



Health Innovation Portal: Archive of Innovative Practices

Theme: Rural and Remote Health

January 2014



Health Council of Canada
Conseil canadien de la santé



Selected Search Output Table (December 17, 2013)

SEARCH TERMS:	N/A	LOCATION:	All
HEALTH THEME:	Rural and Remote Health	FRAMEWORK CATEGORY:	All
HEALTH SECTOR:	All	SEARCH RESULTS:	13 results out of 22

1. 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

2. 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

3. 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: ginny@csfs.org Telephone number: (250) 567 7561 Information last updated on: September 27, 2013



4. Atii!: A Comprehensive Healthy Living Intervention for Children, Youth, and Families in Inuit Communities in Nunavut

Implementation Year: Thursday, February 3, 2011 - 14:00	Location: Nunavut	Practice Website:
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SNAPSHOT:

This innovative practice addresses health outcomes and health literacy among Inuit children. The practice was launched in 2011 in Nunavut and involved a project coordinator, a game facilitator, and an administration person.

CONTACT INFORMATION:

CONTACT INFORMATION: Name: Gwen Healey **Title:** Executive Director **Organization:** Qaujigiartiit Health Research Centre **Email address:** gwen.healey@qhrc.ca **Telephone number:** (867) 975-2476

5. 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

6. High Acuity Response Team (HART)

Implementation Year: Tuesday, March 2, 2010 - 00:30	Location: British Columbia	Practice Website: N/a
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SNAPSHOT:

This innovative practice addresses the provision of mobile intensive care to rural hospitals that do not have critical care services in an effort to stabilize and sustain patient care and, when necessary, transport patients to a higher level of care. The practice was launched in British Columbia in one health region, Trail, and involved six critical care nurses, a basic life-support ambulance team, and, occasionally, a respiratory therapist.

CONTACT INFORMATION:

Name: Brent Hobbs **Title:** Regional Director, Patient Transportation Services **Organization:** Interior Health **Email address:** Brent.Hobbs2@interiorhealth.ca **Telephone number:** 250-870-5758 **Information last updated on:** July 2, 2013

7. Targeted Newborn Screening for Treatable Genetic Disorders in the Old Order Amish Population of Southwestern Ontario

Implementation Year: Sunday, February 2, 2003 - 00:45	Location: Ontario	Practice Website: http://www.biochemgenetics.ca/plainpeople/
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SNAPSHOT:

This innovative practice screens and identifies presymptomatic newborn infants at risk for genetic disorders.

CONTACT INFORMATION:



Name: Dr. Victoria Mok Siu **Title:** Medical Director, Medical Genetics Program of Southwestern Ontario **Organization:** London Health Sciences Centre and Schulich School of Medicine and Dentistry, University of Western Ontario **Email address:** vmsiu@uwo.ca **Telephone number:** 519-685-8140
Information last updated on: March 27, 2013

8. Community and Rural Health Planning Framework: Health Service Planning through the Community Assessment Service Response (CASR) Model

Implementation Year: Thursday, February 11, 2010 - 00:15	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/community&ruralplanning.asp
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SNAPSHOT:

This innovative practice provides a standardized approach to planning community and rural health services across Alberta.

CONTACT INFORMATION:

Name: Maz Rahman **Title:** Senior Planner - Priorities & Performance **Organization:** Alberta Health Services **Email address:** Maz.Rahman@albertahealthservices.ca **Telephone number:** (780) 735-1414

9. Long and Brier Island Community Paramedicine Project

Implementation Year: Saturday, February 3, 2001 - 01:15	Location: Nova Scotia	Practice Website: http://www.gov.ns.ca/health/ehs/documents/Community%20Paramedicine%20Article.pdf
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SNAPSHOT:

This innovative practice focuses on increasing access to health care professionals in remote places. Launched In 2001 in two rural communities in Nova Scotia, the three-year initiative implemented the health service delivery model that uses the more widely practiced model of community paramedicine and introduced a novel collaboration with registered nurse practitioners (NPs).

CONTACT INFORMATION:

Name: Connie Day **Title:** Nurse Practitioner **Organization:** Island Health Centre & EHS Paramedic Excess Line Capacity **Telephone number:** 902-839-2398 **Email:** info@swndha.nshealth.ca

10. 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

11. 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

12. 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.

13. 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.sjnfc.com>.



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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.

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

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.tunnngavik.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.tunnngavik.com/>



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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.

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

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

Personal Communications:

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



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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.

CONTACT INFORMATION:

Name: Ginny Burns

Title: Family Nurse Practitioner and Clinical Support

Organization: Carrier Sekani Family Services Primary Care

Email address: ginny@csfs.org

Telephone number: (250) 567 7561

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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Atii!: A Comprehensive Healthy Living Intervention for Children, Youth, and Families in Inuit Communities in Nunavut

LOCATION:	Nunavut	HEALTH THEME:	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses health outcomes and health literacy among Inuit children. The practice was launched in 2011 in Nunavut and involved a project coordinator, a game facilitator, and an administration person.

PRACTICE DESCRIPTION:

The Atii! (Let's do it!) project is a school-based initiative aimed at improving the ability of Inuit children to make healthy choices about food and activity, and to carry this knowledge forward with them into adolescence and adulthood. The program was designed by and for Inuit youth and is founded on Inuit knowledge, foods, and language. The game divides participants into teams that spin a wheel (similar to those used in television game shows) and compete in trivia and game challenges. Three separate pilots of the Atii! game were conducted in November 2011, and the program lasts one day in each school. The research team conducted the game with classroom teachers participating as assistant facilitators.

The specific goals of the program are to:

- educate Inuit children about healthy choices;
- improve health literacy in Inuktitut;
- engage children in a fun health promotion activity;
- promote and evaluate a local intervention developed by young, motivated Inuit youth workers; and
- hire and train local youth (up to 30 years of age) to lead and implement the project.

The Atii! game is a creative, innovative way to engage children in health education, and is grounded in Inuit knowledge, foods, games, and language. The program is the result of a partnership between the Qaujigiartiit Health Research Centre (QHRC), the Qikiqtani Inuit Association, the University of Toronto, and Nunavut Tunngavik Inc. The mandate of the QHRC is to improve Northern health outcomes through community-driven, Northern-led research and program development. A Nunavut-based graphic design company was hired to produce the game, and the game manual was developed in English and Inuktitut.

IMPACT:

A survey was distributed pre- and post-game for each session in each school to assess children's general knowledge and level of enthusiasm for the game's subject matter. Researchers found that, following Atii! game play, the children's level of enthusiasm on the subjects of nutrition, physical activity, Inuit cultural knowledge, and health increased. Observations collected during the game play indicated that the children enjoyed participating in the Atii! intervention, as did the teachers and community workers who were present. Researchers found that while children had a good knowledge of the link between physical exercise and health, there was an opportunity to improve children's knowledge of the role of traditional Inuit foods in improving and maintaining health. Despite excellent knowledge and vocabulary on this subject, children did not identify traditional Inuit country foods as a source of health.

The results of the evaluation were published in a report published by the QHRC and were presented at the International Polar Year conference in Montreal in April 2012. To date, there has not been an evaluation of the costs and long term benefits of the practice.



APPLICABILITY/TRANSFERABILITY:

The Atii! Healthy Living intervention is one of nine projects under the Government of Canada's Innovation Strategy: Achieving Healthier Weights in Canada's Communities. In January 2013, the QHRC received two-year funding from the Public Health Agency of Canada to extend the Atii! intervention to two additional communities in Nunavut. It is too early to tell whether the results of the initial pilot have been replicated in these sites, but this initiative is theoretically applicable and transferable to other settings.

PRACTICE WEBSITE:n/a

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

CONTACT INFORMATION:

Name: Gwen Healey

Title: Executive Director

Organization: Qaujigiartiit Health Research Centre

Email address: gwen.healey@qhrc.ca

Telephone number: (867) 975-2476

Name: Lissie Anaviapik

Title: Family Health Research Coordinator

Organization: Qaujigiartiit Health Research Centre

Email address: lissie.anaviapik@qhrc.ca

Telephone number: (867) 975-2523

Information last updated on: August, 2013

Publications:

Galloway, T., & Healey, G. (2012, January). *Atii Gameshow: Healthy living intervention for school children in Nunavut. Evaluation report.* Retrieved from

<http://www.qhrc.ca/sites/default/files/Atii%20Gameshow%20Evaluation%20Report%20-%20Galloway%20and%20Healey%20-%20JAN%202012.pdf>

Other:

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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

CONTACT INFORMATION:

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

Information last updated on: June 28, 2013

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

Personal Communication:

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
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External Source: www.blueprintforlife.ca



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High Acuity Response Team (HART)

LOCATION:	British Columbia	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the provision of mobile intensive care to rural hospitals that do not have critical care services in an effort to stabilize and sustain patient care and, when necessary, transport patients to a higher level of care. The practice was launched in British Columbia in one health region, Trail, and involved six critical care nurses, a basic life-support ambulance team, and, occasionally, a respiratory therapist.

PRACTICE DESCRIPTION:

Interior Health (IH) is responsible for delivering comprehensive health care services to a population of 750,000 residents in southern British Columbia. The British Columbia Ambulance Service (BCAS) provides basic life support services to this remote region by ground ambulance, along with the provincial air transport system. However, due to long distances, mountain ranges, severe weather, and limited clinical resources in rural hospitals, the resident health care providers often have to accompany critical patients to a higher level of care, leaving their patients without health care professionals for hours at a time.

To ensure that higher-acuity patients receive optimal care in a rural context, IH developed a flexible-deployment, hospital-based High Acuity Response Team (HART). Interior Health supports HART in partnership with BC Ambulance Services so that HART teams can attend to acute patients at rural and remote health sites by either stabilizing them to avoid transfer or transporting them to a higher level of care.

The program currently staffs one HART member 24/7 at three regional referral centres across Interior Health. HART members are typically registered nurses (RNs) who have specialized training and equipment that allow them to provide expert inter-facility transport services at rural/remote facilities. HART members are required to integrate into their base hospitals, where they deliver critical care outreach (CCO) and other clinical support services when not on transport. Specialized respiratory therapists (RTs) are available on call to the HART program and are typically involved 38% of the time in cases requiring advanced critical monitoring and intervention.

As a core component of HART, clinicians are required to record all in-hospital and out-of-hospital response activity in an electronic data registry. This information includes a staff-initiated quality assurance audit, in which clinicians have the opportunity to identify areas of success and opportunities for improvement, thus empowering staff to take an active role in developing of the program. End-users of the HART service also have an opportunity to provide feedback to HART. All documentation is then reviewed by the clinical team Leader and the base medical director for quality of care, documentation, operational benchmarking, and communication issues. The clinical team leader and local medical director then provide feedback to the HART clinicians, and may also use their findings to identify opportunities for further professional development and operational efficiency.

IMPACT:

In over 1,000 transfers to date, HART is meeting the performance benchmark for patient delivery 88% of the time. When working in the base hospitals, HART responded to a total of 1,027 rapid response requests based on the Early Warning Signs screening tool. With further analysis using standardized Early Warning scores, the program hopes to answer the question of whether HART improves the physiological stability of patients in its care.

IH spends about \$800,000 annually per hospital base team to deliver this service.

APPLICABILITY/TRANSFERABILITY:

After Trail, the program was launched in Cranbrook, Kamloops, and Penticton. Success stories were also prevalent in the other sites, such as two burn victims in Lytton saved due to HART's response team. The HART teams throughout Interior Health have done more than 211 transports in the first year of implementation and have reported a positive reception from the medical community.



High priorities for the program include (1) exploring opportunities to optimize communication and coordination between the sending facility, BCAS, and HART in an effort to improve response times and patient outcomes; (2) expanding the service to proposed HART catchment areas, such as Vernon; (3) increasing the scope of practice to include pediatric patients; (4) formalizing in-hospital rapid response outreach services across all HART bases; and (5) further developing cross-pollination of RN skill sets.

CONTACT INFORMATION:

Name: Brent Hobbs
Title: Regional Director, Patient Transportation Services
Organization: Interior Health
Email address: Brent.Hobbs2@interiorhealth.ca
Telephone number: 250-870-5758
Information last updated on: July 2, 2013

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

Rossi, V. (2012, February 1). Critical care specialists sharpen skills. *BC Local News*. Retrieved from <http://www.bcclocalnews.com/news/138502399.html?mobile=true>

BC Patient Safety & Quality Council. (2013, March 1). *Mobile intensive care: Team approach to continuous quality improvement* [Presentation Notes]. Retrieved from <http://www.slideshare.net/bcpsqc/g3-brent-hobbs>

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External Source: [N/a](#)



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Targeted Newborn Screening for Treatable Genetic Disorders in the Old Order Amish Population of Southwestern Ontario

LOCATION:	Ontario	HEALTH THEME:	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice screens and identifies presymptomatic newborn infants at risk for genetic disorders.

PRACTICE DESCRIPTION:

The Old Order Amish in southwestern Ontario are a distinct, self-defined population with unique health care needs. The Amish are quite knowledgeable about inherited diseases and keep excellent genealogical records. They are also interested in health maintenance and disease treatment, especially for their children. However, they tend to seek medical advice late in the course of illnesses, which may mean treatment is less effective. Through previous research, we had identified the specific DNA mutations causing juvenile glaucoma, cystic fibrosis, galactosemia, and cystinosis in the Amish. All of these disorders are amenable to treatment that may ameliorate or delay the onset of symptoms. In 2003, a targeted newborn screening program was developed with funding from the Change Foundation to identify presymptomatic newborn infants at risk for these disorders.

The targeted newborn screening program entailed (1) screening this under-served population using DNA molecular methods to identify the four specific treatable disorders, (2) involving community elders as advisors in the planning process to ensure acceptance of the program, (3) educating health care providers in the community, (4) collaborating with various health care providers in the region to inform Amish families about the project, (5) including a member of the community in the organization of community education events, and (6) providing screening in homes where deliveries occur. Pregnant women are informed about the Newborn Screening Program, primarily by midwives and public health nurses. They receive information about newborn screening and decide whether to participate. Blood samples are obtained through umbilical cord sampling after delivery and relevant DNA mutation analysis and enzyme analysis are carried out in the biochemical genetics laboratory.

IMPACT:

The screening project has been widely accepted by the Old Order Amish community with over 90% of pregnant women referred to the project opting to have newborn screening. DNA testing detected an extremely high carrier rate for each of the four disorders. Over the past eight years, over 300 babies have been tested and four babies who have one of the disorders have been identified.

An unexpectedly high rate of other rare genetic disorders has also been noted. Research is ongoing in association with a Canada-wide consortium to identify causative genes. The Amish, Mennonite, and Hutterite Genetic Database (<http://www.biochemgenetics.ca/plainpeople/>) is a useful reference for physicians who work with any of these populations.

At this time, the program has not undergone formal evaluation. However, due to the high uptake of screening, targeted newborn screening has been incorporated into routine practice in the community. Key lessons learned from the design and implementation of this program were that (1) sensitivity to cultural differences was essential in project planning and delivery, and (2) collaboration between health care providers in the hospital (London Health Sciences Centre) and in the community led to improved coordination of care, not only with newborn screening but in the management of other rare disorders as well.

APPLICABILITY/TRANSFERABILITY:

The project team is applying for grant funding to expand the screening program and provide carrier screening to the Old Order Mennonite population of southwestern Ontario.

The targeted newborn screening model designed for this program would be appropriate and applicable for any genetically



distinct populations in Canada.

CONTACT INFORMATION:

Name: Dr. Victoria Mok Siu

Title: Medical Director, Medical Genetics Program of Southwestern Ontario

Organization: London Health Sciences Centre and Schulich School of Medicine and Dentistry, University of Western Ontario

Email address: ymsiu@uwo.ca

Telephone number: 519-685-8140

Information last updated on: March 27, 2013

Content was adapted from the following sources and relevant websites:

Other:

Siu, V.M. & Rupar, C.A. (2012). Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care.

External Source: <http://www.biochemgenetics.ca/plainpeople/>



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Community and Rural Health Planning Framework: Health Service Planning through the Community Assessment Service Response (CASR) Model

LOCATION:	Alberta	HEALTH THEME:	Health Policies and Governance
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice provides a standardized approach to planning community and rural health services across Alberta.

PRACTICE DESCRIPTION:

Beginning in November 2010, a provincial planning framework was developed and implemented in the Alberta Health Services (AHS). The Community and Rural Health Planning Framework provides a standardized approach to planning community and rural health services across Alberta. The framework integrates new planning approaches with past planning undertaken by the former regional health authorities and builds on the unique strengths of each rural community.

The framework follows the Community Assessment and Service Response (CASR) model, which outlines a planning process that begins with the collection and validation of community data and ends with specific community recommendations. The assessment process identifies top population health needs, current health services, and gaps in health service delivery. The goal of the framework is to give each rural community a voice in health planning by identifying top health priorities within their own community.

The key to this framework is that those living, working, and accessing health services in a local geographic area are the ones identifying priorities and solutions. Communities are selected for focused CASR planning support using an evidence-based triage tool. Population health and site/service utilization data are gathered and presented to zone leadership. Key community members (community members, health staff, physicians, elected officials) are identified to provide local context and perspective to planning for their geographic community. Top health needs, solutions, and action items are developed with community members. Once approved by AHS leadership, these strategies are implemented by those living and working in the community.

IMPACT:

Action plans have been developed for the communities involved thus far, with solutions such as booking control of a respite bed to community care access to increase respite options and aligning home care offices among neighbouring communities to increase home care support. Feedback surveys are distributed to participants after each engagement session. Internal team evaluations have also been developed to gauge success of the process and point out areas for improvement. These features are part of an overall CASR evaluation framework.

Approximately 1,200 completed surveys were collected from participants in Phase I to III; the response was overwhelmingly positive. For instance, 93.1% of respondents felt that they could contribute their ideas during the session, and 87.4% found the process valuable. Internal team members/zone leaders found the process valuable, stating that the flexibility of the framework allowed them to tailor their process to the specific needs of their communities.

A three-year service plan outlining the process and action items are provided to the community for accountability and to keep participants engaged. With respect to ensuring long-term sustainability, the intent is to revisit these communities in the future to reassess their top priorities as population demographics and health care needs change.

APPLICABILITY/TRANSFERABILITY:



The CASR process is based on community engagement principles that could be used for health needs assessments in diverse settings. The framework represents a success story of empowering rural communities to engage in health planning. Local-level findings have been used to drive not only local planning but also zone and provincial planning, and to align provincial strategies and priorities with local health needs.

CONTACT INFORMATION:

Name: Maz Rahman
Title: Senior Planner - Priorities & Performance
Organization: Alberta Health Services
Email address: Maz.Rahman@albertahealthservices.ca
Telephone number: (780) 735-1414

Information last updated on: April 2, 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

- Gyennin, N. (2012). Content developed from an abstract submission for the Health Council of Canada National Symposium on Integrated Care.

External Source: <http://www.albertahealthservices.ca/community&ruralplanning.asp>



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Long and Brier Island Community Paramedicine Project

LOCATION:	Nova Scotia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice focuses on increasing access to health care professionals in remote places. Launched in 2001 in two rural communities in Nova Scotia, the three-year initiative implemented the health service delivery model that uses the more widely practiced model of community paramedicine and introduced a novel collaboration with registered nurse practitioners (NPs).

PRACTICE DESCRIPTION:

Long and Brier islands are two remote islands in Nova Scotia with a combined population of about 1,240 residents. Reaching these islands requires a one-hour commute by car and ferry from the nearest town, Digby. Access to primary care services on the islands has been minimal for many years because there are no resident physicians. Instead, paramedics and one registered nurse provided health services for these residents; if additional health services were required, a 50-minute trip was taken to Digby's General Hospital. In 2001 the Emergency Health Services (EHS) and the residents launched a three-year initiative focused on increasing access to health care professionals on the islands. The initiative consists of an innovative health service delivery model that uses the more widely practiced model of community paramedicine. In addition, it introduced a novel collaboration with registered nurse practitioners (NPs). The NP also acts as a liaison with an off-site physician in Digby. This model uses the islands' human health resources and demonstrates an innovative approach of tailoring delivery models to the community's needs.

The first phase of this model was established in an ambulatory base with increased access to paramedic care. Paramedics provided 24/7 ambulatory care to the residents in this phase. Paramedic services expanded in the second phase to include clinic roles and delivery of non-emergency services. The third phase marked the addition of the NP and, consequently, led to increased development of non-emergency services by the NP, of complex care by the paramedics, and of prevention and promotion programs by the health care team.

With the needs of the residents expanding, ongoing professional development has been provided to paramedics to help them better adapt to their community's needs and to become proficient in providing various medical services to the Long and Brier islands residents. Learning sessions have been a key resource in promoting these expansions.

This initiative not only models community-based care but also demonstrates the role of effective communication and collaboration among health care professionals, community residents, and provincial leaders in providing accessible and adequate care.

IMPACT:

The Long and Brier model has successfully achieved greater access to primary health care services for the residents of these two islands. Interviews with residents have highlighted personal success stories and satisfaction with the health services provided by the paramedics and NPs. They also noted that their health status has improved, and they expressed satisfaction with the shorter wait times and travel times to obtain access to care. These stories have been documented and shared with the public in recent news releases and program reports on Nova Scotia's government websites.

Furthermore, preliminary data collection has shown a 23% decrease in emergency department visits by islanders and an increase in the project's patient contacts by 250 to 300 during the 2002/2003 fiscal year. Average visits by islanders to Digby facilities decreased by 24% to 28% from 2001 to 2006. Data and figures have been documented in program reports.

APPLICABILITY/TRANSFERABILITY:



In late 2006, the Beausoleil First Nation on Lake Huron's Christian Island in Ontario started a program modelled after Nova Scotia's Long and Brier Island Community Paramedicine Project. In its first year of implementation, from November to July, paramedics provided 1,000 home visits, lasting almost 495 hours to total, in addition to handling their usual volume of emergency calls (approximately 300 calls a year). Community paramedics do an average of six daily home visits, checking on the same three patients every day and sometimes visiting as many as nine. The daily check-ups and expanded practice of paramedics have reduced the number of transports and hospital admissions in this location. Similar programs in remote locations in countries such as Australia and Scotland have also consulted with Long and Brier administrators about their projects.

Those wishing to implement this innovative practice in a different context must be aware that this project dramatically altered the traditional scope of work for the paramedics involved. Accustomed to quickly responding to emergency calls within a specified period of time, paramedics are now called upon to spend more time with residents to conduct falls prevention assessments, participate to monthly first-responder training programs with fire departments on the islands, and generally establish closer relationships with local home-health services, including the Victorian Order of Nurses.

The success of the Long and Brier Island Community Paramedicine Project has spurred interest in expanding the initiative and the facilities in Digby County. In November 2012, Premier Dexter announced a two-year investment in a new health care facility for Digby County that will continue to provide care to Island residents via the expanded scope model. The facility will unite the clinic and EHS base in order to maximize collaboration and centralize services.

Finally, in February 2011, EHS launched a subsequent paramedic expanded scope initiative as part of the Better Care Sooner plan. Similar to the Long and Brier Island Community Paramedicine Project, the Collaborative Emergency Centres care model uses paramedics as health care professionals who can provide a larger repertoire of services to remote areas. The aim is to provide care to seniors in remote resident homes through collaboration among paramedics, NPs, EHS staff, and Capital Health. Further, the Ministry of Health in Saskatchewan is also adopting the community paramedicine concept.

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

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CONTACT INFORMATION

Name: Connie Day
Title: Nurse Practitioner
Organization: Island Health Centre & EHS Paramedic Excess Line Capacity
Telephone number: 902-839-2398
Email: info@swndha.nshealth.ca

Information last updated on: March 6, 2013

External Source: <http://www.gov.ns.ca/health/ehs/documents/Community%20Paramedicine%20Article.pdf>



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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>

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

Information last updated on: December 21, 2012



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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>.