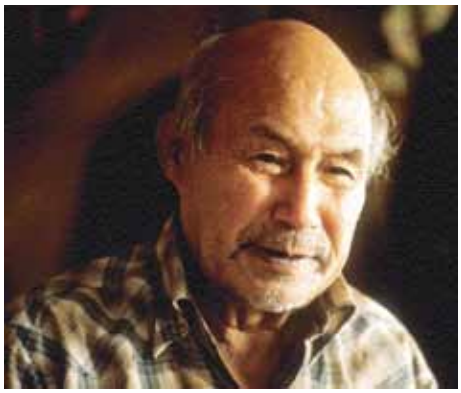

Mind Body Spirit

Promising Practices in First Nations and Inuit Home and Community Care

About the Title: **Mind Body Spirit**

The title of this report was chosen to reflect the First Nation and Inuit interpretation of health.

Traditional First Nations healing treats the whole person, body, mind, and spirit. According to traditional teachings, health can most simply be defined as "living your life in balance according to the natural laws of the Creator." First Nations believe that there are four aspects of man – Emotional, Mental (intellectual), Spiritual and Physical and they must be maintained in balance to be healthy. In First Nations belief, disease is a manifestation of a person's imbalance between these four aspects.

–Annette Cyr

Inuit have a holistic view of health care, where mind, body, and spirit are intrinsically linked and a weakness in one will surface as a weakness in another aspect. Inuit medical knowledge does not only amount to mastering remedies and the necessary techniques to care for the sick body. Illness teaches us how to maintain life by developing a resistant body and a strong spirit, as the mind and body are complementary and are related to their environment, whether it be social, physical, or animal.

–Elisapee Ootoova

Production of this document has been made possible by a financial contribution from Health Canada, First Nations and Inuit Home and Community Care Branch. The views expressed herein do not necessarily represent the official policies of Health Canada.

Cover Photographs
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Mind Body Spirit

Promising Practices in First Nations and Inuit Home and Community Care

2010

About the Canadian Home Care Association

The Canadian Home Care Association (CHCA) is a not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to stay in their homes with safety, dignity and quality of life. Members of the Association include organizations and individuals from publicly funded home care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators and others with an interest in home care. Through the support of the Association members who share a commitment to excellence, knowledge transfer and continuous improvement, CHCA serves as the national voice of home care and the access point for information and knowledge for home care across Canada.

For more information, visit our website at www.cdnhomecare.ca

Forward

Since the first publicly funded home care program was established in 1970, home care across Canada has experienced tremendous growth and has evolved to being recognized today as "an essential part of the health care system."

While demographic changes and financial pressures have had a major influence on the direction and evolution of home care, the most important influencer is the individual and the community. Home care has grown in response to Canadians' desire to remain at home in their communities, and receive the necessary supports and care to make this happen. Communities have collaborated and supported new ways to deliver health care and have embraced home and community based services as a way to meet the growing needs of an aging population.

The First Nations and Inuit Home and Community Care (FNIHCC) program was established in 1999 and has been instrumental in facilitating the development of relevant programs within 606 First Nations reserves/communities and 53 Inuit communities across Canada. To mark the 10th anniversary of the FNIHCC program this profile of 'promising practices', identified from each of the eight FNIHCC Regions across Canada, was commissioned. These practices are a testament to the effectiveness of collaboration and partnerships and how working together in a trusting and open environment leads to positive and sustainable change. This compilation is a celebration of the achievements of communities, tribal councils, regions and jurisdictions over the past 10 years.

The Canadian Home Care Association (CHCA) extends congratulations to the Regions for their successes in home and community care. It was a privilege and honour to work with the dedicated individuals who are engaged in home care every day and to learn about their challenges and successes within their communities. We are grateful for the time and effort provided by countless individuals to support the development of this document.

The CHCA hopes that this compendium will serve to stimulate discussion and facilitate connections between and within the regions. We encourage readers to use these practices as a resource for staff who experience similar circumstances and want to draw on the knowledge of others.

Nadine Henningsen

Executive Director
Canadian Home Care Association

April 2010

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First Nations and Inuit Home and Community Care Program

An Overview

The First Nations and Inuit Home and Community Care (FNIHCC) program was launched in 1999 by the federal government. The First Nations and Inuit Health Branch (FNIHB) of Health Canada provides basic home and community care services to all First Nations people living on reserve and in designated communities and to Inuit living in Inuit communities. These services complement the social home care services (e.g. homemaking) provided by Indian and Northern Affairs Canada (INAC).

Mission of the Home Care Program

The FNIHCC program provides a continuum of services, under First Nations and Inuit control, that are comprehensive, culturally sensitive, accessible, effective and which strive to be equal to those offered to other Canadian citizens and respond to the unique health and social needs of First Nations and Inuit. The Program is a coordinated system of home and community based health related services which enables people with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their home communities.

Principles of the Home Care Program

The guiding principles of the program are based on universally accepted home care precepts with adaptations for First Nation and Inuit cultural values:

- Respect traditional and contemporary First Nation and Inuit approaches to healing and wellness.
- Planning is community-based and community-paced.
- Programs are available to individuals of all ages with an assessed need.
- Services are at least equitable, effective and equivalent to those received by the general population and supported by quality assurance measures.
- Supportive to family and community involvement.

Home Care Program Objectives

The objectives of the FNIHCC Program are:

- To build the capacity within First Nation and Inuit communities to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services at a pace acceptable to the community.

- To assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.

- To facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan.

- To ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible.

- To assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services, where available and appropriate in the care of clients.

- To build the capacity within First Nations and Inuit to deliver home care services through training, evolving technology, information systems to monitor care and services and to develop measurable objectives and indicators.

Any person living on a First Nation reserve, First Nation designated community or in an Inuit community may request FNIHCC services through the local program. The request for service may come to the Home Care Nurse Coordinator from any number of sources, such as the person requesting the service, a family member, a community member, a doctor, community health or social service agencies or outside agencies. Individuals of all ages are eligible for home care services.

Services currently funded by FNIHCC

Home care services, including nursing and home support, are typically provided by staff hired directly by the local program. However, in some instances, services may be contracted to service provider organizations. In total, communities employ 396 registered nurses, 108 licensed practical nurses and 894 personal care workers. Like elsewhere, however, family caregivers provide the vast majority of the unpaid caregiving that is necessary for individuals to remain in their own homes and communities.

The home and community care program is comprised of nine essential service elements that provide the foundation upon which future program enhancements can build. They include:

1. A structured client assessment process that includes on-going reassessment and determines client needs and service allocation.

2. A managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/ settlement.

3. Home care nursing services that include direct service delivery as well as supervision and teaching of personnel providing personal care services.

4. The delivery of home support personal care services that are determined by the community needs assessment plan and that do not duplicate, but enhance existing Indian and Northern Affairs Canada (INAC) adult care services.

5. Provision of in-home respite care.

6. Established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with such providers as hospitals, physicians, respite and therapeutic services.

7. Provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide home and community care.

8. The capacity to manage the delivery of the home and community care program that is delivered in a safe and effective manner, if existing community infrastructure exists.

9. A system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

FNIHCC essential service elements include direct nursing, case management, personal care and respite. Communities may also provide supportive services such as meals on wheels and adult day programs. Service delivery is based on assessed need and follows a case management process. Clients are of all ages, but like other home care programs, clients are generally older, and are more likely to

be female. Clients receiving home care services typically have multiple diagnoses, the most common being:

- Diabetes
- Musculoskeletal (arthritis, fracture)
- Cardiovascular Disease, Heart, Circulatory
- Skin and & Subcutaneous Condition (includes wound care).

Evaluation

Between 2004-2009, three studies were completed to evaluate the implementation of FNIHCC in communities, how the program addresses the needs for home care, and the performance of FNIHCC. The Summative Evaluation, the third of the three studies, was recently completed. The intent is to enable policy makers and program managers to make future decisions on the continuation, funding levels and design and delivery of the FNIHCC, and to introduce changes, as required, to improve program quality to be more responsive and relevant to users. The evaluation confirmed that:

- FNIHCC has built community health capacity – home and community care services are in place where there were no or few formal services before.
- Success is due to the contributions of communities and their dedicated staff and volunteers.
- High rates of chronic disease contribute to high demand, which has been growing every year. At the same time, demand for acute home care continues to increase.

The evaluation made a number of recommendations, including that:

- The FNIHCC program continue and be strengthened to close the health service delivery gap.
- The highest priority be given to providing all essential components of the FNIHCC program in all communities with consideration to addressing areas of unmet health needs and services gaps, including mental health services, palliative/end of life care, rehabilitation care and respite care.
- Closer linkages of the FNIHCC program with regional health authorities, other health care providers, medical services and health institutions be explored and encouraged, so as to provide more integrated and coordinated care to clients.

Addressing Challenges

The key challenges for the FNIHCC program include recruiting and retaining qualified Home Care Nurses and Personal Care Workers; meeting the needs of a population that is growing and aging; and the high rates of chronic illness and disability. Across the country FNIHCC staff have undertaken initiatives to address these challenges and accordingly in its first decade of operation the FNIHCC has made strides in evolving the program to meet the needs of their people.

For information on INAC visit http://www.ainc-inac.gc.ca/index-eng.asp

Admissions	**24,677**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	15%	**2%**	**6%**	**37%**	**28%**	**13%**
Hours of Service Delivered: 2,546,132	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	10%	**16%**	**1%**	**7%**	**4%**	**61%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	6%	**22%**	**32%**	**22%**	**19%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Northern Region

Canada's three territories comprise almost 40 per cent of the country's land mass. But with limited highway accessor, in the case of Nunavut, no highway access – and a total population of just over 100,000 spread across 76 mostly small and isolated communities, the realities of living and working in the North are remarkably different than in the rest of Canada. The make-up of the population in the North is also significantly different, with a much larger proportion of First Nations and Inuit. Almost 85 per cent of Nunavut's population is Inuit, while half of the people living in the Northwest Territories (NWT) are First Nations, Métis or Inuit. In the Yukon, a quarter of the residents are First Nations.

Perhaps the most significant challenge facing people living in the North and their respective territorial health systems is securing the human capital – doctors, nurses, administrators and support staff – necessary for the management and delivery of health programs and services. Despite ongoing, aggressive recruitment and retention efforts, territorial vacancy rates among health professionals are typically higher than in the provinces and, due to lack of economies of scale, have more immediate impacts on service delivery, particularly in smaller communities. There is also a need to address the disparity in health status between those living in the North and those living in the South.

Health Canada's Northern Region (NR), composed of 85 full time employees working in both Ottawa and Whitehorse, have responsibility for all Health Canada initiatives and activities in the NWT, Nunavut and the Yukon. The Region acts as a "single window" – so that Territorial Governments, First Nations, Inuit organizations and other stakeholders do not have to navigate multiple points of entry to access Health Canada. It also means federal departments whose operations touch upon health issues know who to turn to when engaging stakeholders in the North.

The NR does not deliver health care services to Aboriginal People – that responsibility has been transferred to the Territorial Governments. Health Canada does however, pay for the cost of non-insured health benefits such as medical transportation, drugs, dental, medical equipment and vision care for eligible First Nations and Inuit. In terms of Home and Community Care and other First Nations and Inuit Health (FNIH) health promotion and prevention initiatives, the NR works closely with Territorial Governments in Nunavut and the NWT who deliver these programs on behalf of Health Canada. In the Yukon, FNIH funded programs flow directly to First Nation communities.

Prepared by Rob Furlong, Senior Communications Advisor, Health Canada, Northern Region and
Paul J. Hemming, Program Consultant, Health Canada, Northern Region

The Northern Region does not report on ESDRT at this time

Admissions	**2000**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
Hours of Service Delivered: 118,000	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	

Fall Prevention in Yukon Communities

First Nations and Territorial Governments Working Together

A collaboration between various levels of government – First Nations, Federal and Territorial – and community based organizations in the development and implementation of a falls prevention *Checklist and Action Plan* throughout the Yukon.

Special Thanks

Lori Duncan, Director of Health and Social Development Council of Yukon First Nations (CYFN)
Jody Butler Walker, Executive Director, Arctic Health Research Network - Yukon (AHRN-YT)
Jade McGinty, Home and Community Care Coordinator, Teslin Tlingit First Nation
Linda McConnell, Community Liaison Coordinator, Yukon Home Care Program (YHCP)
Heather Alton, Manager of Home and Community Care, Yukon Home Care Program (YHCP)
Dr. Vicky Scott, Senior Advisor–Falls & Injury Prevention, B.C. Injury Research and Prevention Unit

Background

It is estimated that one in three persons over age 65 has a fall each year. Almost half of those who fall experience a minor injury and between 5 to 25 per cent sustain a more serious injury, such as a fracture or a sprain. Falls are the 6th leading cause of death of seniors.

Falls are a significant contributing factor for 40 per cent of all elderly admissions to nursing homes or long-term care facilities. Falls among seniors can cause long-term disability, chronic pain, and lingering fear of falling again. The aftermath of pain or fear from a fall can lead seniors to restrict their activities which in turn can increase the risk of falling because of decreased muscle strength, balance or coordination or increased stiffness – 50 per cent of people with hip fractures never regain their previous level of functioning.

When a senior falls, the results do not only alter the course of their life, they also have a serious impact on their families, their community and the utilization of health resources.

Canadian data reported by the Public Health Agency of Canada (2005) indicates that:

- Falls are the second leading cause (after motor vehicle accidents) of injury-related hospitalizations for all ages.
- Almost 62 per cent of injury-related hospitalizations for seniors resulted from falls.
- The fall-related injury rate for seniors is nine times greater than for other age groups.
- Falls cause more than 90 per cent of hip fractures in seniors.
- 20 per cent of seniors with hip fractures die within a year of their injury.
- 40 per cent of all admissions to nursing homes are the result of falls by seniors.

Clients receiving home support services are at high risk for falling. Home care clients typically have multiple

risk factors which are often further compounded by issues with medications, a significant concern with the elderly. As well, most falls experienced by home care clients are not witnessed or reported. Because a history of a previous fall is a significant risk factor for future falls, this lack of consistent reporting makes the management and prevention of subsequent falls more difficult.

Overview

The Council of Yukon First Nations (CYFN) is the central political organization for the First Nation people of the Yukon operating since 1973 to serve the needs of First Nations within the Yukon and the MacKenzie Delta Council of Yukon First Nations. The CYFN is made up of 10 Yukon First Nations:

- The Champagne and Aishihik First Nations
- The Teslin Tlingit Council
- The First Nation of Nacho Nyak Dun
- The Selkirk First Nation
- The Little Salmon Carmacks First Nation
- The Tr'ondek Hwech'in First Nation
- The Ta'an Kwach'an Council
- The Kluane First Nation
- The Carcross/Tagish First Nation
- The White River First Nation

The **Arctic Health Research Network (AHRN)** is the first Canadian tri-territorial health research network linking northern regions and comprising health research centers in the Yukon, Northwest Territories and Nunavut. With a mandate to improve health outcomes through research, this network is, and must be, a community driven, northern led, health and wellness research network that facilitates the identification and action on health research priorities in the three territories. The network in each Territory is directed by an independent Board which is responsive to Territorial specific issues and priorities. Each network maintains contact with the other networks, and also with the national and circumpolar partners.

Health Canada's First Nations and Inuit Health (FNIH) Branch–Northern Region (NR) has responsibility for all Health Canada initiatives and activities in the NWT, Nunavut and the Yukon. The NR works closely with the Territorial governments of Nunavut and the NWT who deliver home and community care and health promotion and prevention initiatives on behalf of Health Canada. In the Yukon, FNIH funded programs flow directly to First Nation communities.

In November 2008, the Arctic Health Research Network-Yukon (AHRN-YT) hosted an Injury Prevention Workshop to examine current practice and impact to individuals, families and the health care system. It was recognized that there was no formal or consistent method of dealing with falls, especially for Yukoners living in the small communities outside of Whitehorse.

Pursuant to the workshop, Yukon First Nations Home and Community Care (HCC) program and the AHRN-YT worked with Dr. Vicky Scott, Senior Advisor-Falls & Injury Prevention, from the B.C. Injury Research and Prevention Unit, to examine fall prevention in Yukon First Nations communities. Dr. Scott was known to the group for her work on falls prevention which includes the Strategies and Actions for Independent Living (SAIL) project currently in place across British Columbia. This is an evidence-based fall prevention program for clients of home support services. As part of the SAIL program, clients implement a *Checklist and Action Plan for Falls Prevention* to monitor and modify their individually identified fall risk factors.

Dr. Vickie Scott is working to address the issue of falls and related injuries among seniors through collaborating for change in policies and practices. Dr. Scott's work has resulted is a statistically significant reduction in fall-related hospitalizations and deaths for seniors in B.C.

In March 2009, Dr. Scott participated in a three day conference held in Whitehorse, attended by 25 First Nations HCC workers from across the Yukon, where she presented the *SAIL Checklist and Action Plan* for falls prevention. As part of this presentation an Occupational Therapist (OT) from the Yukon Home Care (YHC) program provided information and education on falls prevention to participants.

Implementation

Between 25 per cent and 75 per cent of falls in older people involve an environmental component. It is well known that a number of hazards in the home and environment contribute to falls and related injuries and that these factors interact with other risk factors, such as poor vision or balance, to compound fall-related risk for seniors.

To address this evidence, in April 2009, the fall prevention *Checklist and Action Plan* was adapted with permission from Dr. Scott, to ensure it was as useful in the Yukon as possible. Yukon specific adaptations were achieved through the expertise of Dr. Scott and the knowledge of HCC workers, ensuring relevancy.

Utilizing a collaborative, multi-stakeholder approach (including front line staff), the *Checklist and Action Plan* was reviewed for relevance and applicability for Yukon First Nations rural communities. This transparent and participatory process, involved numerous stakeholders during all stages of review and revision.

The resultant "*Checklist and Action Plan: Yukon First Nations Version*" was distributed by the AHRN-YT to each of the 14 First Nations Health and Social Directors in the Yukon with a request for feedback to ensure that the information, writing style and content would meet the target audience of clients / family and health care workers.

The final "*Checklist and Action Plan: Yukon First Nations Version*" incorporates both the identification of risk factors and an action plan targeted to the client/family member and written to enable the client to complete it on their own or with the help of a family member or their Home and Community Care Coordinator or Home Care Worker.

The *Checklist and Action Plan* guides the client/family to review these factors as they apply to their daily living routines and includes assessments of the sleeping arrangements, living and sitting room areas, bathrooms, dining and kitchen areas. Additional factors that are included in the Checklist and Action Plan are:

- Clothing and footwear
- Personal safety and equipment
- Physical and social activity
- Health management
- Outside the home hazards:
  - garden paths/walks that are cluttered and cracked
  - walkways slippery from rain, snow or ice
  - entrance stairs and poor night lighting.

The falls prevention approach includes a combination of assessment and interventions that focus on the home setting, exercise, health management, assistive and protective devices, and other factors outside the home.

In April 2009, the Yukon Home Care program convened a meeting for Yukon Home Support Workers (HSWs). In support of the utilization of the *Checklist and Action Plan*, training was provided on falls prevention by a Yukon Home Care Physiotherapist (PT) and Occupational Therapist (OT). Participants were provided information on the different risks factors involved in falls and steps to correct these factors, including consulting with and/or referring to other health care providers.

The Home and Community Care Coordinator (HCCC), Home Care Workers (HCW) and Home Health Professional (HHP) are encouraged to assume the role

of coach and provide information about resources and actions to support client decisions. These individuals act as "cheerleaders" and encourage the client / family to continue their ongoing assessment and actions to ensure a safe living environment.

The intention is to promote the *Checklist and Action Plan* as a tool whereby the HCCC/HCW/HHP signs and dates each section once the client has completed it, and answers any questions the client may have. The *Checklist and Action Plans* are presented to the client as an "ongoing" process, and the HCCC/HCW/HHP asks the client which section they want to start with and joins the client in identifying and discussing potential risks.

The "tips" and "reminders" located throughout the *Checklist and Action Plan* provide important information and reinforcement for clients / families. If the client and/or family do not want to make a change, their decisions are respected. The home care staff will try to ensure they are making an informed decision, provide them with information and let them know who to contact if needed.

In May 2009, the Yukon Home Care Regional Therapies Program was encouraged to follow up with Home and Community Care Program staff during their visits to communities outside of Whitehorse. This joint follow-up provided an opportunity to observe the *Checklist and Action Plan* in operation and reinforced the approach in policy and practice throughout the region. Some of the larger communities receive therapy visits three times a year, and the smaller communities are usually visited once a year by PT and OT. Once the initial training and review was completed, the final version of the *"Checklist and Action Plan: Yukon First Nations Version"* was produced and distributed to all First Nations Home and Community Care programs.

Outcomes

The Yukon Falls Prevention Program was developed within a context of continuous quality improvement, where improvements to the tools and application are the result of regular feedback from the clients, management and frontline staff. Feedback was obtained from the Home and Community Care Coordinators, Regional Therapists and HSWs and a reflective process was conducted to determine areas of improvement and actions plans for the team. The feedback revealed two key focus areas:

- **Increased Awareness of Falls Prevention** - The *Checklist and Action Plan* and other initiatives have raised the awareness of the importance of fall prevention amongst the HCC programs.

- **Need for Reinforcement of the Tool** - As a result of the feedback received, it was determined that the HCC Coordinators had either not received the *Checklist and Action Plan* or had it but were not actively using it at the this time.

While the *Checklist and Action Plan* is not currently being used as it was originally intended, the Yukon Home Care Program continues to work with the First Nations programs and other organizations to educate and raise awareness around the issue of fall prevention.

Based on the feedback and reflection the following actions will be undertaken by the team:

Reflections

- The Checklist and Action Plan may be too lengthy and detailed for HSWs to use for individual client assessments at this time.
- The Checklist and Action Plan will be a valuable document to be used for continued HSW training.
- The Checklist and Action Plan may be used as a tool for the regional therapists to teach frontline workers either in a group setting or on a case by case basis.
- The Checklist and Action Plan will be an excellent resource for HCC programs.
- The results of the collaboration between YHC, First Nations HCC, AHRN-YT and other organizations have already spread to support other fall prevention initiatives in Yukon communities.

Actions

- The YHC program will be partnering with First Nation HCC programs and the Yukon Health Promotion unit to look at how to modify the Checklist and Action Plan to make it functional for HSWs.
- Utilization of the document in training programs. The YHC program Community Liaisons will be assisting with continuing fall prevention education.
- The Checklist and Action Plan may be used as a tool for the regional therapists to teach frontline workers either in a group setting or on a case by case basis.
- YHC therapists will model use of the Checklist and Action Plan on client home visits to find a better match between teaching methods and HSW learning styles.
- Distribution of bound copies of the Checklist and Action Plan to First Nation Health Directors.
- Continue working collaboratively to provide a fall prevention program that is accessible and meaningful to all Yukoners.

Conclusion

The success of any strategy is dependent on the effective leadership and active involvement of key shareholders who have the ability to build on the existing strengths and capacities within each setting. Programs are most successful when agencies integrate fall prevention projects into their broader organizational structure and goals, so that fall prevention initiatives can, in turn, support the general missions of the organizations.

The successful partnership of the First Nations Home and Community Care, the Yukon Home Care Program, the Council of Yukon First Nations and the Arctic Health Research Network-Yukon means Yukoners will be receiving safe, quality care in the homes in a way that would not have been possible without this collaboration. This project raised awareness of the importance of fall prevention with front line workers and the value of collaboration with the management and leadership of the organizations. While change is often slow, and must happen at a community level in order to be meaningful and lasting, the Yukon Home Care Program is committed to continuing to work together with the First Nations Home and Community Care Program and other community organizations to keep people healthy and safe in their homes. Staff in the Home Care program are excited to be partnering with the Health Promotion Unit to deliver community based fall prevention intervention pilot projects in Whitehorse and two communities in 2010.

"While change is often slow and must happen at a community level in order to be a meaningful and lasting; a successful partnership based on collaboration and trust ensured we realized our goals."

Sources

Public Health Agency of Canada, 2005, "Report on Seniors' Falls in Canada"

B.C. Injury Research and Prevention Unit, 2005, "Environmental Scan: Seniors and Veterans Falls Prevention Initiatives in British Columbia"

Council of Yukon First Nations website: http://www.cyfn.ca/home

Arctic Health Research Network –Yukon website: http://www.arctichealthyukon.ca

Yukon Collaboration on Falls Prevention Poster Presentation

British Columbia Region

British Columbia First Nations represent a broad range of cultures from northern and interior to coastal groups located throughout the region. The Indian and Northern Affairs Canada (INAC) website states that "BC has the greatest diversity of Aboriginal cultures in Canada. For example, seven of Canada's 11 unique language families are located exclusively in BC– more than 60 per cent of the country's First Nations languages." INAC also reports that 198 of Canada's 615 First Nations are located in British Columbia.

Unlike other parts of Canada, treaties were not negotiated with most of the First Nations of the region. The Treaty Negotiation process is a priority for First Nations, Federal and Provincial Governments. The BC Treaty Commission reports that negotiations are underway with 60 First Nations in the BC treaty process. Because some First Nations negotiate at a common table, there are 49 sets of negotiations.

Another BC Regional distinction is the signing of the Tripartite First Nations Health Plan which occurred June 11, 2007. The signatories of this document are the Federal, Provincial and First Nations represented through the First Nations Leadership Council (FNLC). Since then the First Nations Health Society has been formed and represents the FNLC in the tripartite process.

It is within the context of diversity and a tripartite approach to planning and delivering services that the First Nations and Inuit Home and Community Care Program is delivered in BC Region. 106 Contribution Agreements provide funding for 193 community home care programs. The programs employ approximately 90 Registered Nurses and Licensed Practical Nurses and 170 Personal Care Aides in communities ranging in size from (approximately) 25 to 2500 people.

First Nation Communities in the region are eligible to apply for program funding and once an approved plan is in place can provide a wide range of services to the residents including home care nursing, care planning and case management, personal care and community based supportive activities such as physiotherapy, adult day care and palliative care. Each plan recognizes the way in which each community is unique and each strives to be culturally appropriate based on community identified needs and priorities.

The BC Regional FNIHCCP team supports communities to deliver their programs by providing consultation services including policy and program advice, assistance with recruitment and retention of nurses, training and educational programs for nurses and personal care aides and site visits to assist community health staff with program review and to acknowledge the success of the program at the community level.

Prepared by Elizabeth Pearce, RN BSN, Regional Home & Community Care Manager, FNIH - Health Canada

Admissions	**4461**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	9%	**1%**	**3%**	**46%**	**25%**	**16%**
Hours of Service Delivered: 350,640	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	13%	**27%**	**1%**	**10%**	**3%**	**59%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	6%	**19%**	**34%**	**22%**	**19%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Pathway to Wellness

A Life Long Journey

The *Pathway to Wellness* is a holistic approach to chronic disease management and prevention, implemented in the Tsleil-Waututh Nation.

Special Thanks

Ruth Springate-Ditchburn, RN, Bmp – Community Health Nurse, Tsleil-Waututh Nation

Background

The prevalence and impact of chronic conditions in Canada, and the world, poses a significant challenge to individuals, communities and health systems.

According to the World Health Organization, the burden of chronic disease has major adverse effects on the quality of life of affected individuals; causes premature death; creates large adverse, and underappreciated, economic effects on families, communities and societies in general.

Nine million adult Canadians report having at least one of seven high-prevalent, high-impact chronic health conditions: arthritis, diabetes, cancer, chronic obstructive pulmonary disease, heart disease, high blood pressure, and mood disorders. The statistics paint a clear picture of the urgent need to take action to halt and reverse the growing threat of chronic diseases.

To a great extent, chronic health conditions are rooted in the way we live and many conditions can be avoided and/or managed by focusing on risk factors that individuals can control – weight, physical activity, eating habits, and smoking.

Research shows that the individual living with a chronic condition is best positioned to manage his own health.

Overview

Located on the north shore of Burrard Inlet near the neighbourhood of Deep Cove, British Columbia, the Tsleil-Waututh Nation is a supportive and progressive community.

The territory encompasses 720 square miles of land from Mt. Garibaldi in the north, Coquitlam Lake in the east, the Fraser River in the south and Howe Sound in the west. The nation is a small but growing community of almost 500, with about half the population living on Burrard Inlet Indian Reserve in North Vancouver, and the balance living off the reserve.

The Tsleil-Waututh Nation is governed by one Chief, four elected councilors, and a traditional family-based system of representation by all nine family groups (known as traditional council).

The health budget for this band is developed on an annual basis from the allotment from Health Canada, submitted by Health Supervisor to the Health Director and sanctioned by the Chief and council.

As part of the annual health evaluation and planning process in 2007, a number of health clinics were organized to gather information on the Band members' health. The clinics were held in the Band office or local gym and each clinic addressed a specific health

condition (i.e. osteoporosis, diabetes, heart disease, arthritis). Individuals underwent clinical testing, completed self-assessment questionnaires and were interviewed by Clinical Specialists.

With over 80% of the Band participating (children and infants were not involved), the results of the clinics showed that chronic illnesses were affecting the overall population.

- Obesity was prevalent in all age groups.
- Diabetes was identified in 90 per cent of the Elders and 70 per cent of the young adults–type II with many members on insulin and oral medication.
- Cardiovascular disease was identified in 85 per cent of band members.
- Arthritis was identified in all the Elder population.
- Osteoporosis – bone density testing revealed that 95 per cent of individuals tested in the 30 to 40 age group (male and female) had already developed osteopenia.

After reviewing the clinic findings and through community consultations, the Community Health Director and Health Nurse identified that a holistic approach to healthy living was needed to support chronic disease management and prevention for the members of the Burrard Indian band.

Based on the clinic results and using a holistic approach to chronic disease management and prevention, the *Pathway to Wellness* program, was created by R.E.A.D HEALTH SERVICES, and implemented in the Tsleil-Waututh Nation.

The community members and Council endorsed the establishment of the program and reinforced that a holistic approach should encompass:

Spirit: allowing for spiritual interaction and soul searching within this close knit community

Mind: activities for interaction from pre-school children to Elders

Body: adopting a comprehensive approach to health and wellness including immunization, clinical care and services for general health issues

Physical Activity: encouraging all age groups to participate in the community and enjoy the beautiful outdoors.

Implementation

Through funding support from the Health Department, the initial Pathway program commenced on January 1, 2008. This pilot phase included seven individuals who underwent an initial assessment, teaching session and were provided with the necessary support tools. Six individuals successfully concluded the pilot while one individual felt that they were not ready to make the ongoing commitment and chose to reassess and possibly participate at a future time.

Program Elements

Commitment

The collaboration and involvement of the individuals and their families are critical in each step of the program. Initially, the individual who wishes to embark on the *Pathway to Wellness* is asked to undertake a realistic assessment of their current health status and their willingness to participate in the program.

Specific questions, such as "Are you willing to give two weeks to see a change in your health for the better" or "Are you willing to give another four weeks to follow your *Pathway to Wellness* are posed to the potential client so they are aware of the commitment they are making.

Additionally, a minimal financial commitment is made by the band for each individual to reinforce their participation in the program.

Planning

Based on an individual health baseline, each program is customized with realistic goals for the client. To ensure a clear understanding of the pros and cons about beginning the journey, a discussion is held with the client during the planning stage. The client then signs a contract with themselves to reaffirm their direction and desire to take the Pathway.

Teaching

The program incorporates a series of one-on-one teaching sessions (initial session – 1 hour/subsequent sessions – 20 to 30 minutes) and a self-education manual to provide information and advice for each individual beginning the Pathway. Information on food types, body changes, energy gain, exercise, wellness and "bumps in the road" are included in the packages and discussions. Detailed questionnaires are completed to help individuals understand hormone changes and how they affect weight loss/gain.

Lifestyle Coaching

This element includes information on menu/food choices, portion control, seven (7) day meal planning, shopping tips, vocabulary, recipes, and journal keeping. Each piece of the coaching approach builds knowledge and confidence for the client to support their new lifestyle and ensure sustainability of the program and achievement of their long-term goals.

"Bumps in the Road"
The program describes a number of personal hurdles that individuals may encounter during their six week journey. The "bumps" may include lack of understanding or support from their family, success planning, shopping, social events to name a few. Each "bump" is discussed with the individual and possible solutions are developed to ensure a steady and smooth road ahead.

"You sure have the community talking about this lifestyle program. Everyone from the chief down is chatting about it."

–Program Participant

While the *Pathway to Wellness* is unique for each individual, the participants are typically involved in the following:

- Completion of a health history and signing of the "self" contracts
- Acceptance of a Registered Nurse as their personal coach for the duration of the program
- Completion of detailed questionnaires and discussion to impart information
- Completion of a "calcium sheet" and follow-up (RN contacts the pharmacist to ensure compatibility of recommended vitamins or minerals)
- Review of *The Food Guide for First Nations, Inuit and Metis Canadians* so participants can enjoy traditional foods and include them in their health regime
- Two bottles of 100 per cent pure cranberry juice and phylum husks are provided in initial kit for Wellness cocktails
- Daily journaling: exercise, body functions, supplements, food and fluid intake and inspirational and motivation thoughts.

In addition to the participant manual, a user friendly information kit is provided to each participant. The kit includes a:

- Convenient nylon zip carrying case for information materials
- *Pathway to Wellness* "At a Glance" calendar to assist in scheduling appointments and recording goal achievement
- Writing pen with rotating program "cues" to reinforce positive behaviors
- *Pathway to Wellness* mouse pad for additional cuing for participants who utilize computers (targeted to youth participants).

Based on the principles of self-learning and behavior modification, the *Pathway to Wellness* program incorporates two key approaches:

1. Customization
This stage includes an initial consultation with a Registered Nurse to gain an understanding of an individual's medical history, body measurements and blood readings (blood glucose, cholesterol) to form the basis of a customized *Pathway to Wellness* which will meet the unique needs and requirements of the individual.

2. Goal Monitoring & Coaching
Six weekly visits to a Registered Nurse who measures the client's weight and inch loss, and discusses goal setting and achievements for the upcoming week. On the seventh and last visit on the program, a full complement of body measurements and blood tests are completed again, and are shared with the client and compared to the client's overall goals.

The program is designed to optimize each individual's health within their own context and as part of their home and community living. Through customized goals and on-going coaching, the program educates individuals on the habits of healthy eating and exercise. The results are long-lasting behavior modification and ultimately an increase in overall health and well-being and a decrease in health care visits and expenses. The keys to this successful program are the phased approach to learning and the focus on lifestyle changes as opposed to "dieting" or "quick fixes". The program motto is "Eat to Live, Not Live to Eat.

Through customized goals and on-going coaching, the program educates individuals on the habits of healthy eating and exercise.

Outcomes

The results of the *Pathway to Wellness* program have exceeded the community and health professionals' expectations. Individuals, families and the community have all benefited from the program.

- 20 per cent community participation rate in a community of 500 people.
- 20 per cent of referrals to the program originated from the community physician.
- 75 per cent of successful participants have maintained their health objectives for over 24 months.
- In the first four months of 2008, the number of visits to the health nurse for cold medication, chronic pain issues and depression decreased by 80 per cent and in 2009 the number decreased by 75 per cent.
- Inches faded away from all successful participants, with one individual losing 55 inches overall in the six weeks (appropriate for the size).
- The local day care facility has incorporated a "healthy snack" day.
- Community meetings are serving healthy snacks and water instead of the usual doughnuts and pop/coffee.

Conclusion

The *Pathway to Wellness* program is a holistic, self-management program that incorporates an aboriginal lifestyle within an urban setting. The people of the Tsleil-Waututh Nation, situated in North Vancouver, have embraced a healthy lifestyle in their homes, their workplaces and their community. Led by the Health Supervisor and the Community Health Nurse, the R.E.A.D *Pathway to Wellness* program has proven that by empowering individuals with knowledge, passion and commitment, an impactful change can happen.

The people of the Tsleil-Waututh Nation are continuing on their *Pathway to Wellness* as more and more community members learn about the program and the positive effects on participants. The Pathway program encouraged participation from all ages and many elders embarked on the journey to improve their overall health. Young adults in the community are becoming aware that wellness is a journey and healthy living and eating results in healthy minds and bodies. The Health Department is committed to this program, and along with the immunization program, the *Pathway to Wellness* program will play a large part in encouraging community members to take charge of their health and wellness needs.

"The *Pathway to Wellness* program is a holistic, self management program that incorporates an aboriginal lifestyle within an urban setting."

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www.burrardband.com

Alberta Region

The Alberta region is divided into three Treaty areas, which are further divided into communities, tribal councils and/or independent bands. However, the most commonly used data sources, Health Canada, Indian and Northern Affairs Canada (INAC) and Statistics Canada, do not all identify the same number of communities in each Treaty area. For the purpose of this document, the working number of communities is defined as 45 and includes:

Treaty 6 - located in central Alberta and consists of the following 17 communities: Alexander, Alexis, Beaver Lake, Cold Lake, Enoch, Ermineskin, Frog Lake, Heart Lake, Kehewin, Louis Bull, Montana, O'Chiese, Paul, Pigeon Lake, Samson and Sunchild. Treaty 7 – located in southern Alberta and comprises the communities of Big Horn, Blood, Eden Valley, Piikani, Siksika, Stoney and Tsuu T'ina. Treaty 8 – located in the northern part of Alberta and includes 21 communities: Athabasca Chipewyan, Atikameg, Beaver, Bigstone, Dene Tha', Driftpile, Duncan, Fort McKay, Fort McMurray, Horse Lake, Janvier, Kapawe'no, Little Red River, Loon River, Mikisew, Sawridge, Sturgeon Lake, Sucker Creek, Swan River, Tall Cree and Woodland Cree. Two communities are not included on this list: Smith's Landing, which recently received the status of reserve, and Lubicon which is negotiating recognition as a reserve.

There is great cultural diversity within First Nations communities in Alberta and a broad range of languages spoken. The most common First Nations languages in Alberta are Blackfoot, Cree, Chipewyan, Dene, Ojibway, Sarcee and Stoney (Nakoda Sioux). INAC's Indian Registry shows that 39 per cent of the First Nations registered to Alberta bands are registered to bands in Treaty 6, 26 per cent are registered with bands within Treaty 7 and 35 per cent are registered to bands in Treaty 8. While INAC's Indian Registry also provides residence information to indicate whether an individual is residing on-reserve, on crown land or off-reserve, the data is typically registered at major life events and its accuracy may vary by community. As of December 31, 2008, the Indian Registry for Alberta indicates that 43 per cent of First Nations living on-reserve are Treaty 6 members, 31 per cent are Treaty 7 members and 26 per cent are Treaty 8 members. In comparing statistics, it appears that while the number of individuals registered to Treaty 8 bands is significantly higher than for Treaty 7, its on-reserve population is actually lower than that of Treaty 7.

The 2005 Indian Registry indicates a slightly higher proportion of First Nations living on-reserve (65 per cent) as compared to the 2006 Census (59 per cent). The majority of First Nations who live on-reserve in Alberta live in larger communities. In fact, 67 per cent live in the eleven on-reserve communities with a population over 1,500 and 83 per cent live in on-reserve communities with a population over 1,000. This high proportion of First Nations living in larger on-reserve communities in Alberta is atypical as many other provinces have a very different population distribution. For example, while a similar number of First Nations individuals live in both British Columbia and Alberta, there are five times more First Nations communities in British Columbia (over 200) than in Alberta (45).

Prepared by Lorene Weigelt, Regional Coordinator, Home and Community Care First Nation Inuit Health, Alberta Region

Admissions	**2927**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	21%	**3%**	**6%**	**39%**	**26%**	**5%**
Hours of Service Delivered: 169,260	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	30%	**30%**	**2%**	**8%**	**0.6%**	**29%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	6%	**25%**	**31%**	**20%**	**18%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Wound Management Program

The *Lower Leg Assessment Pilot* – development of a comprehensive assessment to reduce the number of lower leg amputations in First Nations people in Alberta.

Special Thanks

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Background

The prevalence of venous leg ulcers amongst First Nations communities in Alberta is not known; however First Nations home care nurses were concerned by the increasing numbers of clients with leg ulcers that would not heal and the increased numbers of individuals undergoing amputations. Data obtained from Alberta Health and Wellness showed a dramatic increase in the number of amputations amongst First Nations populations in the province between 1999 and 2005. The numbers had doubled – from 32 to 64.

Venous ulcers remain the most common type of lower limb ulceration. Venous leg ulcers are a chronic and recurring problem that can be very costly to the health care system and can significantly impair the quality of life of those who suffer from them. A number of factors are associated with venous disease. These include: advanced age, female gender, varicose veins, deep vein thrombosis, reduced mobility, pregnancy, previous surgery, limb fracture or trauma, social isolation, and a family history of leg ulcers.

Compression therapy remains the "gold standard" for the management of venous ulcers. However, the presence of venous disease does not imply that an ulcer is of purely venous etiology. The individual may have a co-existing arterial disease or the presence of another etiological factor that is responsible for the ulcer. Consequently, it is essential that before compression therapy can be initiated, assessment by trained and experienced health care professionals is done to determine how much compression can be applied.

A program to provide home care nurses with the skills and knowledge to assess the ulcers and initiate appropriate treatment, including compression therapy, was planned. A proposal was developed to introduce a pilot project in remote communities and/or communities with a high incidence of lower leg ulcers. The objective of this project was to provide timely and accessible comprehensive lower leg assessment in First Nations communities and reduce the number of lower leg amputations.

Overview

The comprehensive *Lower Leg Assessment Pilot* was conducted in four First Nations communities in Alberta-Saddle Lake, Cold Lake, Little Red River, and O'Chiese. These communities were selected based on the prevalence of leg ulcers within the community; the interest by members of the community to participate; and, the limited access to health care – primarily because of distance.

Saddle Lake is a settlement in central Alberta. It is located on the Saddle Lake 125 Indian Reserve and is governed by the Saddle Lake Cree Nation. The population is 5883.

Cold Lake First Nations is a Denesuline (Chipewyan) Tribe and part of the Dene nation. It is located 300 kilometres northeast of Edmonton and has a population of 1232.

The *Little Red River* Cree Nation is located about an hour and a half east of High Level in Northern Alberta. It is composed of three communities: Fox Lake (where the majority of the population resides, but has no year round road access), John D'or Prairie (the administrative centre) and, Garden River, which is within Wood Buffalo National Park. The population is approximately 3,161 members.

The *O'Chiese* First Nation is a Saulteaux First Nation located approximately 23 kilometres northwest of Rocky Mountain House. The population is 954 of which 644 live on-reserve where the primary language spoken is Saulteaux.

Implementation

Having secured approval and funding to launch the *Lower Leg Assessment Pilot*, a Project Charter was developed. The scope of the initiative was defined to:

- Purchase handheld dopplers necessary as a key component to the lower leg assessment.
- Identify communities with greatest need according to established criteria.
- Develop an education program as it is vital for clinicians to be able to distinguish between venous and nonvenous ulcers because treatment methods and nursing care differ greatly. The bandages applied for treating venous ulcers can have serious adverse affects if applied inappropriately or incorrectly to arterial ulcers.
- Develop a mentorship program so that nurses would feel confident and supported to conduct the lower leg assessment and determine the appropriate compression therapy.
- Introduce a limited product formulary.
- Develop client teaching tools so that they can maintain the care of their legs and reduce the rate of recurrence which is highly likely - 90% have an ulcer reccurrence (Sibbald, et al (2006) primarily due to complacency related to prevention strategies. To prevent ulcer recurrence clients require life-long compression therapy.

> The collaborative project engages each community through the active involvement of community home care nurses in addition to the Nurse Advisor and other stakeholders.

The Project Team was assembled and an Implementation Plan was developed. Membership on the working group included a home care nurse from each community participating in the project, a home care Nurse Advisor, and additional ad hoc members as required.

The *Lower Leg Assessment Pilot* objectives were to:

- Provide timely and accessible services in First Nations communities.
- Reduce the risk of lower leg amputation in First Nations communities.
- Develop and increase capacity of regional programs.
- Strengthen the knowledge base of health care professionals in First Nations communities.

Education and communication tools were created; and physicians were apprised of the pilot as their support for the treatment plan was essential. Few family doctors see sufficient numbers of clients with leg ulcers to develop extensive expertise with this group of clients and hence their trust in the training and support of the Clinical Nurse Specialist certified in wound management was sought.

The initiation of the Pilot was delayed by the onset of H1N1 management programs but got underway early in 2010.

Assessing the Lower Leg

There are three major factors that can delay ulcer healing:

1. Ulcer size
2. Ulcer pre-treatment duration
3. Limb mobility

Interpretation of Vascular Assessment

ABPI	Toe Pressure	Ankle Waveform	Diagnosis
> 0.8	> 80 mm Hg	Normal/Triphasic	No arterial disease
> 0.6	> 50 mm Hg	Biphasic/Monophasic	Some arterial disease: Modify compression
> 0.4	> 30 mm Hg	Biphasic/Monophasic	Arteial disease predominates
< 0.4	< 30 mm Hg	Monophasic	High risk for limb ischemia

ABPI may be falsely elevated in the presence of calcification.

Before initiating therapy for venous ulcers, a comprehensive lower leg assessment must be conducted. The Alberta First Nations Home Care Comprehensive Lower Leg Assessment Form was adopted. The form is only two pages and uses a lot of "check boxes" to guide the clinician and ensure the comprehensiveness of the assessment and the documentation thereof.

Many clients are coping with several other chronic illnesses in addition to the leg ulcer. These comorbid conditions can negatively influence the healing of the ulcer and will impact the treatment approach. The application of high compression bandaging is the "gold standard" for the treatment of venous leg ulcers but the decision to use compression (and which level of compression) must be balanced in the context of the entire client assessment. The assessment includes a:

- Thorough medical history, including social and psycho logical status; skin and wound history, venous history
- Listing of current medications
- Physical exam
- Mobility assessment
- Visual and Doppler bilateral leg and foot assessment, including monofilament testing; ankle-brachial pressure index (ABPI) and toe pressures.

Diagnosis

Following assessment, a leg ulcer is assigned using the International Leg Ulcer Algorithm developed by the European Wound Management Association as follows:

- Uncomplicated venous ulceration – an ulcer occurring in the presence of venous disease in a limb with an ABPI >0.8 and no other significant medical diseases that would prevent the use of high compression therapy.
- Complicated venous ulceration – an ulcer occurring in the presence of venous disease in a limb with an ABPI <0.8 or with other significant medical diseases that would prevent the use of high compression bandages or may complicate management. This includes mixed arterial and venous ulcer (moderate arterial insufficiency with an ABPI 0.5-0.8). In a normotensive individual an ABPI 0.5 equates to an ankle systolic pressure of 65-75 mmHg and at such pressures high compression bandaging is potentially unsafe.
- Mixed arterial and venous ulcer – severe arterial insufficiency with an ABPI<0.5
- Arterial ulceration
- Other causes of ulceration such as congestive heart failure, renal insufficiency and morbid obesity.

Launching the Pilot

Home care nurses (RNs and LPNs) were selected to participate in the *Lower Leg Assessment Pilo*t. They were provided with a two day educational program to provide the requisite theory and practical application to prepare them to conduct lower leg assessments, select the appropriate compression therapy and apply a variety of compression wraps. Case studies reinforced the learning.

The participants are also required to participate in an ongoing mentorship program with a certified wound specialist employed by First Nations and Inuit Home and Community Care Program. A component of the mentorship requires that each nurse conduct at least two client assessments with the support of the Clinical Nurse Specialist – in person or via video conference. Staff guidelines for setting up a video conference in the home and an information letter with instructions for clients and their families have been established.

Based on the assessment, the nurse contacts the physician to discuss the type of treatment to be adopted. The expertise of the Clinical Nurse Specialist regarding compression therapy is leveraged so that more clients can benefit from this efficacious approach.

Outcomes

The nursing staff was enthusiastic about the program and eager to begin application of their knowledge in the clinical setting. The post educational evaluation was positive. Participants have been delayed in applying their learnings due to other priorities arising within the communities.

Evaluation is a component of the Pilot and will include measuring the following criteria. The number of:

- Home care clients requiring comprehensive lower leg assessment
- Comprehensive lower leg assessments completed by home care staff
- Lower leg ulcers within the community
- Comprehensive lower leg assessments conducted within the community
- Referrals to vascular specialists
- Clients treated with compression therapy
- Lower leg amputations.

Qualitative feedback from home care clients, their families, the home care staff and physicians will also be captured.

An important lesson from this work has been to recognize that it cannot be rushed. It will be introduced when the communities are ready.

A strength of the First Nations communities in Alberta is the extent of their commitment to the needs of their members. The culture is to apply their full attention to priorities and embrace a shared ownership of issues. A single matter may impact the community as a whole or by extension. Accordingly, concerns such as the potential H1N1 epidemic and a sudden death of a community member have been cause for pause and re-adjustment of timelines.

Key Success Factors

- A nurse champion with experience and influence
- Education
- Ongoing mentorship and access to expertise via telephone and video
- Appropriate equipment
- Communication and physician engagement

As of March 2010, there have been two videoconference sessions that were very successful. Feedback from the clients was positive and they were pleased to be able to have this service in their community.

Next Steps

The literature is quite conclusive about the effectiveness of comprehensive lower limb assessments and compression therapy. However change in practice takes time. The intent is to make the program available to other communities, taking advantage of the lessons learned through this Pilot.

Conclusion

The home care nurse is a crucial member of the health care team; and given the location of many recipients of home care, often functions as the eyes and ears for the medical staff. An accurate and comprehensive history and assessment means that clients with lower limb ulceration can benefit from proper management. This means that their wounds heal faster and they are equipped with the knowledge to prevent recurrence. Proper management also contains costs by healing wounds faster.

"A strength of the First Nations communities is the extent of their commitment to the needs of their members."

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Saskatchewan Region

Through the federally funded First Nations and Inuit Home and Community Care program, the First Nations of Saskatchewan offer a wide range of important health services to 82 diverse communities. These communities include five distinct Tribal groupings: Cree, Saulteaux, Sioux, Dene, and Ojibway. First Nation communities can be found throughout the province, to the borders of the far north, the south and right to the neighbouring borders of Alberta and Manitoba. All Saskatchewan First Nation communities are rural and many are remote or isolated. The population served in these communities ranges from less than 20 to over 2500 people.

There are over 30 First Nations health organizations in Saskatchewan who employ over 320 health care providers to deliver home care services in First Nation communities.

The history of First Nations home care in Saskatchewan is really fascinating as it truly was way ahead of its time. With the leadership of the Federation of Saskatchewan Indian Nations (FSIN), and the passion of dedicated community health care professionals, First Nations sowed the seeds of a home care program late in the 1980's. Collaboratively, Health Canada and the department of Indian and Northern Affairs supported early efforts of Saskatchewan First Nations and saw communities actually delivering home care services as early as 1991, a full decade ahead of the FNIHCC agenda, before most First Nations across Canada. This group of pioneers has continued, through the FSIN Home Care Working Group, to lead many progressive and supportive pieces of work such as: policies for client care and program administration; Home Health Aide training programs; education for nurses; client record systems; and client safety tools.

A grassroots approach continues to advance high quality home care services in a consistent way throughout the 82 First Nations communities of this province.

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Admissions	**4853**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	11%	**1%**	**6%**	**34%**	**34%**	**14%**
Hours of Service Delivered: 196,608	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	17%	**10%**	**1%**	**12%**	**0.6%**	**60%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	5%	**28%**	**33%**	**19%**	**16%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Client Safety

in First Nations Home and Community Care

A collaborative approach to the development of policies and procedures in seven patient safety areas based on Accreditation Canada's Required Organizational Practices.

Special Thanks

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Background

Establishing and maintaining clear written policies and procedures is one of the key components of a high performing health care organization. Well written policies and procedures allow employees to understand their roles and responsibilities within predefined limits - be they professional, clinical or operational. Policies provide direction as to how to handle issues as they arise. Procedures provide the reader with a clear and easily understood plan of action required to carry out or implement a policy. A well written procedure helps to eliminate misunderstandings and to facilitate consistency by all staff.

The First Nations and Inuit Home and Community Care Program fosters a climate of continuous quality improvement, seeking to enhance client safety across all the communities it serves. In Saskatchewan, these expectations are addressed through a provincial group - the Federation of Saskatchewan Indian Nations Home Care Working Group. The Group established a sub-group tasked with developing a standardized approach to infection control. The work was, in part, the catalyst for a larger project to standardize the Home Care program's approach to client safety. The group spent another two years developing region wide policies and procedures using Accreditation Canada's 'Required Organizational Practices'.

The project involved a process of research, policy development and field testing and took over two years to complete. A two day forum was held to review the approved practices with First Nations representatives from the province.

Overview

The Federation of Saskatchewan Indian Nations (FSIN) Home Care Working Group (HCWG) is comprised primarily of home care nurse coordinators from across the province. The group was founded in 1993 and has as its mandate to promote a holistic, comprehensive Home and Community Care program that meets the

needs of First Nations in Saskatchewan. The group is comprised of representatives from Tribal Councils, First Nations Health Authorities and independent First Nations and meets bi-monthly.

In 2005 the FSIN HCWG created an Infection Control Sub-group and tasked it to develop infection control guidelines for home and community care. The Sub-group was comprised of representatives from the North, Central and South areas of Saskatchewan. The group developed a number of policies and procedures. At the same time, a "Sterilization Manual" was developed by the Home and Community Care Coordinator, STC Health & Family Services Inc. at the Saskatoon Tribal Council. This valuable resource was adopted by the Infection Control Sub-group and the FSIN HCWG for use across the Region.

It was apparent to the Infection Control Sub-group and the Home Care Working Group that in addition to infection control there was a need to address a broader array of client safety issues.

Data from the World Health Organization, many western countries and within Canada provided compelling statistics about the avoidable safety concerns within hospital and the HCWG knew intuitively that the home care environment would generate similar data. Furthermore, the FSIN Home Care Working Group had expressed a commitment to excellence and wanted to provide a standardized approach to all programs.

The Infection Control Sub-group broadened its mandate to address client safety and became known as the Client Safety Working Group (CSWG).

Patient safety is an important health care priority in Canada; however much of the focus has been on care provided in the institutional setting which does not translate to the home environment. As a relatively new program (the First Nations and Inuit Home and Community Care (FNIHCC) program was launched in 1999), there were few policies specific to the First Nations community context from which the CS Working Group could draw.

In 2008, the CS Working Group, with a mandate to provide guidance and leadership for the development of policies and procedures for FN H&CC safety issues, undertook a scan of the literature to determine an overarching approach to the work. They decided to use the Required Organizational Practices (ROP) from Accreditation Canada to enhance patient and client safety and minimize risk, as a framework for their policy development. This was important as it would add value to the many programs that are preparing for accreditation in the future. As such, the policies and procedures were organized into the seven patient safety areas:

1. Culture of Safety
2. Communication
3. Medication Use
4. Worklife/Workforce
5. Infection Control
6. Falls Prevention
7. Risk Assessment

Policies and procedures are the strategic link between the purpose and the work of the organization. They are important when there is a need for consistency in daily activities. Policies and procedures also provide clarity on issues of accountability, health & safety, legal liabilities, regulatory requirements and/or issues that have serious consequences.

Benefits of Written Policies and Procedures

- Prevent mistakes
- Facilitate consistency
- Save time
- Improve quality
- Provide confidence and clarity

Implementation

The Client Safety Working Group (CSWG) developed a work plan and identified the policies that related to each of the Accreditation Canada's Required Organizational Practices. Each member of the CSWG took responsibility for specific policies and as a group identified reference resources, including experts amongst their staff.

Typically, a scan of the literature was conducted and professional colleges and colleagues accessed as part of the development process. Using regional funds, a consultant was hired to draft specific policies identified by the Client Safety Working Group. The consultant resource was used for a short period of time and primarily served to pull together background information which the Client Safety Working Group used to develop into full policies and procedures.

> Stakeholders consulted with their respective communities to confirm applicability of the policies in a variety of settings.

The review process involved the Client Safety Working Group and the Federation of Saskatchewan Indian Nations Home Care Working Group. Members of these groups consulted with their colleagues from their respective communities as a means of testing the applicability in a variety of settings. The policy/procedure cycled through a minimum of two readings before it was finalized.

Once the policies and procedures were developed, accompanying forms were reviewed and revised or developed. The process for forms mirrored that established for the policies and procedures. Approximately 30 policies and forms were addressed through this process which took approximately two years to complete.

Policies and procedures that were developed and/or revised within the seven patient safety areas include:

1. Culture of Safety

a. Development of a written strategic priority /goal for client safety

b. Establishment of quarterly reports on client safety, including recommendations arising out of adverse incident investigation and follow up, improvements made

c. A reporting system for adverse events, near misses and sentinel events

d. A formal process of disclosure of adverse events to clients and families, including support mechanisms for clients, family, and staff involved

e. Preventive client safety analysis

2. Communication

a. Client education verbally and writing about their role in promoting safety

b. Transfer of information across care transitions

c. Medication reconciliation

d. Verification system for high risk activities

e. Establishing approved abbreviations

f. Use of at least two client identifiers prior to initiation of procedure or service

3. Medication Use

a. High alert/risk medications, including concentrated electrolytes, heparin products, and narcotics

b. Training on infusion pumps

4. Worklife/Workforce

a. Implementation of a client safety plan

b. Patient safety plan

c. Identification of roles and responsibilities for client care and safety across the care team – including

providers, leaders, family and volunteers

d. Preventive maintenance program for all medical devices, equipment, and technology

5. Infection Control

a. Adherence to infection control guidelines

b. Education/training on hand-hygiene to the entire care team, including family and volunteers

c. Cleaning, reprocessing and maintenance of equipment

d. Strategies to reduce the risk of pneumococcal and influenza disease in high risk populations

e. Hand-hygiene audit

f. Sterilization of equipment

g. Infection tracking

6. Falls Prevention

a. Establishment of a fall prevention strategy for client population and to track outcomes

7. Risk Assessment

a. Prevention of Pressure Ulcers

b. Suicide Risk Assessment

> Approximately 30 policies and forms were addressed through this process which took roughly two years to complete.

This comprehensive package of work was shared informally over the course of the two years and in some cases, out of necessity, elements were adopted. The formal presentation of the work was provided at a two day conference in January 2010. Seventy staff were in attendance to receive the comprehensive binder and participate in presentations and discussions about client safety in home care.

Key Success Factors

While recognizing the importance of policies and procedures there were several factors that enabled the CS Working Group to complete this impressive task:

- There was existing knowledge as to how to structure, review, revise and evaluate policies and procedures.
- The group supported the rationale for the work and had clarity of purpose.
- The process reflected the First Nations perspective.
- A strong process of checking with key stakeholders – clinical and administrative.
- Use of a dedicated team to launch the process.
- The process was collaborative and driven from the needs of the communities.
- There was a willingness to work to establish continuity across the Saskatchewan region.
- Funding and support from FNIH.

Outcomes

The unwritten rules and practices were documented and consistency of practice was assured through the documentation of the policies.

The Client Safety Conference provided an opportunity for 70 staff representing all 30 programs to receive the information first hand and participate in workshops to apply and test their knowledge. Feedback from the event was positive. 93 per cent of respondents rated the workshop as being “relevant” to “extremely relevant” to their learning needs.

To date the Saskatchewan First Nations Home and Community Care Client Safety Policies and Forms manual has been disseminated to all 30 programs. While the communities were consulted during the developmental process, the CS Working Group intends to

conduct an evaluation of the entire package of policies and forms within the next twelve months. The feedback will be instructive as to the need for revisions; development of additional policies or forms and to the extent by which the manuals are used.

Staff participants stated that the material covered at the conference was "all relevant to my job and speakers were excellent"; and that the policies are "very relevant for home and community care".

In the meantime the CS Working Group will work on the necessary revisions to staff orientation programs and potentially more policies. As a key component of continuing quality improvement, the Working Group anticipates that their work will continue and form a regular part of the Saskatchewan First Nations Home Care program.

Conclusion

Home care has emerged as a vital component of the overall health care system and will need to increase its capacity to serve the increasing numbers who wish to remain independent at home for as long as possible. The establishment of documented policies and procedures and willingness to adopt consistency across the Region is guaranteed to assure improved quality for the individual recipients of the home care service.

"Policies and procedures are the strategic link between the purpose and work of the organization."

Sources

Presentation at the 2009 Canadian Home Care Association Home Care Summit. Client Safety-Working Together for Safer Client Care

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Federation of Saskatchewan Indian Nations (FSIN) Client Safety Working Group. (2008) Terms of Reference

Manitoba Region

Manitoba Region is comprised of 64 First Nations communities. There are seven Tribal Councils with 49 affiliated communities and 15 Independent communities. The Assembly of Manitoba Chiefs (AMC) oversees the political and advisory aspect to 64 bands. The Southern Chiefs Organization (SCO) represents the Southern bands (36 FN) and Manitoba Keewatinowi Okimakanak represents the Northern bands (28). The population is 83,206 on-reserve and 49,087 off-reserve (SVS, June, 2009) and languages spoken are Ojibiway, Odji-Cree, Saulteaux, Dakota, Dene and Cree. There are 22 Nursing Stations which are situated in semi–remote, and/or isolated settings and 42 Health Centres which have drive-in capability within the Region.

The First Nations and Inuit Home and Community Care Program (FNIHCCP) has been in existence in Manitoba since 1999. Since that time the Program has completed Health Care Aide (HCA) training for over 300 staff and communities have continued to train and recertify Health Care Aides. Approximately one-half of these HCAs remain in the community. Licensed Practical Nurse (LPN) training was done by the program to ensure human resources were in place to deliver direct nursing care services for home care clients. LPN training continues today with different educational, private and government sectors partaking in this activity. Today there are three Regional nurses, four Tribal Nurse Coordinators, 27 RNs and 48 LPNs working in the FNIHCCP. Capital requirements around program space and health professional accommodations for the nurses were established very early on in the program. The majority of Home and Community Care (CCC) programs are located in the Health Centre or Nursing Station.

Service Delivery Plans were developed by the communities and are used as a guide for the delivery of home care services to clients. Standards, policies and procedures are in place as an added support for Homemakers/Health Care Aides and the nurses. They serve to assist staff with some administrative decision-making and provide clinical guidelines to support them in their day-to-day practice. Regular face-to-face meetings are held on a quarterly to bi-annual basis to further dialogue and share experiences with the Regional/Tribal Council/Independent Nurse Coordinators team. More emphasis is being put towards educational sessions and utilization of @YourSide Colleague (an interactive e-learning tool), webinar sessions and the utilization of telehealth for meetings and communication.

As communities now progress into more flexible funding arrangements, processes have been put in place to ensure that the essential elements of the program will be delivered on an ongoing basis

Prepared by Edna Stevens, RN, BN, Nurse Manager - Home Care, Manitoba Region, First Nations and Inuit Health Branch

Admissions	**2717**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	12%	**3%**	**4%**	**36%**	**29%**	**16%**
Hours of Service Delivered: 255,456	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	10%	**21%**	**0.3%**	**12%**	**2%**	**54%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	3%	**19%**	**33%**	**26%**	**19%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Integration of the INAC Program

The assimilation of two programs and creation of the Personal Assisted Living Support (P.A.L.S.) program.

Special Thanks

Virginia Lukianchuk, Home & Community Care Coordinator, Sandy Bay First Nation
Annie Osada, Home Care Nurse-Case Manager, Sandy Bay Home & Community Care Program

Background

Indian and Northern Affairs Canada's (INAC) Assisted Living Program is intended to support First Nations people with functional limitations (because of age, health problems or disability), to maintain their independence, to maximize their level of functioning, and to live in conditions of health and safety. Because of restrictions to the residential component of the program in 1988, INAC increased the availability of its in-home care, which provides homemaker services.

In 1989 a joint Health Canada/INAC Adult Care working group was established to support the development of a comprehensive community-based continuing care program.

The First Nations and Inuit Home and Community Care (FNIHCC) Program was announced in 1999 and implemented over the subsequent three years. The program was designed to provide core elements of a home care program building on INAC's in-home support services for the elderly; people with disabilities; the chronically ill; and, those requiring short-term acute care replacement services. The Home and Community Care Program (HCCP) builds on INAC's Assisted Living Program.

INAC's Assisted Living Program is provided under a separate policy and funding authority to that of the FNIHCC Program and accordingly in many communities the programs run in parallel with a shared intent of providing services to help people remain at home but based on separate data and funding formulae.

The misalignment of the two programs has resulted in inadequate funding and more importantly people not gaining access to the services they require in order to remain at home. To resolve these challenges, FNIHB and INAC intend to integrate their programs in the next three years. The Sandy Bay Health Centre has undertaken to prepare for this integration by beginning to link its INAC In-Home Care Services within its Home and Community Care Program at the community level.

Overview

Sandy Bay First Nation is an Ojibway Nation located 90 kilometres Northwest of Portage La Prairie, Manitoba. The community is about six square miles and abuts the western shore of Lake Manitoba. Winnipeg is 165 kilometres Southeast of Sandy Bay.

The Sandy Bay First Nation member population on reserve is approximately 4,500 with an estimated 90 per cent speaking the Ojibway language.

Health care services are provided through the Sandy Bay Health Centre. A physician provides care on site three hours per day. A Nurse in Charge (NIC) RN/BN and team of three Community Health Nurses (CHN) along with 35 various Health Care Professionals including a visiting Pharmacist, Registered Dietician and Mental Health Therapist assume responsibility for the community's health care needs. The closest hospital is in Portage.

The First Nations and Inuit Health Branch (FNIHB) Home and Community Care Program is provided through the Health Centre. The staff consists of a home and community care coordinator, case manager, two home care nurses, three health care aides, a medical equipment supply technician (MEST), an administrative assistant and a clerk. Up until April 1, 2009 the INAC Assisted Living Program In-Home Care Services were run through the Sandy Bay Ojibway First Nation Band administered Social Assistance Program.

The transfer of the INAC In-Home Care Services is a proactive community-based effort to ensure timely development toward successful integration within the next three years. Eleven In-Home Care Services staff and one In-Home Care Services coordinator clerk are impacted by this initiative.

Implementation

In October 2008 the Sandy Bay Health Centre adopted the Mustimaw Electronic Charting System from British Columbia's Cowachan Tribe. (This was accomplished as a result of participation in Manitoba's Patient Wait Time Guarantee project.) The system provided the means to obtain effective data collection; and along with provincial assessment tools, positioned the Sandy Bay Ojibway First Nations to integrate components of the In-Home Care Service with the Home and Community Care Program (HCCP) so that the home care offering is comparable and equitable to provincial programs. The evidence confirmed what staff believed – that the numbers of people needing care at home is increasing and that additional funding is required.

In order to avoid confusion with the HCCP staff the In-Home Care Service was renamed – Personal Assisted Living Support (P.A.L.S.). Prior to the transfer of the In-Home Care Services Program a considerable amount of work was done to facilitate a smooth transition. A key step was the presentation made to the frontline staff and union, the Manitoba Government Employee Union (MGEU). The nature of the change was explained and staff was reminded of the overriding objective of both programs – *to enable individuals with a chronic illness or disability to maintain functional independence in their daily activities, allowing them to remain at home and in their community.*

The transition was explained in the context of continuous quality improvement and the increasing requirement by funders for program providers to demonstrate that they are meeting the needs of their population and achieving the outcomes that were intended through the funding. And where the need is increasing, there is an obligation to the community, on the part of the program providers, to have a process for maintaining safe and reliable service within existing constraints and to present good information to support a request for additional resources.

> Quality Improvement – the process or methods that a program uses to identify needs in all aspects of its services and to make changes to improve these identified need. It also involves avoiding or minimizing the risks of danger, of loss or of injury to its clients or staff.
>
> –Excerpted from the staff presentation

The need for written policies and procedures was presented. Policies and procedures are important to assure fairness and consistency for staff and clients. They provide clarity on issues of accountability, health and safety, legal liabilities, regulatory requirements and/or issues that have serious consequences.

Staff was assured that they would continue to work and be a part of the MGEU, but that their work would be structured differently. Changes were explained in the

context of client care and employee practices.

Client Care Changes

- An assessment and review of all clients would be conducted in order to develop a care plan that articulates responsibilities for clients and families and identifies the services required for the client to remain independent.
- Specific hours of service would be assigned for the care plan.
- Documentation of the services and specific duties would be required.
- Supervision of care in the home would be conducted randomly through home visits, calls and regular review of services and outcomes.

Employee Practice Changes

- An obligation to follow the Sandy Bay Health Centre policies and code of conduct to encourage professionalism between staff and the community.
- Establishment of assignment of staff protocols including procedures for illness, vacation, leaves and coverage by relief/casual staff.
- Obligation to sign an oath of confidentiality.
- Special permission required before undertaking to drive clients anywhere.
- Obligation for ongoing training.
- Timesheets are required to be submitted on specified dates.
- The coordinator will work out of the home care office.
- Compensation would be enhanced by a benefits plan that includes short and long term disability, life insurance, retirement plan, and severance. Dental and vision packages would be optional.
- Monthly 'birthday luncheons' would be hosted to facilitate team building.

Support from management was assured and staff was reminded to report any concerns through the usual channels of immediate supervisor to manager. Regular performance feedback was assured and grounds for disciplinary action outlined. These included:

- Serious misconduct
- Habitual negligence of duty
- Willful disobedience
- Theft, fraud, or dishonestly
- Insubordination
- Excessive absenteeism despite corrective consultation
- Abandonment of client.

Staff was provided with one week of basic training prior to assignment in homes in order to bring all to a consistent level of skill and ability. Training was comprehensive and included CPR and First Aid certification, privacy and confidentiality standards through to basic infection control knowledge and techniques as well as Safe Food Handling Certificates.

Ongoing training was identified as vital to improve knowledge and skills; and enabling the ability of staff to identify a potential crisis situation and/or react appropriately and in a timely manner for the benefit of the client. Staff was advised that attendance at continuing education programs would be expected. The programs include, but are not limited to: updates on safe food handling, meal preparation, understanding diet restrictions, CPR and First Aid, pandemic awareness, universal precautions, updates on policies, confidentiality, the personal health information act, incident reporting, palliative care signs and symptoms, hypo/hyperglycemia, heart attack and stroke.

While the one week training course was comprehensive, on-going training was identified as a vital to enhance staff knowledge and skills.

Outcomes

The integration of the staff has been completed. Currently home support and nursing staff work together under the direction of the Sandy Bay Health Centre Home and Community Care Program. The transition was hardest on the older staff who were not used to the level of accountability that was introduced. Four employees chose to resign. Most report however, that they feel better supported and valued in their roles. They are proud of the professional approach to the program.

The P.A.L.S. team appreciates the ongoing training and are experiencing improved collaboration with the rest of the health care team.

The administrative policies have made scheduling of service and coverage for leaves smoother and have supported the coordination of duties. For example, staff are not sent by the client to the store daily but rather shopping is incorporated as a specific activity within the care plan. With the improved coordination some clients have required less service which has freed up service for others.

The integration processes that have been achieved include:

- Client referral process with guidelines, policies and procedures identifying strict eligibility criteria. This ensures a non-biased process for members to access services with no room for political interference.
- A safe client record system which is comparable to Provincial standards.
- Policies, procedures and best practice guidelines have been developed to reflect safe delivery of services to community members.
- A structured client assessment and care plan process delivered by a licensed home care nurse.
- A measurable process for collecting and managing data required for monitoring, planning, reporting and evaluation purposes.
- A decreased chance of duplication of services while meeting a broader range of needs to community members to assist them in alleviating hardship, maintaining functional independence and to encourage self sufficiency.
- An established documentation and communication process to identify changes in client needs.
- A defined process for program linkages both internal and external to the community.
- A Quality Assurance process to measure expected outcomes identified in the program work plan.

Feedback from the Sandy Bay community has also been positive. There is a sense that the home care service is fair and effective. Clients are satisfied with their services. The Band Council is no longer required to deal with calls from members and subsequent to the transition has not received any complaints. While regular feedback has been provided to staff, the formal performance reviews were conducted in January 2010, ten months after the integration. Generally staff are satisfied with the new model. They are eager to receive more training and are hopeful that funding will allow for a wage increase. Key Success Factors:

- Having a trusted champion
- Providing explanations about and rationale for the changes
- Being consistent

Next Steps

The Sandy Bay Home and Community Care Program recognizes a number of opportunities that need to be addressed in order to strengthen its services and meet the needs of the community. Through improved processes, documentation and data collection the management team is hopeful that they will be able to demonstrate the value of the services that are provided and be able to quantify the growing need.

Currently the HCCP has identified the need for:

- Funding for continuing staff education in order to ensure safe delivery of services.
- Respite services for families caring for disabled children.
- Respite for the elderly who wish to be at home for as long as possible.

- Support services for palliative members with conditions such as cancer, end stage renal disease and HIV

- Short term assistance with activities of daily living (ADLs) such as meal preparation or light and heavy household chores are required by numerous HCC qualifying community members.

- Post-Hospitalization intervention – people are discharged early from hospitals.

- Transportation for non-mobile members with no other means, to and from the nearest village or city to go shopping for groceries, banking or bill payments.

- Medical Escort for members with language barriers to appointments to assist in translation or to ensure they do not get lost in big hospitals or clinics due to poor literacy skills.

- Medical Equipment and Supplies (Non-Insured Health Benefits (NIHB) requires a lot of documentation from physicians at a cost to the client on a regular basis, there are long wait times for pre approval on supplies and increased cuts to products that were covered).

Conclusion

The Sandy Bay Health Centre has embraced the anticipated changes in the FNIHB and INAC programs and taken charge of the ramifications to its community. In so doing they have created an approach that works for them and have made impressive steps to improve the services they provide. Through integration, duplication and waste within the system has been eliminated. There have been a number of changes that have strengthened the program and both staff and clients have benefited. Through enhanced and consistent service delivery, the HCCP is able to measure its impact and quantify the community's needs.

"This evidence based approach will be key to the future health care program in Sandy Bay."

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Ontario Region

As per Indian and Northern Affairs Canada (INAC), "many First Nation communities are in close proximity to urban areas, while many others are either remote (more than 350 km away from an urban centre) or accessible year-round only by water or air" (33 Fly-in communities) (INAC, 2010). According to INAC (2010), "some of the largest and most sophisticated First Nations in Canada are located in Ontario, but there are also many communities that face the challenges of being remote and isolated, whose priorities are to meet basic daily needs like adequate housing, electricity, and water and wastewater systems."

The Ontario Region Home and Community Care Program works in close partnership with the Chiefs of Ontario. This partnership has been in place since the beginning of the program in 1999 and has evolved over the years. We work with honour and respect towards the traditional ways of the First Nation communities that we serve.

Most Home and Community Care Programs at the community level are operating in collaboration with the Ontario Ministry of Health and Long Term Care and INAC's Assisted Living Program. The Region is divided into four zones. Each zone faces different needs and challenges. The Ontario Region Home and Community Care Program provides active health care services to a total of 114 communities. Moreover, three communities are currently in the phase of planning the implementation of a Home and Community Care program. The Region estimates that the bands and tribal councils employ approximately 130 Home Care nurses (RN's and RPN's) and over 300 Certified Personal Support Workers.

Prepared by Annie Fleurant, Nurse Advisor, Home and Community Care, FNIH Ontario Region, Health Canada

Admissions	**5978**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	18%	**3%**	**9%**	**35%**	**24%**	**12%**
Hours of Service Delivered: 739,513	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	7%	**10%**	**2%**	**6%**	**5%**	**70%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	8%	**19%**	**33%**	**22%**	**18%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Telehomecare Project

Impact on Clients' Concentric Circle of Care in a Remote First Nation Community

A partnership between the Keewaytinook Okimakanak (KO) Home and Community Care Program and KO Telemedicine using existing staff and technology to enhance program deliverables and services.

Special Thanks

Heather Coulson, Program Development Coordinator, Keewaytinook Okimakanak Telemedicine,
Marney Vermette, Nurse Supervisor, Keewaytinook Okimakanak Home and Community Care Program

Background

It is widely accepted that technology solutions can increase the efficiency and effectiveness of the health care team. Within home care, technology can enhance the capacity of the team by enabling access to health care when the provider cannot be present in person. As a strategy to increase the capacity to serve its community the Keewaytinook Okimakanak Home and Community Care (KOHCC) Program has been engaged in developing technology solutions.

Since 2000, investments in information and communication technology infrastructure and distributed health services policy, human resources and partnership development have enabled what is believed to be Canada's largest and busiest First Nations telemedicine service – KO Telemedicine (KOTM).

KO Telemedicine (KOTM), through its partnership with Ontario Telemedicine Network (OTN), facilitates access to specialists and health care services through video consultations. Beginning in 2003, KOHCC used telehomecare as a means of video and audio linkage to conduct team meetings, provide training and education and strengthen the linkage with staff. To date, KOTM has facilitated more than 10,000 interactions.

Building on the evidence that shows that home telehealth can produce clinically similar care as face-to-face visits with health practitioners; that it can improve patients' access to care; and, can reduce hospital and patient travel costs, the KOHCC and KO Telemedicine Program launched a pilot to serve individuals in remote communities.

Today, Keewaytinook Okimakanak Home and Community Care Services have successfully integrated the use of information and communication technologies and distributed learning and clinical care methodologies into their existing programming. These material and service innovations have extended KOHCC's capacity to meet the community health needs of its home care clients, all of whom live in geographically isolated communities with uneven access to health service providers and support systems.

Overview

Keewaytinook Okimakanak (KO) is directed by six member First Nations – Deer Lake, Fort Severn, Keewaywin, MacDowell Lake, North Spirit Lake and Poplar Hill First Nations, which have a combined population base of approximately 2,700 Cree, Oji-Cree and Ojibwa

speaking people. With the exception of Fort Severn – which is situated on Hudson's Bay and is Ontario's most northerly community – member Nations are clustered in an area known as the Sioux Lookout Zone.
The KO communities are located within the north west portion of the geographical health region known as the North West Local Health Integration Network (NWLHIN).

Each community has a nursing station that provides primary health care and is run by specially trained R.N.s. Physician services, depending on the community size, are monthly but can often be affected due to weather or poor travelling conditions. While the closest acute care hospital is located in Red Lake, this facility is only equipped to support individuals in the Red Lake community. The Sioux Lookout Men-Ya-Win Health Centre (two hospitals formerly known as the District Health Centre and the Sioux Lookout Zone Hospital) provides health services to all residents within Sioux Lookout and the surrounding area and operates at eight existing sites under one administration.

Keewaytinook Okimakanak Home and Community Care (KOHCC) is directed by a Health Advisory Board that includes representatives from member nations. Delivery of home and community care services is provided by nursing staff who visit each KO community monthly, local personal support workers and a home and community care coordinator in each First Nation.

This service infrastructure provides a continuum of home-based services – respite to direct clinical care – and is linked with provincial (MOHLTC) and federal (FNIH) nursing services.

> KOHCC Service philosophy states that services "must be accessible, responsive, personalized, individualized and delivered with compassion and sensitivity"; that "dialogue and collaboration are fundamental to the way in which [KOHCC] carries out day–to–day activities"; and, that "service must be affordable, cost-effective and efficient."

The focus of the *Telehomecare Project* was to determine the feasibility, benefits, challenges and scalability of enabling videoconference encounters with housebound clients living in one of KO northern member First Nations fly-in community more than 300km distant from the health centre.

The Project involved a partnership between KOHCC and KO Telemedicine utilizing a secure, encrypted health videoconferencing network to support and supplement delivery of home care services.

The objectives of the Project were to:

- Identify and offer home care services via the KO Telemedicine network.
- Help people in remote areas stay in their homes safely and comfortably for as long as possible.
- Assist clients and their families with long term needs through education, training, and access to support services in their homes.
- Expand current home care services.
- Support the delivery of services that have not other wise been available to people in remote communities, i.e. rehab.
- Present training and real time support to care providers in communities while with clients.
- Sustain and develop community resources.
- Decrease dependency on outside supports such as hospitalization.

Implementation

The KOHCC has leveraged the KOTM to support community based services since 2006. Early applications used technology to facilitate:

- Team meetings via video conferencing with community based Home and Community Care Coordinators
- Personal Support Worker (PSW) training
- Case conferences with home care nurses and Community Health Nurses from different localities

In December 2007 the pilot commenced with a telehomecare response to the needs of a palliative client who lived in a fly-in only First Nation community in northwestern Ontario.

Telehomecare (THC) is defined as the application of information and communication technologies to enable effective delivery and management of health services such as medical diagnosis, treatment, consultation, and/or health maintenance between a patient's residence and a health care facility or professional.

The service was integrated with existing home and community care and First Nations and Inuit Health nursing services. The telehomecare program was able to support the palliative client and later his disabled spouse by way of a videoconference unit that was installed in the client's home and connected to the community owned internet provider. This level of connectivity was supported by a NAN-wide (regional) First Nations network integrator (K-Net) that is linked to the provincial health network service provider (eHealth Ontario).

A videoconference unit was installed in the client's home and was connected to the community – owned internet provider through a cable modem and a virtual private network (VPN) device. This secure connection linked the client to KO Telemedicine and – by extension to the telemedicine utility – the Ontario Telemedicine Network (OTN). The regional KOTM technician coordinated the installation, testing and certification of the technology in the home and the Telemedicine coordinator provided the end user knowledge to the client, family members and the local home and community care staff.
People who choose to die at home have a range of end-of-life needs – support with the activities of daily living, personal care and home management activities. This type of practical care is usually provided by Personal Support Workers (PSW). The KOHCC Nurse Supervisor, through the use of the telehomecare system, provided ongoing support and coaching to the PSW in the home as the client was dying.

After the client's death, home and community care staff offered his spouse the opportunity to participate in the program to support her needs in the home. In her late 50's, speaking Oji-Cree as her first language and with limited English, the spouse had recently suffered a stroke. She had distinct right sided weakness, difficulty walking and severe aphasia. She was also diabetic and suffering from hypertension.

The videoconferencing unit was set up in the client's living room and appointments were arranged by the KOTM scheduling office. As a privacy safeguard, the unit was locked in a secure metal cabinet, and only health professionals could initiate calls to the home – the client has no call out privileges. During a typical telehomecare visit, the home and community care nurse would review a specific task list with the client as well as the Personal Support Worker.

A typical session included a review of:

- Medication compliance
- Personal care regime
- Exercise regime and compliance
- Risk assessment – falls, injuries, footwear, etc
- Client health – vital signs, diet, appetite, elimination patterns, social outings, etc
- Client independence with ADLs – doing dishes, cooking

Other services provided to the client by video-conferencing in the home were Physiotherapy, Occupational Therapy, Speech and Language Pathology, diabetic counselling/ Teaching, mental health counselling, Long Term Care nursing as well as family visitations, elder's sessions and educational events.

There are currently two (2) units in use in the community. The first unit is still in the home of the original client where, following the one year evaluation, it was determined that the unit should remain to support the ongoing needs of the deceased client's wife. The second unit

has been moved twice within the community to support other individuals as identified by the home care staff to have a need for regular intensive support.

Outcomes

In an isolated First Nations setting, telehomecare offers a unique value to the client and system, specifically, the capacity for elderly and frail individuals to live out their lives in their established communities while receiving health care and supports similar to other more populated communities.

The KO community responded to the community-based demand for equitable and effective home care services in First Nations through this THC videoconferencing Project by:

- Supporting end of life care and chronic/long term disability and enabling regular nursing supervision, client monitoring and risk reduction measures.
- Linking family members and friends who would other wise not be able to visit with the home-bound client prior to passing. This is culturally significant as First Nations people stay with family continually, sharing stories, supporting not only the client but each other in the grieving process.
- Providing real time education, training and specialized support services to the client and their PSW in the home (almost 50 unique interactions (one per week) in the client's home were conducted during the pilot – with 40 per cent of all the telehomecare involving home and community care nursing services).
- Responding to individual needs and empowering caregivers.
- Improving client outcomes.

Observation of the clients over the course of the Project showed a link between the additional service supports provided by telehomecare and improved health status. Specific examples include:

- The client, with limited mobility at beginning of the project, was able to successfully complete a six kilometre fundraising walk. This client, who also suffered from severe aphasia, experienced increased capacity to communicate, by way of a picture board that was developed by the SLP. The client also was able to cope with domestic tasks that contributed to their independence and well-being.
- A client with a post-hip replacement utilized the system to receive "virtual visits" to review and encourage the exercise regime set out by the physiotherapist. The client recovered quickly and only needed a few visits.
- A client with diabetes and multiple co-morbidities including, hypertension, left below knee amputation, diabetic ulcers, currently has the second unit in their home. This client has had consultations with a diabetes nurse from Sioux Lookout, several HCC nurse visits and has attended an Elders education session from home via THC videoconferencing.

Next Steps

The KOHCC service model is built on a scalable Telemedicine network platform. The success of the pilot project has stimulated discussion among home and community care leaders in the Sioux Lookout Health Zone and with the Ontario Stroke Strategy to expand the geographic scope of telehomecare beyond the five Keewaytinook Okimakanak communities and to introduce stroke rehabilitation specific services using a videoconferencing camera that has two way audio and telestration and one way video.

Other forms of technology – such as tablettes and two way video; and opportunities to integrate home monitoring and patient records – including store and forward applications are being explored.

To support the unique aspects of home-based installation, service, support and redeployment, staff are currently developing functional technical service requirements, and documentation outlining roles and responsibilities of community, vendor and network service providers. The integration of these service functions within the role and responsibilities of the Home and Community Care Nurse, the Long–Term Care Nurse, the community Home Care Coordinator and the Personal Support Worker will be reviewed and completed.

Conclusion

The Telehomecare service improves access to health care for those living in geographically isolated communities while supporting the client's preference to remain close to family and community. This Project demonstrates a cost-effective and efficient way to access nursing consultations and client specific health information which supports the community coordinators, personal support workers, home care clients and their family. The Nurse Supervisor has been able to, in real time, assess, educate, collaborate, network and support from a distance. The use of technology has increased the confidence of program supervision. Technology has enhanced, not replaced, the program effectiveness and requirements of five different geographically isolated First Nations communities.

Telehomecare has offered a way in which the client, if they choose, can stay in their home, longer, safer and still have health care support that is timely, appropriate and culturally sensitive. This begins the transition to equality of care for all Canadians regardless of geographic location or culture.

The holistic approach utilized within this Telehomecare initiative encompassed the body, mind and spirit of all involved – the client, family and friends, the community and the service providers.

"As we move forward in our search for quality of care, let us all keep an open mind to the possibilities that technology and the willingness to use it can bring."

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Quebec Region

The Quebec Region consists of the province of Quebec including Nunavik. Nunavik shares its borders with both the Côte Nord region of Quebec and the Labrador region of the province of Newfoundland and Labrador. There are no road links between Nunavik and southern Quebec although the Trans-Taiga Road ends several hundred kilometres south of Kuujjuaq, the transportation hub of the entire region. There is a year-round air link to all villages and seasonal shipping in the summer and autumn.

The indigenous people comprise 38 First Nation Bands and 14 Inuit communities. These 52 communities consist of three cultural groups, the Algonquins, the Iroquois and the Eskimo-aleoute. The Abenaquis, the Algonquins, the Attikameks, the Cree, the Malecites, the Micmacs, the Innus and the Naskapis form the Algonquin culture; and the Huron-Wendat and the Mohawk are of the Iroquois culture. The Inuit represent the Eskimo-aleoute. In 2009, the First Nations population in the region was 73,227 and the Inuit were 10,987. (ref. INAC website)

Approximately 70 per cent of First Nations people live in communities dispersed throughout the province of which 50 per cent of these First Nation communities are isolated. The Inuit are concentrated in 14 isolated communities on the North coast. Fifty per cent of these communities speak French as a second language and fifty per cent identify English as a second language.

The indigenous communities have their own vision of health which encompasses body mind and spirit. Health care services consist of primary and home care to the 52 First Nation and Inuit communities. Typically services are provided by nurses though community clinics which have linkages to regional hospitals.

Under the James Bay and Northern Quebec Agreement, responsibility for health and social services in Cree communities is the responsibility of the Cree Board of Health and Social Services of James Bay while in Nunavik, these services are provided by la Régie régionale de la santé et des services sociaux du Nunavik. Other indigenous communities provide these services through community health clinics and nursing stations.

Prepared by Francine Charade , RN. BSc, MSc, Programs Coordinator Nursing, Health Canada

Admissions	**2674**					
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**
	13%	**1%**	**7%**	**29%**	**33%**	**16%**
Hours of Service Delivered: 543,895	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**
	8%	**13%**	**1%**	**6%**	**3%**	**69%**
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**	
	7%	**21%**	**21%**	**23%**	**27%**	

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Integrated Funding to Improve Care Delivery

The merging of two programs to enhance the delivery of health care services and improve the quality of the experience for the recipients of care.

Special Thanks

Hélène Tremblay, RN, Home and Community Care Nurse, Manawan
Carole Dubé, RNA, Home and Community Care, Manawan

Background

Much has been written about the need to integrate health care programs in order to realize improved outcomes for health system users and improved utilization of limited resources – both human and financial. With escalating health costs, governments are interested in the efficiencies that can be achieved through integration of services. Duplication of processes and under-utilization of the health team is not acceptable. There is a sense of urgency amongst health care providers, funders and policymakers to leveraging every opportunity to improve the delivery of health care.

Within health care, integration typically refers to removing the "silos" and improving the coordination of services. Concepts central to integration in health care found in the literature include: *across the continuum, coordination, complementary, seamless, unified and system.* While there are various definitions of integration, the Canadian Home Care Association (CHCA) believes that integration is not an outcome but rather a process, or strategy to achieving specific outcomes.

Recognizing the overlap and redundancies in the delivery of home and community care programs in Manawan, the community came together under the leadership of the home care team to develop a new approach. The issue that was addressed was the duplication arising from two separate funding streams – First Nations Inuit Health Branch; and, Indian and Northern Affairs Canada. The health care team of Manawan undertook to integrate the structures in order to achieve consistent, collaborative and comprehensive services.

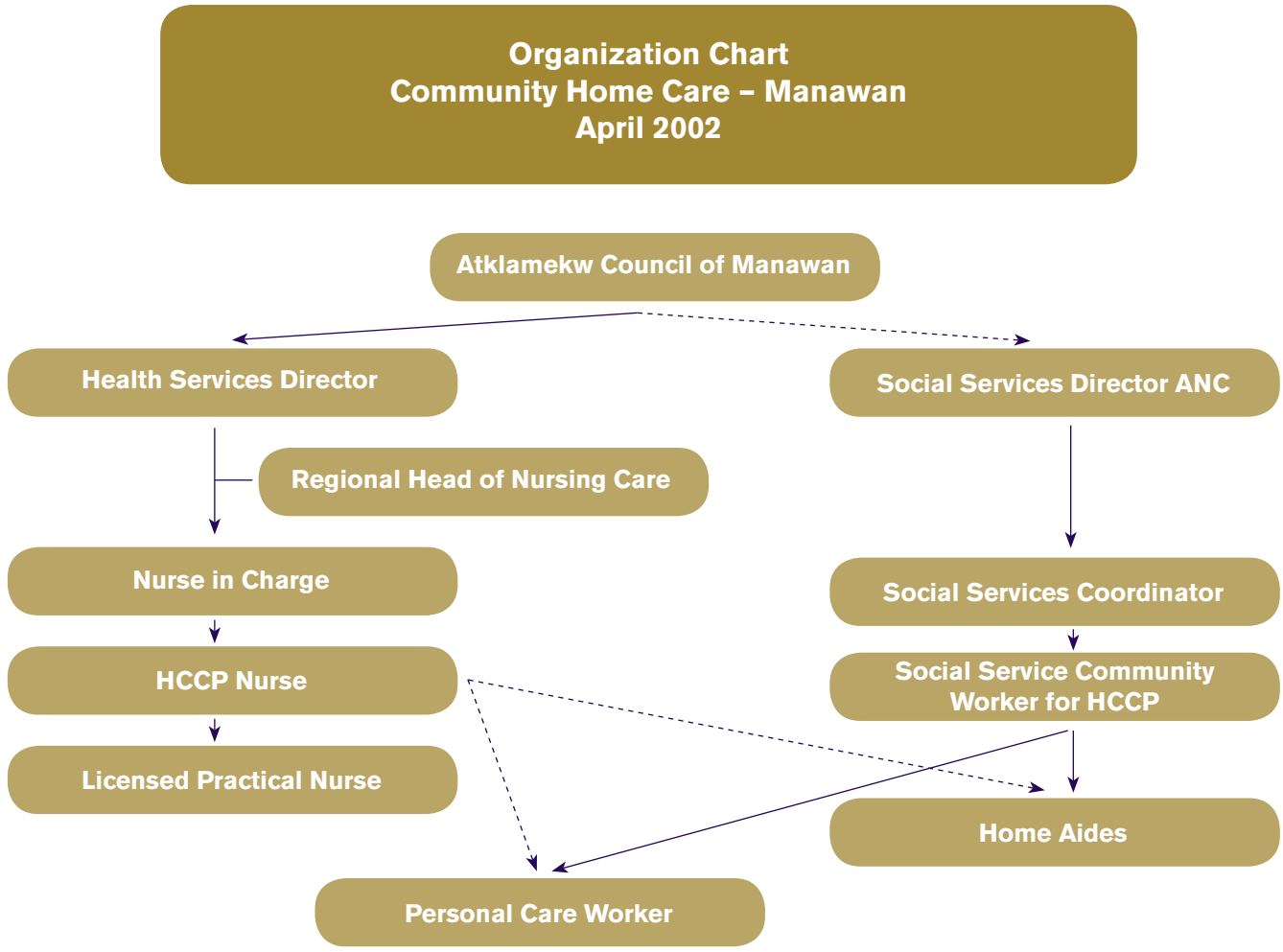
Overview

Manawan is one of the three communities that forms the Nation Atikamekw. Located about seventy–two kilometres from Saint-Michel-des-Saints, the community is only accessible by gravel road. The territory is about eight square kilometres and has a population of approximately 2000. The principle language in Manawan is Atikamekw, although French is equally taught and used.

Health care services are delivered through a local health centre. Two physicians visit the community about three days per week and otherwise primary care is provided by the nurses 24 hours per day, seven days per week. The closest hospital is 200 kilometres away in Joliette and the CLSC (centre local de services communautaires, local community service centre) is situated in Saint-Michel-des-Saints.

Manawan had two funding structures to support the delivery of home and community care – First Nations and Inuit Health Branch (FNIHB) provided resources for home care services and Indian and Northern Affairs Canada (INAC) funded social services. The result was a community home care program with two administrative streams. The programs were separate and distinct and while the frontline providers knew each other, there was no formal mechanism to enable the delivery of comprehensive home and community care services.

Home care programs provide a comprehensive range of coordinated health care services for individuals of all ages for the purpose of promoting, maintaining or restoring health within the context of their daily lives. Home care services are designed to meet the needs of persons who require assistance or support in order to remain at home, or whose functioning without home care is likely to deteriorate making it impossible for the person to stay at home in the community. Home care is often considered to be the care provided outside of a hospital and to include health and social care and support on a long or short-term basis.



Implementation

The move to integrate the professional home care services funded by FNIHB and the social component funded by INAC began as an internal quest to improve services to clients. The Home and Community Care Nurse began to imagine the gains that could be realized through integration of the two care teams.

Specifically, she envisioned better care for clients and alignment of staffing policies resulting in parity across the care team. She persuaded her colleagues and superiors of the benefits, and a process to engage the community and secure support from the funding and administrative bodies was undertaken.

> Better care for clients and alignment of staffing polices resulting in parity across the care team were two significant gains which could be realized through integration.

Over the course of six years the value proposition was articulated in the form of a "community assessment" and "Service Delivery Plan" (2002).

Informal meetings were held with the Manawan and Wemotaci Health Branches and with the Atikamekw Nation Council (ANC) as they were each administering a program. The Manawan was in charge of the FNIHB service and the ANC oversaw the INAC program.

Support for the concept was obtained and in 2003 a resolution was adopted by the ANC for the establishment of a committee mandated to improve the delivery of home and community care services. The focus of the committee work was to address the two sources of funding and two separate home care teams operating under different health branches within the community. Because the plan called for the consolidation of staffs a legal opinion was secured in 2004. The resolution from Manawan Atikamekw Council to take over the INAC program was also achieved.

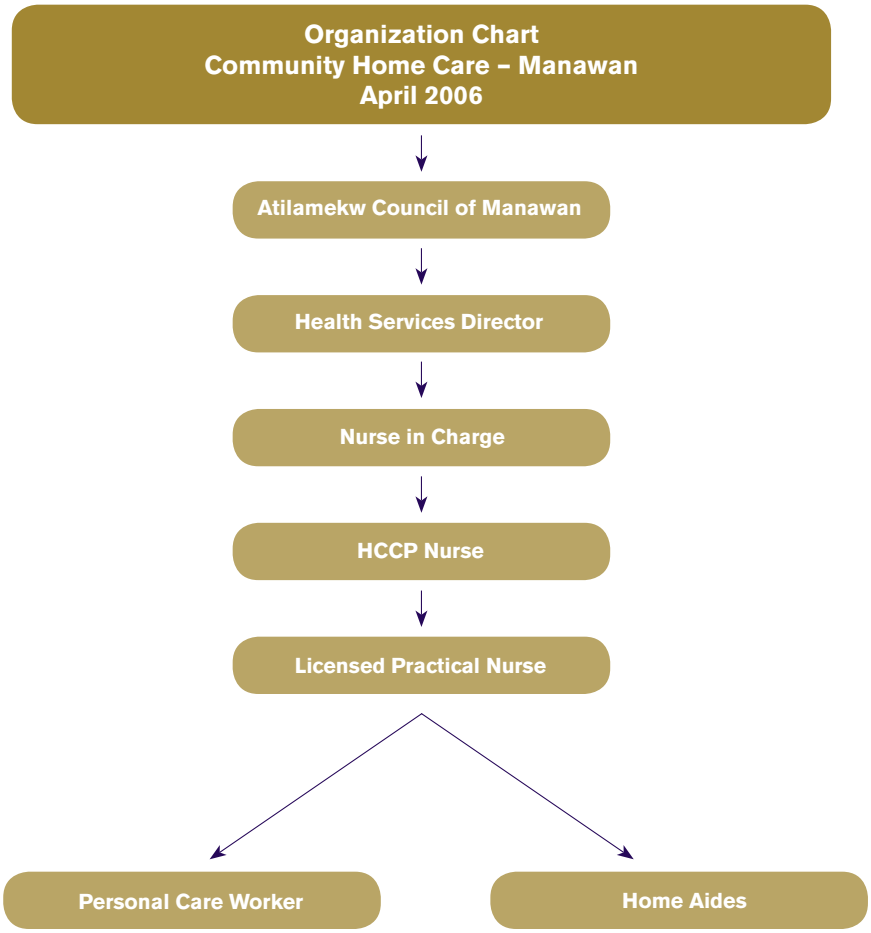
By 2006 a fully dedicated home care team was established. Policies and Procedures had been developed by staff as a parallel activity while the legal and policy work was underway.

Key Success Factors

Merging organizations is often the basis for much strife. Individuals often have a vested interest in the way things have been done; fear loss of autonomy, stature and ability to influence. Accordingly, the resistance to change can be significant.

Staff believes that the success in Manawan came from:

- A shared vision of how the home and community program should be provided.
- The concept of integrating the programs was promoted and led internally.
- Policies and procedures were developed as an early component of the process which resulted in a strong commitment to the outcome, long before the final approvals were made.
- The process was grounded in trust and transparency and a shared vision for improving care for the people they serve.
- The patient/client was at the center of their efforts – an unassailable position which kept the teams focused and able to overcome concerns or resistance to change.



Outcomes

Today there is a single coordinated home and community care team. The funding continues to flow from each of FNIHB and INAC and budgets for each stream must be developed and accounted for individually. However, the frontline practitioners are integrated and the administration within the community falls under the Atikamekw Council of Manawan. The organizational structure is streamlined, and, as such, designed to ensure consistency.

There were no reductions in staffing positions. However, with the elimination of redundant processes, new duties were assigned to some of the administrative team. Parity in human resource policies was established. This impacted the staff funded through INAC resulting in an improvement in wages and benefits.

The integrated program has resulted in streamlined programming starting with a single entry to the system. The combined team has better knowledge of the resources and how to leverage services to benefit clients, coordinating the timing of care delivery for example to achieve better coverage. A comprehensive palliative care service has been developed that includes the provision of palliative care and supporting the competence of the family and Health Care Aides through training in this domain.

An evaluation in the form of satisfaction surveys to clients and staff has recently been launched. Results are pending but anecdotally, staff and clients report that services are more organized; there is better teamwork and communication. Service delivery is better – a benefit to clients and their families and a benefit to staff who feel more satisfied with their contribution on an individual and program basis.

Next Steps

Further assessments of the needs of the population are planned. As an integrated team, the home and community care providers intend to evolve their policies and procedures in order to further the service offering. Some of the initiatives that are anticipated include increasing nutrition services and social encounters, such as the Day Center.

The program staff hopes to harmonize INAC statistics with the FNIB branch data collection system (eSDRT). This is an important step in integrating the programs and will be important to understanding where and how programming needs to evolve. Ultimately transferring money between funding programs at the community level would facilitate responsive care and position the home care leadership to direct funds where they are most needed.

Conclusion

Integration of care is generally accepted as being the most appropriate approach to responding to this increasing demand and yet system change is difficult to effect and slow to happen. The implementation and sustainability of integration strategies requires a willingness to change throughout the system – from policy to practitioner.

This initiative demonstrated leadership from practitioner to policymaker and shows how quality improvement initiatives from the frontline can lead the way and realize significant change. Through their tenacity and creativity, these home and community care providers have demonstrated a practical way to improve the services to their community.

"The integration process was grounded in trust and transparency and a shared vision for improving care for the people we serve."

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Atlantic Region

Atlantic Region is made up of four provinces: Nova Scotia, Prince Edward Island, New Brunswick, and Newfoundland & Labrador. Within the region, there are 33 First Nations bands and 5 Inuit communities. Four distinct Aboriginal communities are represented within this unique region. This geographically diverse area is home to both urban communities and remote fly-in communities.

There are more than 22, 295 Mi'kmaq people living in the Atlantic Region: approximately 16,121 live on-reserve; more than 5,269 Maliseet, with nearly 3,030 living on-reserve; 1,235 Innu–also known as Montagnais-Naskapi–and 2,634 Inuit.

The Mi'kmaq people's traditional territory stretches from the southern regions of the Gaspe Bay to most of New Brunswick, Nova Scotia and Prince Edward Island. There is also a community in Newfoundland and Labrador. Historically, the people hunted, fished and gathered their food; and their settlement patterns were determined by the changing seasons. The Maliseet's traditional lands stretch along the bank of the St. John River and its tributaries, between New Brunswick, Quebec and Maine. Wolastoqiyik is the proper name for the people who named themselves after the Wolastoq (St. John's) river, also known as "People of the River." This group would traditionally travel downstream in the spring to plant crops by the ocean, and travel upstream in the winter to hunt. Fishing was also a food resource throughout the year. Innu peoples settled in the far north of Newfoundland and Labrador. Their main source of food is caribou. Innu are also known as the "Barren Lands People." The Inuit live on the Labrador Peninsula. Their people are descendents of hunters who were drawn to Labrador for its abundance of whales and wildlife.

All of Atlantic Region's 33 First Nations communities and 5 Inuit communities deliver Home and Community Care Programming and Services. These services are increasingly important as the complexity of care is being transferred from the acute care sector to the community. The Region is unique in the way that there are five sets of legislation, and each province has numerous acts that home care services fall under. The Region's program delivery is currently being transferred to district and regional health boards.

The regional office is involved in two Aboriginal Health Transition Fund projects with Nova Scotia's and Prince Edward Island's Provincial Departments of Health.

Prepared by Peter McGregor, Regional Manager, Treatment Services, First Nations and Inuit Health Branch and
Molly Kehoe, Regional Communications Advisor, Public Affairs, Consultation and Communications Health Canada–Atlantic Region

Admissions	**1067**						
Clients by Program *(Using CIHI Definitions)*	**Acute**	**End of Life**	**Rehabilitation**	**Long Term Supportive**	**Maintenance**	**Other**	
	36%	**3%**	**5%**	**49%**	**32%**	**8%**	
Hours of Service Delivered: 317,152	**Nursing**	**Personal Care**	**Therapy**	**Case Management**	**In-Home Respite**	**Assisted Living**	
	6%	**17%**	**0.5%**	**3%**	**11%**	**62%**	
Client Mix by Age	**0-16 yrs**	**17-45 yrs**	**46-64 yrs**	**65-74 yrs**	**75+ yrs**		
	4%	**21%**	**33%**	**23%**	**19%**		

Source: Electronic Service Delivery Reporting Template (ESDRT) 2008-2009 data

Occupational Health and Safety

Conne River

This initiative describes the approach to promoting wellness and safety for a community through policies to support and value Home Support Workers.

Special Thanks

Ada Roberts, BScN, RN, NP, Program Coordinator, Conne River Wellness Centre

Background

Community based health care and support services are not delivered in the same way as institutional care. Clients are seen in their own homes and, to a much greater degree than the institutional patient, on their own terms. As a result, community care providers must achieve a delicate balance between the need to create a safe working environment for staff and providing safe care for clients while respecting their individual rights within their own homes.

Each new client environment poses potentially new and different challenges for the home and community care provider and can create an element of unpredictability for staff. Staff is at particular risk for injury due to the variety and dynamic of the work setting. Accordingly, in order to manage successfully, staff, who often work alone, display personal attributes of maturity, self confidence, flexibility and creativity in providing care in a manner that ensures their own and their client's safety.

Recognizing the need to resource their staff with policies to support their rights to a safe work environment, an occupational health and safety initiative targeted at front line home care workers was undertaken by the Nurse Practitioner in Conne River.

Occupational health and safety strategies that work well for the institutionally-based acute and long-term care sectors do not readily translate to home and community care. Understanding the unique aspects of providing care as a 'guest' in someone's private home was critical to the initiative. The intent was to ensure that staff are well informed and trained in safety procedures but also have the ability to improvise in the home setting.

Overview

The Miawpukek Band Reserve (Conne River) is located on the South East Shore of Newfoundland. The Reserve covers an area of some 14 square miles. It lies 560 km from St. John's and 180 km from Grand Falls. The population of Conne River is 800. The community is economically self-sufficient and guided by traditional native values.

Health care services are provided through two main centers, the health center – serving the acute care needs and the wellness center – serving the health prevention and promotion aspect which includes home care. The Wellness Center is staffed with two full-time

licensed practical nurses (LPN), a Community Health Nurse and a Nurse Practitioner (NP).

The NP is the program coordinator for the Home Care program. A physician is available by telephone and resides about 45 minutes away. The physician visits the health clinic two half days per week, holding morning clinics. The closest hospital is 170 kilometres away from Conne River. Home care services are provided through the NP and one LPN and at present, a total of 10 Home Support Workers. The team estimates the need for about 15-20 more home support staff to respond to the demand for care.

Implementation

Smoking was addressed by the health team in early 2000 as an important initiative toward establishing a healthier community. The Band council's decision to ban smoking in all Band buildings was seminal to the establishment of a home care policy that would require clients to refrain from smoking when staff were in the house providing care.

Consistent with the goal of achieving a healthier community, the health team, under the leadership of the Nurse Practitioner, recognized that if clients could not smoke at the clinic which was of benefit to staff, then they should refrain from smoking at least while workers were present in their homes. This was potentially a contentious issues as many believed that smoking in the home is a client right; and yet the rights of the staff needed to be considered as well.

The Miawpukek First Nations and Conne River Health & Social Services subscribe to the principle of establishing a safe work environment for all employees.

A draft policy and procedure was developed by the program coordinator and then sent to the Director of the Health Unit and the Band lawyer for review. The goal was to create practices and obligations that would promote and facilitate the health and safety of the home care team. The merits of the policy, potential challenges with implementation and enforcement were debated. A policy was drafted. The policy was then taken to the Policy and Procedure Committee for endorsement. As the approval process was underway, the home support staff was apprised of the policy in staff meetings.

Staff discussed a protocol document detailing the procedure to be taken if an employee were to exercise their right to leave the home where smoking was occurring. The need for consistency in approach was emphasized as the program coordinator was concerned that a staff member who smoked or who thought they were being extra considerate to the client might turn a blind eye to smoking. In so doing, staff could unwittingly create confusion and/or friction on the team if some allowed smoking and others did not.

The non-smoking policy provides every home health care worker with the right and obligation to request a person not smoke while home care services are being provided. Where a person refuses to comply with the request not to smoke, the home support worker will advise the client and/or family of the policy and contact the program coordinator for further follow-up. The program coordinator will, on behalf of the staff, contact the family and inform them of the policy. The family is provided with an opportunity to rectify the concern. If the issue is not resolved, as planned with the family, home support services will be terminated until such time that the is issue rectified.

Prior to implementation of the policy a letter was developed and sent to clients advising them of the requirement and explaining the rationale. Overall the reaction from the community was favourable.

Other Policies

The program coordinator subsequently undertook to address differences in employee rights and practices between the health unit and home care staff. Policy alignment has been established for Band holidays. Health and safety policies have been developed to address housing conditions, such as flee infestation; threat of violence, exposure to alcohol and drugs while in the home, the requirement to have access to a telephone, running water, adequate cleaning supplies and food for meal preparation and clear access to the house. Clients are also required to remove animals and pets from the care area; clear hallways and secure firearms.

The program coordinator also enforced the already existing band policy directing staff off the road in the event of inclement weather – the premise being that if the clinic had to close, then home care staff should be sent home as well.

At the time of service initiation a package of information and instructions is provided to clients. Within the package is an overview of the requirements of the client and their family in order to comply with home care safety policies. These include securing pets, storing firearms, refraining from smoking and ensuring walkways are lit and clear.

A component of the initial visit is the creation of a plan for support in the event that the home care worker cannot be present. This ensures that if the worker cannot travel due to weather, the client has a plan and support until service can be resumed.

Outcomes

While respecting the rights and choices inherent to clients within their own homes, the home care program has been able to establish parameters for clients to ensure that their environment will enable a safe visit for staff. Staff feels valued and supported for the work that they do. The Band Council is no longer placed in the position of having to referee concerns as the policies serve to provide objective and consistent approaches to the delivery of services.

> "It feels good that my safety counts."
> – Home Support Worker
>
> "This change is fair and serves the interests of clients and workers."
> – Family member
>
> "We feel that we are being treated fairly and as any other employee with the Band."
> – Home Support Worker

People want to receive care at home for as long as possible and recognize the need to work with the home care team to achieve that goal. On average the home care program has had to withdraw services because of non-compliance to safety policies on three occasions. In these situations the home care team worked with the family to address the problem and service was successfully resumed. In some instances, services are not automatically removed without giving family the opportunity to resolve the issues. The program coordinator is responsible for following up on these issues and achieving resolution of such in collaboration with the client and/or family involved.

Staff believe that key to the success of the implementation of the occupational health and safety policies have been:

- An underlying premise that the home care team and family are working together.
- Flexibility in balancing client and staff needs.
- Recognition that institutional policies do not readily translate to the home setting.
- Understanding the unique aspects of providing care as a 'guest' in someone's private home.
- A commitment to supporting and resourcing staff to provide safe care in a safe environment.

- Engagement of the Band Chief and Council.
- Regular and ongoing dialogue with staff as to the rationale for and development of the policies.

The Home Support staff has been very supportive of the policies and procedures and feel their safety is protected and acknowledged when situations outlined as above, arise and the policies have to be referred to for their benefit.

Conclusion

Home care programs are accountable to maintain the health and welfare of their employees. They must also balance risk with the need to deliver care. Policies that consider the changing work environment with every person served as is the case in home care are vital to a highly functioning program.

"We should never forget that every day Home Support staff are out in the community facing the elements on their own. The intent of the policies is to keep them protected and safe and demonstrate that they are a valued and important component of the health care team."

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