Framework*. Ottawa, ON: Government of Canada.



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Drop the Pop

LOCATION:	Northwest Territories, Nunavut, Yukon	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:		FRAMEWORK CATEGORY:	

SNAPSHOT: This innovative practice addresses the issue of childhood obesity and other nutrition-related health issues as part of a jurisdictional health promotion strategy. The practice was launched in 2004 in Nunavut, starting with 14 schools and involved a government lead, community partners, and administrators/teachers leading individual school efforts.

PRACTICE DESCRIPTION:

Concern has grown over time about over the high rate of pop consumption and the increasing rates of obesity, diabetes, and dental cavities in children and adolescents in Canada’s north. This innovative practice has been implemented in various jurisdictions as part of a larger strategy to prevent childhood obesity and chronic disease later in life. “Drop the Pop (DTP)” is an annual health promotion campaign designed to increase students’ awareness of how sugary drinks affect their health, and to encourage students and their families to drink/eat healthier beverages and foods and make healthy lifestyle choices. It was first implemented in Nunavut, targeting students in kindergarten to grade 12. The original Nunavut approach included (1) schools, classrooms, and students competing for prizes by not drinking pop for one school week, and (2) teachers and students learning about the health impacts over time of drinking pop regularly. The first year involved 14 schools and the number of participating schools grew year over year.

A pan-territorial implementation of DTP began in 2011; the campaign runs between January and March of each year. The campaign theme is adapted in each territory according to differences in funding, personnel, and community-based partnerships. Funding supports provincial promotional activities, school incentives and awards, and school/classroom projects. Sources of funding can include government, non-governmental organizations, and philanthropic organizations. Partners may contribute in-kind resources, such as store coupons for a free fresh fruit or milk. Other resources include the time of territorial (government) leads, school coordinators, community partners, and administrators/teachers leading school efforts. To receive government funding, schools complete an application. Past projects have included, for example, school activities regarding healthy eating and active living, family and community events, school/student challenge projects, health fairs, and nutrition education.

The Childhood Obesity Foundation has proposed that the success of the DTP program is due to its flexible and evolutionary approach. It responds to needs that are identified at the school level and reflects the innovations and ideas of teachers, schools, and communities.

IMPACT:

A 2011 evaluation studied the implementation and short-term outcomes of the 2010/2011 pan-territorial “Drop the Pop” campaign, using survey information.

- Schools (77%) indicated their students brought healthier beverages and foods to school during the campaign period.
- Students reported drinking/eating healthy beverages/foods at school and home duringthecampaignmonth.
- Many parents replied that their children asked them to buy healthy foods or drinks for them to eat at home during that time.
- Students (71%) could identify three foods of which they should eat more, and 86% could identify three foods of which they should eat less.

Personal testimonials and observations suggest that this practice has the potential for positive long-term outcomes on health. An assessment of the costs and savings of this practice has not been completed at this time.

APPLICABILITY/TRANSFERABILITY:

This practice was developed in Nunavut by nutrition and dental health specialists in 2003 and the campaign was launched in 2004. “Drop the Pop” was adopted by the Yukon and Northwest Territories in 2005/2006 and subsequently by other Canadian



jurisdictions. In 2007, the Cree Board of Health and Social Services of James Bay adapted Nunavut's *Drop the Pop Teacher's Guide* for its campaign. The Kidney Foundation of Manitoba invited First Nations schools, parents, and communities to participate in a one-week DTP Challenge. In 2011, Nunavut and Yukon daycares became eligible to apply for funding and to participate in the "Drop the Pop" Challenge

Lessons learned that would affect applicability/transferability of the practice include:

- Local partnerships with retailers have contributed to the program's success.
- Small cash incentives are useful motivators.
- Prize draws are offered to schools to encourage all participants to submit their project and/or financial and evaluation reports.
- It is useful to tie the DTP Challenge to annual jurisdictional initiatives such as nutrition month or dental health month.
- The campaign has been aligned with the Sip Smart! Initiative in some parts of Nunavik in Quebec.

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Publications

Childhood Obesity Foundation. (n.d.). *Drop the Pop*. Retrieved from <http://www.cdpac.ca/media.php?mid=999>

Cree Board of Health and Social Services of James Bay. (2007). *Drop the Pop Teacher's Guide*. Retrieved from <http://creehealth.org/sites/default/files/DTP%202009%20Teachers%20Guide.pdf>

Glacken, J.B. (2011, March). *Pan-Territorial evaluation of Drop the Pop: Summary evaluation report*. Retrieved from http://www.hlthss.gov.nt.ca/sites/drop_the_pop/pdf/pan_territorial_evaluation_of_drop_the_pop_2011.pdf

Kidney Foundation of Canada, Manitoba Branch. (2009). *Drop the Pop: Overview and general information, 2012–2013*. Retrieved from <http://www.kidney.ca/document.doc?id=3974>

Priest A. (2006). *Nunavut's Drop the Pop program*. Retrieved from

<http://www.canadian-nurse.com/images/pdf/2006/cnj-apr-2006/files/assets/downloads/page0014.pdf>

Alternative Profiles:

Canadian Public Health Association. (2009). *Drop the Pop campaign—Detta, Northwest Territories*. Retrieved from <http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/stories/kaw-tay-whee.aspx>

External Source: www.dropthepopnwt.ca



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Social Work through Hip Hop (BluePrint For Life): Promoting physical and mental health in youth

LOCATION:	National	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the issue of compromised physical and mental health in youth, especially those living in Canada’s North and inner cities. This practice was first launched in Nunavut in 2006 and involves hip hop artists and facilitators with social work training, as well as community members to support the event and follow-up activities.

PRACTICE DESCRIPTION:

Social Work through Hip Hop is a mental health promotion workshop that integrates hip hop, traditional practices (such as throat singing and drumming), education, and dialogue. The workshops have been implemented in Canada’s North and its major cities. The workshop targets youth at risk of chronic disease, inactivity, and poor mental health, especially Aboriginal youth who live with the adverse health effects of colonization. It also serves as a community development model. It was first launched in Iqaluit, Nunavut, in 2006. Workshops are usually held in schools or community centres. The BluePrint outreach team includes dancers, youth facilitators, cultural artists, and outreach workers, including Inuit youth who are leaders in training. Communities have paid for the workshops via sources such as territorial government grants and land claims funds.

Youth participate in a five-day workshop to learn hip hop, be educated, and engage in discussions about respect, healthy living, cultural pride, bullying, anger management, suicide, drugs and alcohol, abuse, and healing. There is a hip hop performance for the community on the last evening. Parents, elders, community members, and teachers are encouraged to participate in the dance lessons. Complementary workshops include *Healing through Hip Hop* and *Leadership through Hip Hop*. A variety of therapy techniques, such as cognitive behaviour therapy, are used when dealing with complex issues in the education and dialogue aspects of the workshop. The program supports community empowerment and intergenerational healing. This practice is innovative because the “kids come for the dance, but stay for the healing.”

IMPACT:

Personal testimonials, observations, and early evaluations suggest the practice has the potential for positive health outcomes, including increased physical activity and reductions in suicidal ideation, bullying, alcohol and drug abuse, violence, and vandalism. Surveys at the end of each workshop are used to continually evaluate, improve, and adapt the program. An assessment of the costs and savings of this practice has not been completed at this time. In 2009, an early program evaluation was held of workshops held in three Nunavut communities, using interviews, focus groups, and an evaluation questionnaire. Results indicated that the collective objectives of both workshops were met: to address wellness issues and physical inactivity among youth, to create a support network, and to teach leadership skills. Both workshops were perceived positively by youth and community members who felt the programs had improved the youths’ confidence and self-esteem, communication skills, leadership, and future outlook. The first workshop was thought to have enhanced the youths’ physical health. It was also perceived as having helped to bring the community together. Concerns were raised about whether the content “sufficiently supported Inuit tradition and culture” as well as sustainability and funding issues.

APPLICABILITY/TRANSFERABILITY:

Social Work through Hip Hop has not been adapted from another jurisdiction. The program has been implemented in a range of geographic locations (all three Territories, and major Canadian cities) and with non-Aboriginal participants. There are now seven types of workshops offered by BluePrintForLife. Workshops have been customized for groups, such as female Muslim teenagers and Sudanese refugee children. A program variation has been created for children ages 10 to 13. As well, the program has been adapted for youth in correction facilities, with a focus on the themes of anger, rage, and gangs. The Calgary Young Offender Centre, using post-workshop surveys, found that 92% of participants agreed/strongly agreed that they had accomplished something worthwhile, 94% agreed/strongly agreed that they found new talents and abilities, and 96% agreed/strongly agreed they would want to participate in a program like this again.



Challenges and lessons learned for the programs implemented in Northern communities include:

- Early meetings with community Elders were helpful in overcoming their negative impressions of hip hop.
- The presence of parents and Elders was important to youth involvement and healing.
- A small community team is important for successful workshop planning.
- Youth have created hip hop clubs to sustain the program; they need leadership training and mentorship opportunities.
- A story from Nunavut offers insights into implementing and sustaining this initiative:
www.youtube.com/watch?feature=player_embedded&v=l1RMVRwxmw

PRACTICE WEBSITE www.blueprintforlife.ca

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Leafloor, S. (interview, June 28, 2013). [BluePrintForLife].

Publications:

Forneris, T. (2009) *Evaluation of hip hop workshops in Arctic Bay, Pond Inlet and Leadership Youth Hip Hop Summit in Pangnirtung, Nunavut*. Retrieved from
<http://www.blueprintforlife.ca/wp-content/uploads/2013/04/Government-of-Nunavut-Evaluation-Final-Report.pdf>

Hager, N. 2012. *Blueprint for Life: 'Social work through hip hop.'* Selkirk First Nation Northern Strategy Initiative. Retrieved from
<http://www.blueprintforlife.ca/wp-content/uploads/2013/04/BPFL-Final-Report-Pelly-Crossing2.pdf>

Alternative Profiles:

Johnston Research Inc. (2011). *Physical activity approaches at the ground-level: Promising practices targeting Aboriginal children and youth*. Vaughan, ON: The Federal/Provincial/Territorial Activity & Recreation Committee and the Health Living Issue Group, pp. 32–41. Retrieved from: <http://www.nada.ca/wp-content/uploads/1034.pdf>

Other:

Swoboda, I. Letter of support to the Canada Research Chair, Interactive Media and Performance. (2009, September 28). Retrieved from <http://www.blueprintforlife.ca/wp-content/uploads/2013/04/Letter-for-Blueprint-from-Irene-Mental-health1.pdf>

External Source: www.blueprintforlife.ca



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Nuka: The Customer-Owner Model

LOCATION:	International	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Leading

SNAPSHOT: This innovative practice aims to provide customer-owned, community centered, team-based models of care to Alaska’s native population.

PRACTICE DESCRIPTION:

Southcentral Foundation (SCF) is a health care organization that provides integrated primary health care and behavioural health services; dentistry, complementary medicine, traditional healing, and home-based services; and education. SCF created extensive employee development programs and developed a uniquely community-centred, team-based model of care called Nuka, an Alaska Native word used for strong, giant structures and living things. In this model, people receive health care as customer-owners of their own care.

The Nuka Model of Care is the “whole health care system” created, managed, and owned by Alaska Native people to achieve physical, mental, emotional, and spiritual wellness. The relationship-based Nuka System of Care is comprised of organizational strategies and processes; medical, behavioural, dental, and traditional practices; and supporting infrastructure that work together—in relationship—to support wellness.

When the organization became Alaska Native–owned, administrators wanted to formulate a new model of care that would be patient-centred, community-centred, and owned by the people it serves. SCF moved to calling those receiving services at SCF “customer-owners.” Senior administrators noted that customers demand and receive respect, whereas the patient/provider relationship is characterized by inequality. This is more than a simple language shift: Alaska Native people are shareholders in the Alaska Native Regional Corporation of which SCF is a part. The transition to a customer-owned system was completed in 1999. Many of SCF’s customer-owners are experiencing the types of chronic diseases that have become commonplace in the United States, especially in disenfranchised communities, including diabetes, hypertension, chronic obstructive pulmonary disease, and obesity. SCF realized customer-owners had more control over the outcomes of these conditions than the health care system, and that only by enhancing customer-owner empowerment could SCF even begin to address these conditions.

The Nuka Model is unique because it transcends organizational boundaries by including the community, partners, and stakeholders in developing flexible strategies that fit individual health care needs. SCF has an annual budget of \$210 million. The organization receives approximately 44% of its funding from the Indian Health Service, 49% from third-party reimbursement (from Medicare, Medicaid, and others), and 7% from grants and investments.

IMPACT:

The SCF has 1,350 staff members who provide world-class quality services to some 45,000 customer-owners, including 10,000 in 55 remote villages. SCF has increased the number of patients it serves while improving health outcomes and decreasing unnecessary use. Outcome and process measures to evaluate and improve the SCF continuously are a key operational principle for the Nuka Model. The Model itself has produced excellent balanced scorecard outcomes and very satisfied owners. So far, the Nuka Model has achieved

- a 50% drop in the use of urgent care and emergency departments, due to same-day access to care;
- a 53% drop in hospital admissions;
- a 65% drop in specialist utilization;
- a childhood immunization rate of 93%; and
- customer and staff overall satisfaction over 90%.

Because SCF is invested in evidence-based practices, it maintains extensive data to measure its progress over time in a number of realms. The implementation of electronic health records is in progress in order to further enhance coordination of care and measurement of outcomes. Qualitative and quantitative findings that further outline the successes of the Nuka Model



of Care have been published in peer-review journals.

APPLICABILITY/TRANSFERABILITY:

The Nuka Model of Care is recognized around the world as being a truly transformed health care delivery system. The Model has been adopted in Portland, Oregon, where they developed a training centre and changed their payment methodology; this resulted in remarkable cost reduction and improvement in satisfaction over the past six years. This model was also applied in British Columbia, where payment methodology was changed to support a focus on complex patients. This resulted in savings of \$125 million in one year. SCF has also done some work with Saskatchewan and Alberta, suggesting that this innovative practice can be tailored to different jurisdictions in Canada with positive results. In addition, New Zealand, Australia, the United Kingdom, and Sweden have expressed interest in the Nuka Model.

Organizations from around the world visit SCF every year to learn from what they are doing. SCF has organized a formal program to host site visits and teach others about how to implement its model. Visitors generally use the components of this model that work best for their unique situations. The two most common challenges cited by would-be replicators are the staffing costs of the interprofessional team approach and scope of practice concerns.

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Content has been adapted from the following sources and relevant links:

Publications:

- O'Connor, P., Ritchie, J., Drouin, S., & Covell, C. L. (2012). Redesigning the workplace for 21st century healthcare. *Healthcare Quarterly*, 15, 30–35. Retrieved from <https://www.longwoods.com/product/download/code/22827#page=32>
- Shaw, J. L., Brown, J., Khan, B., Mau, M. K., & Dillard, D. (2013). Resources, roadblocks and turning points: A qualitative study of American Indian/Alaska Native adults with type 2 diabetes. *Journal of community health*, 38(1), 86–94.

Other:

- Ball, T. (2013, March 25). Nuka: The customer-owner model [Blog Post]. Retrieved from <http://quantumtransformationtechnologies.com/category/blog/>
- Blash, L., Dower, C., & Chapman, S. (2012, January). Southcentral Foundation—Nuka model of care provides career growth for frontline staff [Research Brief]. Retrieved from http://futurehealth.ucsf.edu/Content/11660/2011_09_Southcentral_Foundation-Nuka_Model_of_Care_Provides_Career_Growth_for_Frontline_Staff.pdf
- Southcentral Foundation. (2012, June 18). Nuka system of care: It's all about relationships. Retrieved from https://www.scf.cc/files/NukaBrochure_2012.pdf
- Leizens, T. (2012, August 20). Nuka system of care builds trust by treating patients as “customer-Owners.” *Indian Country Today Media Network*. Retrieved from <http://indiancountrytodaymedianetwork.com/article/nuka-system-of-care-builds-trust-by-treating-patients-as-customer-owners-130101>
- Alaska Health Policy Review. (2009, November 17). Vol. 3, Issue 21. Retrieved from <http://archive.constantcontact.com/fs092/1011270028002/archive/1102826817661.html>

External Source: <https://www.scf.cc/nuka/>



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First Nations Health Authority

LOCATION:	British Columbia	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice transfers all service delivery to improve the health and well-being of First Nations peoples, to eliminate gaps in health between First Nations people and other British Columbians, and to provide a role for meaningful involvement of First Nations in decision-making regarding the health of their peoples. Launched in 2012, the First Nations Health Authority will design and deliver all federally funded health programs and services for British Columbia.

PRACTICE DESCRIPTION:

In 2012, the First Nations Health Authority (FNHA) was created in BC to reform First Nations health care. This is the first provincial FNHA in Canada. The FNHA evolved out of a series of health plans agreed to by the federal and provincial governments, including the 2006 *Transformative Change Accord: First Nations Health Plan*, the 2007 *Tripartite First Nations Health Plan*, and the 2011 British Columbia Tripartite Framework Agreement on First Nation Health Governance.

The FNHA will have authority over service delivery within the BC First Nations Health governing structure, and the British Columbia Tripartite Framework Agreement on First Nation Health Governance mandates the FNHA to design and deliver all federally funded health programs and services for British Columbia. Currently, these are administered by Health Canada, First Nations Inuit Health Branch–Pacific Region.

The purpose of transferring all service delivery to the FNHA is to improve the health and well-being of First Nations peoples, to eliminate gaps in health between First Nations people and other British Columbians, and to provide a role for meaningful involvement of First Nations in decision-making regarding the health of their peoples. Over time, using evaluation results and citizen input, the goal is to modify and redesign current federal health programs and services to make them more appropriate for First Nations’ needs.

The FNHA is considered innovative because it puts decision-making around health and health services into the hands of the First Nations people. This is the first time that all First Nations in a province have come together under a common political mandate for a shared outcome. Further, extensive group consultation and public input directly informed the governance structure of the FNHA, which is the mechanism for this agreed-upon model of service delivery. To determine the role and structure that the FNHA would take, 120 regional meetings with First Nations leaders, people, and health professionals were held.

With respect to the service delivery roll out of the FNHA, a phased approach has been developed to ensure that the community is engaged at every step along the way. The three phases of the roll out are:

- **Transfer:** All Health Canada’s First Nations programs and services in BC will be transferred to the FNHA by October 1, 2013. Through this period the FNHA will “buy back” certain services until it is able to establish the necessary infrastructure.
- **Transition:** A five-year transition period will allow the FNHA to offer seamless delivery of care. Ongoing monitoring, evaluation, and practical improvements will be made in this phase.
- **Transformation:** The FNHA will transform First Nations programs and services to meet First Nations’ needs by, for example, improving integration with the provincial systems and regional health authorities and further including traditional medicine and practice).

IMPACT:

The parties recognized early on that this initiative is a truly tripartite effort and that improving First Nations and Aboriginal health is a joint responsibility. With this in mind the parties have agreed to jointly evaluate the implementation of the Framework Agreement every five years. The items to be included in these evaluations are articulated in the 2011 Tripartite Framework



Agreement on First Nations Health Governance:

“The Parties shall, within eighteen (18) months of the signing of this Agreement, prepare an evaluation plan and begin collecting data and reports to track at least the following:

(a) Health indicators:

(i) life expectancy at birth;

(ii) mortality rates (deaths due to all causes);

(iii) Status Indian youth suicide rates;

(iv) infant mortality rates;

(v) diabetes rates;

(vi) childhood obesity rates;

(vii) number of practising First Nations health care professionals who are registered or otherwise accepted members of recognized health professions under the BC *Health Professions Act*, and

(viii) any other additional indicators, including wellness indicators supported by the governance stakeholders; namely the Tripartite Committee, the FNHC and the FNHDA.

(b) Governance, tripartite relationships and integration:

(i) the effectiveness of the new Health Governance Structure described in section 4; and

(ii) the effectiveness of the new federal, provincial and First Nation relationships set out in section 6.

(c) A tripartite evaluation report will be finalized within one year following the first five year period of the Transfer of Federal Health Programs. The report shall be made public.

In addition, the FNHA will provide for the preparation of an independent evaluation every five (5) years that includes review of the FNHA's:

(i) plans and programs;

(ii) organizational structure and organizational effectiveness; and

(iii) management of First Nation Health Provider relationships and health benefit (former FNIHB) provider relationships.”

These evaluations, which will address the purpose and intent of this Agreement, will be carried out within the wider context of the health partnership with BC First Nations. Evaluation reports will be available to the FNHA members, the governments of Canada and British Columbia, and the public.

APPLICABILITY/TRANSFERABILITY:

The British Columbia FNHA works closely with a similar health authority in Alaska, which is currently celebrating their 15th year in service. Alaska offers a good basis for lessons learned due to the similarity of its demographics to those of the First Nations people living in BC (with respect to, e.g., remoteness of tribes and multitude of languages). Although Alaska has not experienced a significant change in health indicators since committing to culturally appropriate service delivery, there are moderately positive outcomes occurring and an overall satisfaction among Alaskan Native users.

The BC FNHA considers itself a “learning” organization that will support First Nations across Canada that are interested in exploring the creation of similar authorities. Saskatchewan achieved a tripartite Memorandum of Understanding, and Manitoba First Nations leaders have expressed interest in the model of service delivery that the FNHA offers. The goal is to use the outcomes of the evaluation to inform the spread of the FNHA to other contexts in Canada and abroad.

Content has been adapted from the following sources and relevant websites:



- First Nations Health Authority. (2008–2011). *About the FNHA*. <http://www.fnhc.ca/index.php/iFNHA/>
- First Nations Health Council & First Nations Health Authority. (2012, December 17). *Quarterly transition update*. http://www.fnhc.ca/index.php/news/press_releases/
- Tripartite Committee on First Nations Health. (2012). *Together in Wellness: 2011/2012 Tripartite Committee on First Nations Health interim annual report*. http://www.fnhc.ca/pdf/together-in-wellness_2011-12_interim_report.pdf
- MacKenzie, D. (personal communication: interview and feedback, January 10, 2013). [First Nations Health Authority].

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Information was last updated on: January 14, 2013

External Source: <http://www.fnhc.ca>



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Health Service Delivery Models in Remote and Isolated First Nations Communities

LOCATION:	National	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice focuses on issues that lead to program fragmentation and that affect continuity of care in remote and isolated communities within the multi-jurisdictional First Nations health service environment. In August 2010, Health Canada and the Assembly of First Nations initiated a two-year research project, *Health Service Delivery Models in Remote and Isolated First Nation Communities*, to identify a path towards transforming health service delivery in remote and isolated First Nations communities.

PRACTICE DESCRIPTION:

Issues that lead to program fragmentation and that affect continuity of care in remote and isolated communities have been identified within the multi-jurisdictional First Nations health service environment. In August 2010, Health Canada and the Assembly of First Nations initiated a two-year research project, *Health Service Delivery Models in Remote and Isolated First Nation Communities*, to identify a path towards transforming health service delivery in remote and isolated First Nations communities. The goals were not only to improve the quality, effectiveness, efficiency, and sustainability of care in these communities, but also to enhance the integration and coordination of care internally within the provincial health system. The project consisted of primary and secondary research as well as focus groups of health providers, clients, and system managers to identify issues, challenges, and service delivery patterns. Funding was provided by Health Canada.

Currently, in remote and isolated First Nations communities services are primarily focused on acute episodic care and a series of stove-piped programs that are rarely integrated or complementary at the community level, let alone with provincial health services. There are significant unmet health service needs, particularly in areas of chronic care and mental health, and a growing inability to meet basic public health needs. Costs are becoming unsustainable with growth rates of over 5% per year. There are significant problems related to recruiting and retaining nursing staff. System incentives reward high utilization and dependency. Moreover, there is a lack of surveillance and monitoring, as well as inadequate or non-existent data collection systems.

The project identified that a new paradigm of service delivery was needed for these communities—one that is grounded in the holistic First Nations vision of health; provides a comprehensive range of high quality and effective health services; focuses on population health and health determinants; has a strong infrastructure of professional and allied health services; is built on cooperation and integration at all levels; and is more responsive, resilient, sustainable, affordable, efficient, effective, and accountable than the current paradigm.

Five key directions for change over the next five years were identified through the consultations and data analysis: re-orienting services to an Interdisciplinary Expanded Care Model; addressing cost drivers; addressing service access; strengthening the community voice in service design and increasing the focus on population health; and optimizing technologies, information management, and infrastructure. It is expected that through the effective use of change management processes and related activities such as community/regional transitional plans, readiness assessments, change agents, health team composition changes, and the integration and coordination of community-based services, health services in remote and isolated communities will become more sustainable, of higher quality, and more effectively coordinated with provincial health services.

The second phase of this work has been initiated and includes a five-year managed change process involving the active participation of First Nations communities, First Nations and Inuit Health Branch (FNIHB) Regions, and Headquarters. The various phases of the project and timelines are to build momentum (2012/13), test change (2013/14 and 2014/15), and expand and consolidate (2015/16 and 2016/17).

IMPACT:

An evaluation framework and performance measures are currently in development.



The anticipated benefits of this new service delivery paradigm are that it will

- facilitate integration with provinces, as they are more closely aligned with provincial health service direction;
- facilitate eventual First Nations management, as it will address issues already identified by them and involve them in redesign;
- work equally at the Community, Tribal Council, or other First Nations health authority level;
- bring more stability and predictability to the system;
- improve nursing recruitment and retention in time;
- increase the capacity and skills of the community-based health workers; and
- improve the quality of health care and health outcomes of the population.

APPLICABILITY/TRANSFERABILITY:

While the work is unique to remote and isolated First Nations communities, the approach will be useful for rural health services in provinces and territories.

Content developed from the following sources and relevant websites:

<http://www.healthcouncilcanada.ca/content.php?mnu=4&mnu1=34#Presentations>

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Clinique Minowé

LOCATION:	Quebec	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for an appropriate model of care for the provision of integrated health and social services for Aboriginal people living in urban centres. In December 2008, with support from Health Canada’s Aboriginal Health Transition Fund, the partners began work on a project to develop a new urban-based health and social services model. Their goal was to establish a model that would introduce new mechanisms for collaboration and partnership, would be based on knowledge and understanding of Aboriginal people’s health and social service needs.

PRACTICE DESCRIPTION:

There was an enormous system of organizations that provided health and social services. Trying to get a large public service system and structure to change or adapt the way it provided services to Aboriginal peoples was like trying to change the direction of a really big ship. We knew we needed to establish new mechanisms for collaboration, new ways of thinking, and new ways of doing.

– Edith Cloutier, Executive Director, Val-d’Or Native Friendship Centre

Clinique Minowé, in Val-d’Or, Quebec, is an innovative model for the provision of integrated health and social services for Aboriginal people living in urban centres. The Clinique Minowé project was developed through a partnership between the Val-d’Or Native Friendship Centre (the main service organization in contact with Aboriginal people in the region), the Centre de santé et de services sociaux de la Vallée-de-l’Or (CSSSVO, the regional office of provincial health and social services), and the Centre jeunesse de l’Abitibi-Temiscamingue (CJAT, the regional youth protection services centre). The organizations came together to address concerns shared by many communities across Canada. The first is the existence of significant and disadvantageous disparities between the health status and health service usage of Aboriginal peoples and those of the rest of the population. The second is that Aboriginal families in the region are reported to social services far more frequently than non-Aboriginal families.

In December 2008, with support from Health Canada’s Aboriginal Health Transition Fund, the partners began work on a project to develop a new urban-based health and social services model. Their goal was to establish a model that would introduce new mechanisms for collaboration and partnership, would be based on knowledge and understanding of Aboriginal people’s health and social service needs, and would support the planning and provision of health and social services in ways that increased accessibility for Aboriginal people. The model they developed offers integrated and culturally appropriate health and social services for Aboriginal people at a community-based Aboriginal organization.

Clinique Minowé opened in February 2011 with a licensed practical nurse, a social worker, and a coordinator on staff. Health services available at the clinic include prenatal, natal, and postnatal care for children and families, and activities that promote a healthy lifestyle for all community members. The nurse has also been authorized to prescribe and inject the contraceptive Depo-Provera, with follow-up care provided by a clinic-affiliated doctor. The social worker provides support to children, youth, parents, and extended families at different phases of the youth protection process.

Clinique Minowé’s culturally relevant services address the real-life needs of the Aboriginal people and communities it serves. Its location at the Friendship Centre provides a culturally safe environment. The clinic and its practitioners approach health and wellness holistically, and are committed to community development. The nurse and social worker connect community members with a broad range of services and programs, including many available on-site at the Friendship Centre. The clinic staff members are a visible, active presence in the community, and have built considerable trust with community members. Both the nurse and the social worker make home visits and will travel together (sometimes a four- or five-hour drive) to visit encampments of families who spend their summers on the land.

Over the less than two years that Clinique Minowé has been in operation, it has grown rapidly. Service demands and the caseloads for the nurse and social worker have increased significantly. Families who are referred to social services and seek



those services through Clinique Minowé are more likely to follow through on their appointments than families were before the clinic was available. Testimonials from the clinic's clients describe how the clinic's services have affected their health and well-being by relating compelling narratives. For example, one is about a pregnant woman who had struggled with addiction. As her due date approached, she considered giving up her child. After connecting with Clinique Minowé's nurse and social worker, she was able to enter—and complete—a long-term residential treatment program. She has maintained her sobriety, and today has full custody of her young child.

The value and importance of the Clinique Minowé model has been acknowledged regionally, nationally, and internationally. The partners are currently working with representatives of other Friendship Centres on a plan to implement the Clinique model in other Quebec communities. The ODENA community-university research network has held the clinic up as an example of how community action coupled with research can provide a strong evidence base for the development of public policy.

Several factors have made important contributions to the clinic's success. The Friendship Centre provided strong leadership, and team members' commitment ensured that the project kept moving forward, from development through implementation. The money provided through the Aboriginal Health Transition Fund (AHTF) gave the partners the time and resources they needed for effective planning and start-up. The partners sought and gained the trust of decision-makers, including regional department heads and ministers in provincial government departments. The partners have also leveraged their own resources to support the clinic project: CSSSVO has taken responsibility for the salary of the clinic's nurse, and CJAT pays the salary of the social worker. The Friendship Centre has drawn on its relationship with a university-affiliated researcher to support research activities for the project. The partners have also been able to secure funding from a private foundation to support the clinic coordinator's position.

The most significant challenges for the Clinique have related to the need for adequate sustainable funding, and to the clinic's rapid growth. To manage current and future growth, the Friendship Centre is reorganizing its own internal structure to make it more integrated. Coordinating services will help leverage internal resources and support the clinic's holistic approach to service delivery. As demand for services continues to grow, the Friendship Centre recognizes that the Clinique will need additional physical space for its activities, and is planning a construction project to expand the building it currently occupies. The clinic keeps careful statistics of its activities and gathers qualitative data on the impacts of its services. These data will provide invaluable support for future requests for funding.

CONTACT INFORMATION:

Inquiries about Clinique Minowé should be directed to Edith Cloutier, Executive Director, Val-d'Or Native Friendship Centre (edith.cloutier@caavd.ca). Additional information on Clinique Minowé is available online at http://caavd.ca/admin/editor/asset/CliniqueMinowe_ANGw_2fev.pdf



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WRHA Framework for Action: Cultural Proficiency & Diversity

LOCATION:	Manitoba	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice emphasizes the need to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. Developed in the Winnipeg Regional Health Authority in 2011, The Framework for Action is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the interests and experiences of a diverse population and authentically engaging and collaborating with community.

All the services at the Winnipeg Regional Health Authority that were developed to support Aboriginal people are now within the context of a larger framework for cultural proficiency and diversity. The framework came from the recognition that in a system of this size, it's easy to silo. We wanted to retain the strength of all activities, but also recognized the need for a framework that supported the cultural proficiency of the organization, so that we wouldn't further marginalize already marginalized populations.

– Dr. Catherine Cook, Vice President, Population and Aboriginal Health, WRHA

The Winnipeg Regional Health Authority (WRHA) has demonstrated its commitment to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. WRHA's Aboriginal Health Programs (AHP) have focused on building WRHA's capacity to respond to the Aboriginal community's needs. The reach and impacts of AHP's activities are being strengthened by the recent introduction of a system-wide *Framework for Action: Cultural Proficiency & Diversity*, a comprehensive plan designed to enable WRHA to deliver the best possible health care to all people, regardless of cultural identity or language proficiency.

WRHA serves residents of Winnipeg and surrounding rural areas, northwestern Ontario, and Nunavut. First Nations, Inuit, and Métis people constitute a significant and growing proportion of the population in each of these regions, and the city of Winnipeg is home to the largest community of urban Aboriginal people in Canada. As is true across the country, significant inequities exist between the health status of First Nations, Inuit, and Métis people and other residents. Working collaboratively with other WRHA programs and departments and with community and government organizations, AHP brings a coordinated approach to the needs of First Nations, Inuit, and Métis people and communities, and provides a wide range of services. To enhance the health care experiences and cultural safety of First Nations, Inuit, and Métis patients, AHP facilitates patients' access to spiritual and cultural care, traditional healing, and interpreters in local Indigenous languages. In addition, it connects patients with community resources, offers advocacy services, and supports effective and comprehensive discharge planning and coordination. AHP also leads and participates in activities that enhance the cultural competency and cultural proficiency of health care providers, WRHA staff members, and the organization as a whole, including workforce development activities and education that builds staff members' awareness and understanding of First Nations, Inuit, and Métis people's cultures, historical experiences, and culturally distinct approaches to health and wellness.

The AHP, Human Resources, Community Development, and Research and Applied Learning departments are executive sponsors, leading the development and implementation plan for WRHA's *Framework for Action: Cultural Proficiency & Diversity*. The region served by WRHA includes a large Aboriginal population (as noted above), and is home to a significant and growing number of newcomers to Manitoba. In response to the complex needs of the increasingly diverse population it serves, WRHA identified the development of cultural proficiency as a key strategic priority. The *Framework for Action* was completed and approved in 2011. WRHA is now in the process of implementing the framework.

The *Framework for Action* is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the interests and experiences of a diverse population and authentically engaging and collaborating with community. It calls for system-wide organizational, structural, and clinical interventions, with the goal of transforming WRHA from a "one size fits all" health care system to one that responds to the needs of a diverse population.

- Organizational interventions focus on developing a representative workforce and leadership for WRHA. WRHA's actions



in this area have included a preferred Aboriginal hiring philosophy, outreach, recruitment, and retention activities for Aboriginal staff, and a respectful workplace policy and campaign.

- Structural initiatives focus on making the health care system more client-friendly and culturally appropriate for all clients. WRHA's actions in this area have included forming a multi-year partnership with a local tribal council to identify and develop an action plan to address gaps and challenges to health system access for Aboriginal people; establishing Community Health Advisory Councils (which report directly to the WRHA Board) and other processes to support public engagement and input; providing access to Aboriginal traditional healing services and health and wellness supports; putting in place Aboriginal patient advocacy and discharge coordination supports; providing interpreter services for all language constituencies; establishing community-based ACCESS centres ("one stop shops" for health and social service delivery) throughout the region; and establishing the BridgeCare Clinic for recently arrived, government-sponsored newcomers to Manitoba.
- Clinical interventions focus on helping health care providers gain the knowledge, skills, and tools they need to effectively manage the impacts of culture on clinical practice. WRHA's actions in this area have included Aboriginal awareness training and other cultural proficiency and diversity workshops for staff members, and partnership in the Dignity in Care initiative, which provides practitioners with practical ideas and tools to support the development of a culture of compassion and respect in WRHA.

One of the lessons learned at AHP has been that, in spite of the fact that the board and senior management at WRHA have consistently supported, championed, and resourced the program's activities, AHP is still, to some extent, marginalized as a "special" program. As Dr. Cook, WRHA's Vice-President, Population and Aboriginal Health, commented, "It's important that all of the programs *think* about the Aboriginal population, *think* about the diversity of the population when they're planning their work.... They still think that somebody will tell them if they need to do it. That's been a challenge." Lasting change will require changes in knowledge, attitudes, values, policies, and practices at all levels of the organization. The framework is designed to support that kind of transformation, by building on the organization's strengths and successes, bringing a commitment to cultural proficiency to all staff, and integrating and embedding cultural proficiency as an essential characteristic of WRHA's system.

WRHA has accumulated considerable evidence to demonstrate the impacts of framework-related activities undertaken by AHP and other departments. It has documented and published anecdotal information that demonstrates support for the activities described above, and strengthened and extended its community partnerships. Aspects of AHP and other WRHA programming (including workforce development, service delivery, program development, partnerships and collaboration, and accountability) have been adopted and used by organizations in Manitoba, Saskatchewan, Australia, and New Zealand.

CONTACT INFORMATION:

Additional information on WRHA's Aboriginal Health Programs is available at <http://wrha.mb.ca/aboriginalhealth/index.php>. WRHA's *Framework for Action: Cultural Proficiency & Diversity* can be found at http://www.wrha.mb.ca/community/commdev/files/WRHA_cpd_framework_final.pdf.



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St. John's Friendship Centre

LOCATION:	Newfoundland & Labrador	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice supports First Nations, Inuit, and Métis people who travel to St. John's for medical care. Launched in 2004, the Friendship Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

The Aboriginal Patient Navigators have opened the eyes of many practitioners. I've gotten support notes that say, "I never knew this. This is great! What did we ever do before these people were here?" It's been very well received by medical staff.

– David Penner

Executive Director, St. John's Native Friendship Centre, NL

The St. John's Friendship Centre in Newfoundland and Labrador has developed innovative ways to bring much needed supports for First Nations, Inuit, and Métis people who travel to St. John's for medical care. The Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

The Aboriginal Patient Navigators (APNs) are employees of the Friendship Centre, but work out of EH's Health Science Centre. The two APNs serve as many as 500 First Nations, Inuit, and Métis clients and their families each year, and have taken broad responsibility for supporting clients' cultural safety throughout their experiences in the acute care system. The APNs are embedded in a multidisciplinary team, participating in medical rounds each morning and supporting the hospital's capacity to provide health care services to Aboriginal people in culturally specific and sensitive ways. The APNs help clients and their family members navigate the health care system, accompanying them to medical appointments, ensuring that they understand their medical conditions and needs, arranging on-site ceremonies, and attending to other culturally distinct needs. The APNs are skilful communicators, and are often fluent in one or more of the local Indigenous languages. They have helped medical staff learn how to incorporate respect for culture into their practice, and how to communicate and interact more effectively with Aboriginal clients.

The APNs try to minimize the length of time their clients must spend in care by making sure that appointments are scheduled as closely together as possible and assisting with the development and implementation of discharge plans. In a few instances, when the hospital has not been able to release a patient because the patient cannot find a way to purchase or access a specific piece of medical equipment they will need at home, the APNs have ordered and temporarily covered the cost for the equipment. This has allowed patients to return home without having to wait for the issue of which jurisdiction is financially responsible to be resolved. The APNs also ensure that clients' family members understand their medical conditions and needs.

Shanawdithit hostel and shelter, which began operating in 2004, offers temporary accommodations to Innu and Inuit residents of Labrador who are visiting St. John's to access medical services (a group that now constitutes approximately two-thirds of the facility's occupants), new Canadians, and people who are homeless. In its early years, Shanawdithit often struggled to fill its rooms. Today, demand for accommodations typically exceeds capacity. Shanawdithit is the only hostel/shelter in St. John's that has a cultural focus or that is equipped to take in families. To support residents' comfort and safety, management has implemented zero tolerance policies with respect to alcohol or drug use and aggressive behaviour. In addition to accommodations, Shanawdithit's health clients can access the shelter's transportation services to move between the airport, hostel, and health care sites, and they have on-site meals laundry and computer access. If needed, the hostel also arranges counselling for clients (a service used most often by women who have experienced violence) and assists them to find employment or more long-term housing.



Shanawdithit and the APN program work well together. The APNs often come to meet and visit with clients or family members in the culturally respectful environment provided by the shelter. For patients and clients, the combination of supports available through Shanawdithit and the APN program enables them to manage their time in St. John's productively and return to their home communities as quickly as possible. In the environment of Shanawdithit and with the support of the APNs, clients generally feel less socially and culturally isolated, and more comfortable and more confident through the care experience.

The APN program and Shanawdithit have succeeded, in large part, because they meet the real-life needs of the people and communities they serve. As David Penner, the Friendship Centre's executive director acknowledges, consultation is a "must-have" for success: "You need to get everyone's opinion, so that you can provide not what *you* want or even what the people might think they want, but what the people need." Research and documentation are also crucial components of success. Evaluations of the APN program have indicated that the services provided by the APN have minimized clients' stress and anxiety, enhanced coordination of after-hours care, and raised awareness of cultural differences, practices, and traditions within the health care system. Medical staff have confirmed that the combination of Western and traditional medical approaches and practices has improved outcomes for their patients, and that the APNs, by demonstrating and supporting culturally sensitive care, have helped them become more effective practitioners.

The APN program started in 2009 as a pilot project, initiated by the Ethics Department at Eastern Health and supported by the federal Aboriginal Health Transition Fund (AHTF). Eastern Health's leadership and its recognition of the need to work in partnership with an urban Aboriginal organization (which led to the Friendship Centre's participation in the project) have been invaluable. In the development phase of the project, the partners completed consultation activities in St. John's and Labrador, and established a steering committee and advisory committee to guide the project's development. These bodies evolved into standing committees that continue to monitor the program and ensure that activities are informed by and attend to community members' needs.

The most significant challenges for the APN program and Shanawdithit have related to the need for adequate sustainable funding. When the AHTF ended, Eastern Health and the Friendship Centre had to find alternate funding sources for the APN program; to date, it has not yet been able to secure sustainable funding. The Friendship Centre received some funding from the Homelessness Partnering Strategy (to cover Shanawdithit's capital expenditures and start-up) and other provincial and federal sources, but it relies primarily on per diem funding to support day-to-day operations. This has affected Shanawdithit's ability to recruit and retain staff because it cannot offer wages that compete with those provided by other local shelters, which receive block funding from the province. The centre has established tighter financial management for Shanawdithit, and now applies a social enterprise approach to this and all other programs at the centre. As David Penner has observed, "You need to do things that are going to sustain themselves, work towards the future, beyond your current activities, and bring a business approach to your work. Just because you are a not-for-profit doesn't mean you can't use a profit approach to your operations."

CONTACT INFORMATION:

Additional information on St. John's Friendship Centre is available at <http://www.sjnc.com>.



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Provincial Health Services Authority's (PHSA) Aboriginal Health Program

LOCATION:	British Columbia	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice delivers a facilitated online training program that acts as an educational bridge to transform attitudes, behaviours, and practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 Transformative Change Accord (more information on the Accord can be found [here](#)) signed by the Province of British Columbia and the First Nations Leadership Council.

We think there is room to address health disparities from an educational perspective—that training can actually create change. Our objective is transformation in health care. We want to participate in that and we believe that there is an appetite in health care workers to change. When people are provided with the opportunity, they're behind it. Health care workers are forward thinking, and they have a high readiness for Indigenous Cultural Competency Training and an understanding that things need to be done differently. The status quo isn't working and they are ready to learn what can be done differently.

– Cheryl Ward, Provincial Lead

Indigenous Cultural Competency Training, Provincial Health Services Authority

In British Columbia, the Provincial Health Services Authority's (PHSA) Aboriginal Health Program delivers a unique facilitated, online training program that acts as an educational bridge to transform attitudes, behaviours, and—most importantly—practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 *Transformative Change Accord* (more information on the Accord can be found [here](#)) signed by the Province of British Columbia and the First Nations Leadership Council. The *Transformative Change Accord* and ICC training both seek to reduce disparities between the health status of First Nations people and that of other BC residents. The accord includes a commitment from the partners to develop a curriculum for cultural competency and establish mandatory training for staff of the Ministry of Health and regional health authorities in BC. The ICC program provides that training. By placing the ICC training online, PHSA has the capacity to provide foundational cultural competency training to all 100,000 health care workers in the province.

The objectives of the ICC training are to increase knowledge, enhance awareness, and promote the development of cultural competency skills in learners, and to develop culturally safe health care environments. Participants proceed through online courses in cohort groups with the support of a facilitator. The curriculum is interactive and based on transformative learning models. The training gives participants an opportunity to learn about the present-day experiences of Indigenous people and historical experiences that continue to affect psycho-social determinants of health for this population; to self-reflect, and recognize and undo unconscious biases and stereotypes; and to draw on leading evidence-based cultural safety practices to develop new approaches for health service delivery that can be implemented in the real-world context of their work environment.

The combination of a custom-designed online training platform (incorporating a wide range of materials and activities that engage people with a variety of learning styles) and guidance from highly skilled and knowledgeable facilitators enhances safety and responsibility for learners, and offers an ideal environment for both learning and unlearning. This has been a critical component of the program's success. Participants have described feeling shock, horror, disbelief, and anger as they learned about the history of Indigenous Peoples in Canada. Some wonder how they could have performed their jobs without knowing and understanding the ongoing effects that this history has on the health status and health experiences of Indigenous people. In the safe learning environment of ICC training, participants are able to recognize their own connections to that history and its implications for practice, take the time and space they need to reflect on and process what they are learning, and deepen their understanding through interactions with other students in their cohort and the facilitator. PHSA has also recognized that while its core training programs have been very successful in meeting the learning needs of non-Indigenous people, Indigenous learners have distinct needs, particularly with respect to cultural safety during the learning process. To support these needs, PHSA has established a protocol through which Indigenous learners can complete the training in cohorts in which all participants are



Indigenous people, and have access to both facilitators and an Elder throughout the training.

PHSA understands that cultural competency is developed through a lifelong learning process, and the ICC foundational courses as only the first leg of that journey. PHSA is launching a post-training website where graduates will be able access supporting resources for each module, connect with Elders, and continue their relationships with the facilitation team. The ICC training addresses some of the more challenging and fundamental issues (such as the residential school system, Indian hospitals, and the historical legacy of inequality and inequity) that affect all First Nations in British Columbia. It lays a strong foundation that regional health authorities and health organizations can build on by providing additional training that reflects more local needs, including teachings from First Nations people in the region they serve. As Cheryl Ward observed, “We’ve heard about people going in to do training and asking inappropriate, disrespectful, and hurtful questions. We want to give them the information they need to not ask those questions, so that when they learn from First Nations or other Aboriginal people, they can do so in a respectful way.”

The ICC training has been extremely successful. Completion rates for trainees are very high, demand for the training is growing, and internal and external evaluations have indicated that the curriculum, content, and facilitation meet learners’ needs. PHSA has also gathered considerable anecdotal evidence of the positive impacts of the training. Participants who have completed the training have reported that it has helped transform both their own practice and practice within their units. In addition to the core ICC health training course for health professionals and the core ICC for allied professionals, PHSA offers a core ICC mental health training module, and is currently developing new modules. These include modules on decolonizing anti-racism (which will equip learners with tools for anti-racist action) and narratives and counter-narratives (which will tackle pervasive harmful narratives about Indigenous Peoples that are circulated through, for example, the media, education system, criminal justice system, and everyday interactions among Canadians). PHSA is also consulting with colleagues in two other provinces who are interested in establishing similar activities.

The success of the ICC training program is related to several key factors, including (as already noted) the 2006 *Transformative Change Accord: First Nations Health Plan*, and the unique structure of the training. The process through which the training was developed has also played a critical role in its success. The provincial lead for ICC training assembled a skilled team to develop and implement the program. Early in the development process, Indigenous scholars, academics, front-line people, community members, and thought leaders came together to form a provincial think tank that explored what the training should be and how it should be developed. PHSA drew on that guidance as they laid out the syllabus. Other Indigenous and non-Indigenous leaders in health have supported the program from its inception, stepping up to contribute at various points throughout development and implementation. Strong leadership from PHSA’s senior management team (including Leslie Arnold, PHSA VP and President of BC Mental Health & Addiction Services, the project’s executive sponsor, and Leslie Varley, Director, PHSA Aboriginal Health, under whose direction the training program was developed) has also been invaluable to the program’s success.

Once the training package took shape, a year was devoted to piloting, evaluating, and refining the training before it was finally rolled out. Since the ICC program began formally delivering training, the facilitation model and facilitation team members have proven to be “must haves” for program success. The facilitation model used in the training is one of its unique features. The model includes protocols to guide, assess, and respond to the online interaction of students, and tools to support collaboration among facilitation team members and enable them to work effectively with the large volume of learners. The facilitators consistently demonstrate their commitment to participants’ learning, to the goals and objectives of the ICC training program, and to the social justice ends that the training will help achieve.

Additional information about the PHSA Indigenous Cultural Competency Training Program is available online at www.culturalcompetency.ca, or from Cheryl Ward, Provincial Lead for Indigenous Cultural Competency Training (cward-02@phsa.ca).



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Interior Health Authority (IHA)

LOCATION:	British Columbia	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the need to make changes to the way a health region plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population. The Interior Health Authority (IHA) in British Columbia has developed and implemented the Aboriginal Health & Wellness Strategy, 2010–2014, which recognizes that the gap between the health status of Aboriginal people and other residents.

Dollars have to be applied to closing the health disparity gap—money, resources, and people. Highlighting those gaps and knowing some of the reasons they are there, when communities can't access care because it's not available or because they don't want to use the services that are available—those things are wide open for people to see and they can't be ignored. Once you put that information out there, you can't sweep it under the carpet. You have to take action to address it.

– Dion Bedard, Aboriginal Health, Interior Health Authority

The Interior Health Authority (IHA) in British Columbia has made significant changes to the way it plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population.

Aboriginal people constitute nearly 7% of the population in IHA's service region, home to 55 First Nations and 13 Métis Chartered Communities. IHA recognizes that the gap between the health status of Aboriginal people and other residents cannot be closed without also addressing inequities in health determinants, collaboration with Aboriginal people to identify and develop health care solutions that will meet their needs, and change across IHA's care and service continuum. The organization, working in partnership with First Nations, Urban Aboriginal, and Métis people, has developed and implemented the *Aboriginal Health & Wellness Strategy 2010–2014*. The strategy set goals in five strategic areas:

- Develop a sustainable Aboriginal Health Program. Action in this area includes ensuring that services are aligned between a new province-wide First Nations Health Authority (to be fully operational in July 2013) and Interior Health, contracting with Aboriginal communities to provide programs and services identified by the communities, and standardizing Aboriginal Patient Navigators positions.
- Ensure Aboriginal people's access to integrated services. Action in this area includes advocating for services that meet community-identified needs, considering the implications to and for Aboriginal people and communities in strategy development and implementation, and recruiting and retaining Aboriginal employees.
- Deliver culturally safe services across the care and service continuum. Actions in this area include providing Aboriginal Patient Navigators, providing space for sacred or ceremonial activities, integrating cultural practices in the provision of care, and having staff participate in the provincial Indigenous Cultural Competency Training program. IHA brings a cultural safety lens to its activities, emphasizing its responsibility to provide inclusiveness, accessibility, adaptability, acceptability, and accountability to all people in the region.
- Develop an information, monitoring, and evaluation approach for Aboriginal health. Action in this area includes implementing a voluntary Aboriginal self-identification initiative for both clients and employees, monitoring key performance indicators, and evaluating selected initiatives.
- Ensure ongoing and meaningful Aboriginal participation in health care planning. Action in this area includes establishing formal relationship documents with local First Nations, and engaging the community through the Aboriginal Health & Wellness Advisory Committee (a subcommittee of IHA's board of governors that has 14 members from First Nations, Métis, and urban Aboriginal communities).



Interior Health's ability to make system-wide changes was enhanced significantly when, in 2007, the Aboriginal Health Transition Fund (AHTF) provided support to a three-year project that enabled IHA to bring Aboriginal Patient Navigators on staff, add staff positions to its Aboriginal Health program, begin the self-identification initiative, and develop Aboriginal human resources policy. These activities generated momentum for change, and when AHTF support ended, IHA allocated funding in its own budget to sustain positions and activities developed through the project.

IHA's transformation is inseparable from the context in which it is taking place—the 2007 *Tripartite First Nations Health Plan* (TFNHP), signed by the First Nations Leadership Council of BC, the Province of BC, and the Government of Canada. The plan recognizes Aboriginal rights and title, and formalizes a commitment to implement a First Nations health governance model in the province (with a new First Nation Health Authority operational in July 2013). The plan also includes 35 action items for which the parties share responsibility (more information on the TFNHP can be found at http://www.healthcouncilcanada.ca/tree/Aboriginal_Report_EN_web_final.pdf#page=30).

IHA has taken action in several areas to comply with TFNHP and with its own strategy. Aboriginal Health has been established as a core program of IHA's Community Integration program, expanding its influence on activities. IHA has moved more employees through the Indigenous Cultural Competency training program than any other health authority in the province, and the baseline data that IHA collects through the Aboriginal self-identification initiative for employees have improved its ability to recruit and retain Aboriginal employees.

The client Aboriginal self-identification initiative will provide an evidence base for further change. When fully implemented, the initiative will enable IHA to track individual clients through their service experience. Data describing the experience of Indigenous clients will be anonymized and shared with local First Nations to support planning processes. Over the long term, the data will help First Nations evaluate the impacts of their own health investments on, for example, community members' use of hospital services.

IHA is well prepared for the introduction of the First Nations Health Authority. IHA has already signed Letters of Understanding (LOUs) with two of the seven First Nations in the region, and is in the process of establishing similar relationship documents with the other five. The LOUs acknowledge inherent Indigenous rights, and empower the First Nations to work directly and as equal partners with IHA. The seven First Nations and the Métis Nation of British Columbia are forming a regional executive table, with which IHA will also work collaboratively.

One of IHA's most significant strengths—and challenges—in the transformation process has been its relationships. IHA has established strong relationships with its Aboriginal partners, but recognizes that there is still work to be done. IHA rightly acknowledges that sustainable change to health outcomes cannot happen without change to determinants of health, a process that will require IHA to develop new relationships with municipalities and organizations that are mandated to address determinants. As one manager stated, "Relationship management is crucial and understanding what that means in an Indigenous context is vital.... It's really understanding what 'All My Relations' means in an Indigenous sense."

CONTACT INFORMATION

Additional information on IHA's Aboriginal Health Program and the *Aboriginal Health & Wellness Strategy, 2010–2014* can be found at www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/default.aspx.



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All Nations' Healing Hospital (ANHH)

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice offers a model for collaboration in health service delivery, straddling cultural and jurisdictional boundaries to offer a full range of services to all community members in Fort Qu'Appelle and the surrounding region, which lies within the traditional territories of the 35 Treaty 4 First Nations. . The All Nations' Healing Hospital (ANHH) has drawn national and international attention, is unique in its approach to service delivery, governance, and funding.

The All Nations' Healing Hospital (ANHH) in Saskatchewan offers a new model for collaboration in health service delivery, straddling cultural and jurisdictional boundaries to offer a full range of services. ANHH serves all community members in Fort Qu'Appelle and the surrounding region, which lies within the traditional territories of the 35 Treaty 4 First Nations. ANHH's model, which has drawn national and international attention, is unique in its approach to service delivery, governance, and funding.

ANHH brings a holistic and integrated approach to health care delivery to address the health needs of the whole person. ANHH's clients can access on-site both traditional health and wellness services and supports (including access to ceremonies, Elders, and helpers) and conventional Western treatment and care. ANHH provides services to clients across the continuum of care, including on-site acute and palliative care, diagnostic and emergency services, physicians' and visiting specialists' services, a Women's Health Centre, maternal child health services, CRI clinics, and telehealth services. The hospital is also home to the First Nations Health Service department (which provides community health programs ranging from home and community care through child development, nutrition, and health education to water quality testing for 11 First Nations), and to the White Raven Healing Centre (which provides clinical counselling and other integrated services to address mental health and addiction-related needs, and cultural services within both the hospital and the community). Both of these organizations are overseen by the File Hills Qu'Appelle Tribal Council.

The physical environment at ANHH reflects the hospital's commitment to a holistic and integrated approach. The facility is designed in a culturally sensitive way, with the First Nations Health Service and White Raven enclosed in a circular wing of the building. Acute care, emergency, and operations are each housed in one of three wings that radiate from the centre of the circular structure. The structure of the building represents the integration of traditional health and wellness and Western medical practices. Interior design elements evoke the earth, water, and fire, and the connection between mind, spirit, body, community, and land. Areas of the facility and grounds have been reserved for traditional health and wellness activities, including a Ceremony Room (where smudge and other ceremonies can take place), a Winter Lodge (where sweat lodge ceremonies are held several times a week), a Medicine Room (where traditional medicines can be processed and shared), and an Elders' Suite (where Elders may hold ceremonies, or simply rest while they are on site).

ANHH is one of the first hospital or health care facilities in Canada owned and operated by First Nations' governments. It opened in 2004 on tribal land in the town of Fort Qu'Appelle. Fifteen First Nations, represented by the File Hills Qu'Appelle Tribal Council and Touchwood Agency Tribal Council, own the hospital. The Board of Governors overseeing the hospital includes representation from the First Nations' leadership and the local municipality. The process of establishing tribal control of the hospital began in the early 1990s, a time when the federal government was actively exploring options for increased First Nations control of health service delivery. When it became clear that the 70-year-old Fort Qu'Appelle Indian Hospital needed replacement, the Chiefs of the First Nations and Tribal Council were ready to take leadership in the development of the new facility.

ANHH is an affiliate of the Regina Qu'Appelle Health Region (RQHR), and under this arrangement RQHR (and, indirectly, the Government of Saskatchewan) is responsible for funding all acute care costs. Since 2006, a unique agreement between the two Tribal Councils and the Government of Canada has also been in place, providing federal funding to support ANHH's traditional and cultural services. The federal government also provides funding to support the First Nations Health Services department and the White Raven Healing Centre.

ANHH's unique governance structure and, in particular, its ability to bring the federal and provincial governments together as partners gives the hospital an unusual capacity to engage in innovative, creative activities, including the provision of holistic,



integrated services. ANHH has considerable flexibility in service delivery and the hospital can monitor and respond quickly to the needs of the people and communities it serves. For example, after a 2007 needs assessment on maternal child health revealed that women in the region were not fully accessing available services, ANHH secured funding from Health Canada and other partners to enhance access by establishing a Women's Health Centre. A full range of services, including midwifery, are available at the centre. ANHH has developed a horizontal, multi-disciplinary approach to care. Doctors, nurses, midwives, practitioners, mental health therapists, diabetes educators, nutritionists, and other service providers work as a team to provide patient-centred wrap-around care. From a patient perspective, this approach has succeeded. Community members have let staff know that they are more comfortable coming to ANHH than to other facilities, and client and patient feedback gathered through activities such as a quality improvement survey indicate high levels of satisfaction.

ANHH counts among its successes its ability to recruit and retain professional, paraprofessional, and nonprofessional staff. As one staff member commented, "We don't have to go out looking. They come to us." This may be, in part, because ANHH is a teaching facility, hosting practicums and mentorships for students in health-related programs. ANHH, in partnership with health-related programs at Saskatchewan universities and colleges, RQHR, on- and off-reserve schools, and other organizations, has established a Pre-Health Professions Club, offering career development experiences to students at secondary schools in the region.

ANHH has grown rapidly since its start in 2004. In the last five years, the number of people accessing emergency services has doubled. The midwife at the Women's Health Centre has a caseload of 80 to 90 women, far more than any other midwife in the province. Even while ANHH is growing, two other hospitals in ANHH's broader catchment area have lost physicians and reduced services. This rapid growth presents new challenges to ANHH. It has outgrown its space, which limits its ability to develop new programs. With no federal or provincial money available for capital improvements, ANHH must now explore options for delivering programs and activities off site.

ANHH recognizes that its current success—and its ability to manage its current and future growth—is very much about people and relationships. Excellent staff, strong leadership, and willing partners have been "must-haves" for ANHH. Communication plays a crucial role in preserving, strengthening, and building on the trusting and collaborative relationships it has developed with its partners. ANHH's senior management meets regularly with the Board, and with Health Directors of the First Nations and Tribal Council. The organization works hard to attain the objectives and goals it has set for itself and consistently strives for quality improvement, assessing its activities and looking for ways to make them better for clients and staff. In 2011/12, ANHH received accreditation with "exemplary standing" from Accreditation Canada.

CONTACT INFORMATION

Additional information about ANHH is available online (<http://www.fortquappelle.com/anh.html>) or from Gail Boehme, Director of ANHH & Health Services, File Hills Qu'Appelle Tribal Council (gboehme@fhqtc.com).



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Regina Qu'Appelle Health Region's (RQHR) Aboriginal Home Care Program

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. Launched in the Regina Qu'Appelle Health Region's (RQHR), the program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

Most often, service providers are considered “experts” on what’s best for the people they serve. When a problem arises, they develop a program. This can be a recipe for apathy and non-compliance, as well as a poor use of resources. It is critical that the people receiving services have an active voice in clarifying issues, determining solutions, and developing and evaluating programs. Taking the time and flexibility needed to build trust and relationships—particularly with a population that has come to distrust the system—pays huge dividends. Recognizing that individuals have their own priorities and using a holistic approach helps make practitioners more sensitive to where clients are in their lives and their ability to absorb, comprehend, and take action to effectively address health issues.

– Dorothy Lloyd, Eagle Moon Health Office, Regina Qu'Appelle Health Region

The Regina Qu'Appelle Health Region's (RQHR) Aboriginal Home Care program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

The Aboriginal Home Care program began after RQHR's Home Care Services recognized that while First Nations and Métis people constituted a significant proportion of the population they served, very few Aboriginal people were accessing Home Care Services. In partnership with RQHR's Eagle Moon Health Office, Home Care Services brought together RQHR managers, First Nations and Métis Elders, knowledge keepers, and health workers to form a working group tasked with identifying why the service gap existed and how it might best be addressed. Based on the working group's findings and with financial support from the Aboriginal Health Transition Fund, Home Care Services developed and implemented the Aboriginal Home Care program.

The program's aim is to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. The program has transformed service delivery to First Nations, Inuit, and Métis people, introducing changes that have included:

- strategic relocation of the home care team to offices in the North Central neighbourhood in Regina (where a significant proportion of residents are Aboriginal) along with decentralization of files and referral intake;
- introduction of a position for a community liaison worker. This position is currently filled by an Aboriginal woman who skilfully navigates both traditional and Western ways, builds and strengthens relationships in the community (including relationships between health care workers and their clients), and has helped build community members' trust and confidence in home care services;
- access to traditional healers, as well as increased understanding of and sensitivity to Aboriginal cultural knowledge and practices;
- enhanced case management services, enabling more timely and effective assessments of and responses to clients' needs and returning clients to a more active role in caring for their own wellness;
- flexibility in scheduling, to support client-centred care;
- development and introduction of a holistic assessment tool, used alongside a standard comprehensive assessment tool. Holistic assessment enables practitioners and clients to consider all aspects of well-being (physical, mental, spiritual,



and emotional) and clients' self-identified needs, which has increased communication, trust, and compliance. Attention to clients' emotional and spiritual needs enables clients to draw on their own internal resources and find the strength and motivation to move forward on their path to wellness;

- increased focus on client education that, where possible, engages family and other people who are significant to clients. In this way, clients and their significant others become more deeply involved in the care process;
- enhanced foot screening, care, and referral services;
- enhanced resources to support referrals and links between urban and rural/on-reserve services, thus improving follow-up and continuation of care and treatment;
- establishment of a steering committee (which evolved out of the original working group) that monitors and provides guidance to program activities and consistently seeks input and feedback from community Elders and Healers throughout the program; and
- training for staff members to enhance their cultural awareness and cultural competency, along with weekly talking circles at which the on-site team can debrief and share knowledge.

The care experience for clients accessing services through the Aboriginal Home Care program has changed profoundly. Clients can now access holistic, patient-driven care. When they identify and voice their needs, service providers are ready to listen. Clients have a more active role in the "what" and "how" of the care they receive. For practitioners, the program enables them to bring services to a sector of the population that had previously been underserved. Training activities and resources developed for the program have enhanced practitioners' skills and capacity, and the emphasis on consistency in team members has enhanced cohesiveness, communication, and relationships, improving the scope and quality of care the team members provide.

The impacts of the Aboriginal Home Care program are assessed quantitatively and qualitatively. An increasing proportion of individuals in the region who qualify for home care are accessing the services they need. As a group, clients who access services through the program are demonstrating more positive attitudes, increased participation, and increased compliance compared with what typically occurred before the program was introduced.

To a considerable extent, the success of the Aboriginal Home Care program has come from its many internal and external partnerships and working relationships. RQHR's Eagle Moon Health Office (which works with departments in the health region to make service delivery more effective in meeting the needs of First Nations and Métis people) partnered with Home Care Services in the earliest stages of needs assessment and planning, and has provided knowledge, guidance, and support through development and implementation. The program also collaborates with RQHR's Native Health Services, urban and rural home care managers, and RQHR's research department. The executive director of Home Care Services has consistently championed the program, and having someone in a senior management position committed to the program and empowered to make change has been invaluable. External partners supported the creation of an online directory of services, which has greatly enhanced practitioners' ability to make timely and appropriate service referrals for their clients. Aboriginal community members have also played a key role. By sharing their perspectives and insights on how they experience care, clients have contributed significantly to Home Care Services' ability to adapt services to meet the real-life needs of Aboriginal people and communities.

CONTACT INFORMATION:

Additional information about this program is available online at
http://www.rqhealth.ca/programs/comm_hlth_services/homecare/homecare.shtml.

External Source: http://www.healthcouncilcanada.ca/rpt_det.php?id=437



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Aboriginal Support Workers, Southern Regional Health Authority

LOCATION:	Manitoba	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve. Launched in Manitoba's Southern Regional Health Authority in 2012, Aboriginal Health Services have adapted their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people.

In Manitoba, the Southern Regional Health Authority's (Southern RHA's) Aboriginal Health Services has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve.

The Southern RHA was formed in 2012 through the merger of two existing health authorities, the Regional Health Authority—Central (RHA Central) and the South Eastman Health Authority. In the region Southern RHA serves, approximately one of every 10 residents is an Aboriginal person. In 2008, after community health assessments confirmed significant disparities between the health status of Aboriginal people and other residents of the region, RHA Central collaborated with local First Nations, Métis, and urban Aboriginal organizations on an initiative to adapt their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people. Supported by the Aboriginal Health Transition Fund, the project enabled RHA Central to create two positions for Aboriginal Support Workers (ASW) within Aboriginal Health Services (AHS). The first ASWs began working out of the Portage District General Hospital (PDGH) in January 2009.

The ASWs are highly accessible and visible at PDGH and in the community, and available seven days a week. They circulate throughout the hospital, join the medical team for rounds, stop in at patients' rooms for a check-in, assist clients as they arrive at the Portage Hospital and guide them through the admissions and triage process in the emergency department, and visit with residents at personal care homes. Their presence has greatly enhanced Southern RHA's capacity to provide culturally appropriate health services. Clients can now request ceremonies or other traditional healing practices and, for example, within minutes of a request, the ASWs can arrange a smudge ceremony for a patient at PDGH. When the ASWs visit personal care homes, they are often joined by local Elders who facilitate monthly sharing circles and other cultural activities for residents. As Doretta Harris, Regional Director of AHS and a former ASW observed, "The residents yearn for their culture and traditions—and since they can't get back to their community, we try to bring the community to them."

The ASWs and AHS work closely with health practitioners and other staff in the RHA to ensure that Aboriginal clients can access the health care services they need. They have collected and developed culturally specific and culturally appropriate resources (available in local languages, including English, French, Ojibwe, and Dakota), offering information to support Aboriginal clients' ability to access existing services. For example, AHS is collaborating with Aboriginal partners and Southern RHA staff to provide translation for signage about the triage process that will be posted in emergency departments. Content in the patient handbook given to all clients who use hospital facilities has been translated into Aboriginal languages. This information will help dispel the frequent assumption that the order in which clients receive treatment in emergency departments is influenced by cultural identity or race.

The emergency department's triage process is only one of many sites within health systems where cultural conflicts can arise. The ASWs and AHS have played a major role in decreasing these conflicts. The ASWs often act as interpreters for clients and health practitioners, facilitating conversations between English, French, Ojibwe, or Dakota speakers. However, their communication skills extend well beyond language interpretation. They have also taken responsibility for interpreting meaning. One example of these valuable interventions involved surgical staff at PDGH who had contacted AHS because they were concerned about a client who had missed several appointments for a surgical procedure. The ASW participated in a meeting with the client and surgical staff, and as they talked, it became clear that the client did not understand what the procedure involved, but had imagined the worst. The client had been too afraid to show up for the surgical appointment, and delaying the



surgery was having a negative effect on his well-being and daily life. When the ASW was able to interpret and explain the procedure, the client's fears were alleviated. The next day, the client asked the ASW to accompany him to the appointment, and the surgery took place.

In this story, the client could not understand the surgical staff. The ASW was able to take the information the surgical staff had tried to share and communicate it in a way that made sense to the client. Physicians and other care providers have come to rely on the ASWs, because they recognize that the ASWs have the trust of Aboriginal clients. In turn, the ASWs demonstrate to clients through their interactions with staff that they, too, are trustworthy, and this can help patients and physicians develop more confident, trusting relationships.

The ASWs are connectors. They have built strong, reciprocal working relationships with practitioners that enable collaboration in service delivery, and are valuable to all parties. Emergency medical services workers are able to contact the ASWs directly to request that they meet an Aboriginal client being brought into emergency. The ASWs are able to participate in clients' planning meetings, and they connect with providers in clients' home communities to make sure that clients will be linked to whatever services they might need when they return. Medical personnel recognize and appreciate that through these relationships they have increased their own cultural knowledge and cultural competency. The ASWs appreciate the extra efforts that are made to support their clients, improving the quality and continuity of care for their clients. Together, these relationships support patient-centred, patient-driven care and help create a culturally safe health care experience for Aboriginal clients.

An external evaluation completed in 2010 affirmed the important contributions the ASWs have made to the cultural competency of staff and to the care experience and cultural safety of Aboriginal patients. Communication, relationships, and collaboration have been key to the success of the ASWs and Aboriginal Health Services. The ASWs first appeared as part of a project undertaken in partnership with Aboriginal organizations, and the ASWs and AHS have maintained, strengthened, and built upon those relationships. They look to community leaders and community members for feedback, guidance, and direction, and find new ways to engage the participation of Aboriginal people. They recognize that the diverse perspectives that broad and deep engagement provides can only enhance and strengthen their own capacity.

The most significant challenges the program has faced have related to funding—in particular, whether funding can match the growth in demand for the ASWs' services. AHTF funding supported the ASW positions for their first three years; since then, the RHA has allocated permanent funding to support the positions. The RHA's commitment to support Aboriginal people, and the unwavering support (through initial planning and development stages to the program's implementation and delivery) from the organization's CEO, senior management, and board of directors have been "must haves" for success.

The commitment to a shared responsibility to improve health experiences and health outcomes for Aboriginal people has filtered throughout Southern RHA. As Doretta Harris acknowledged, "We all have a responsibility for the health of our patients. Patients share that responsibility too. We help them understand their own role in the healing journey, and discover their own ability to help themselves."

CONTACT INFORMATION

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