

Vancouver Coastal Region

First Nations Primary Health Care Service Development & Investment

October 23, 2014
Vancouver Coastal Caucus

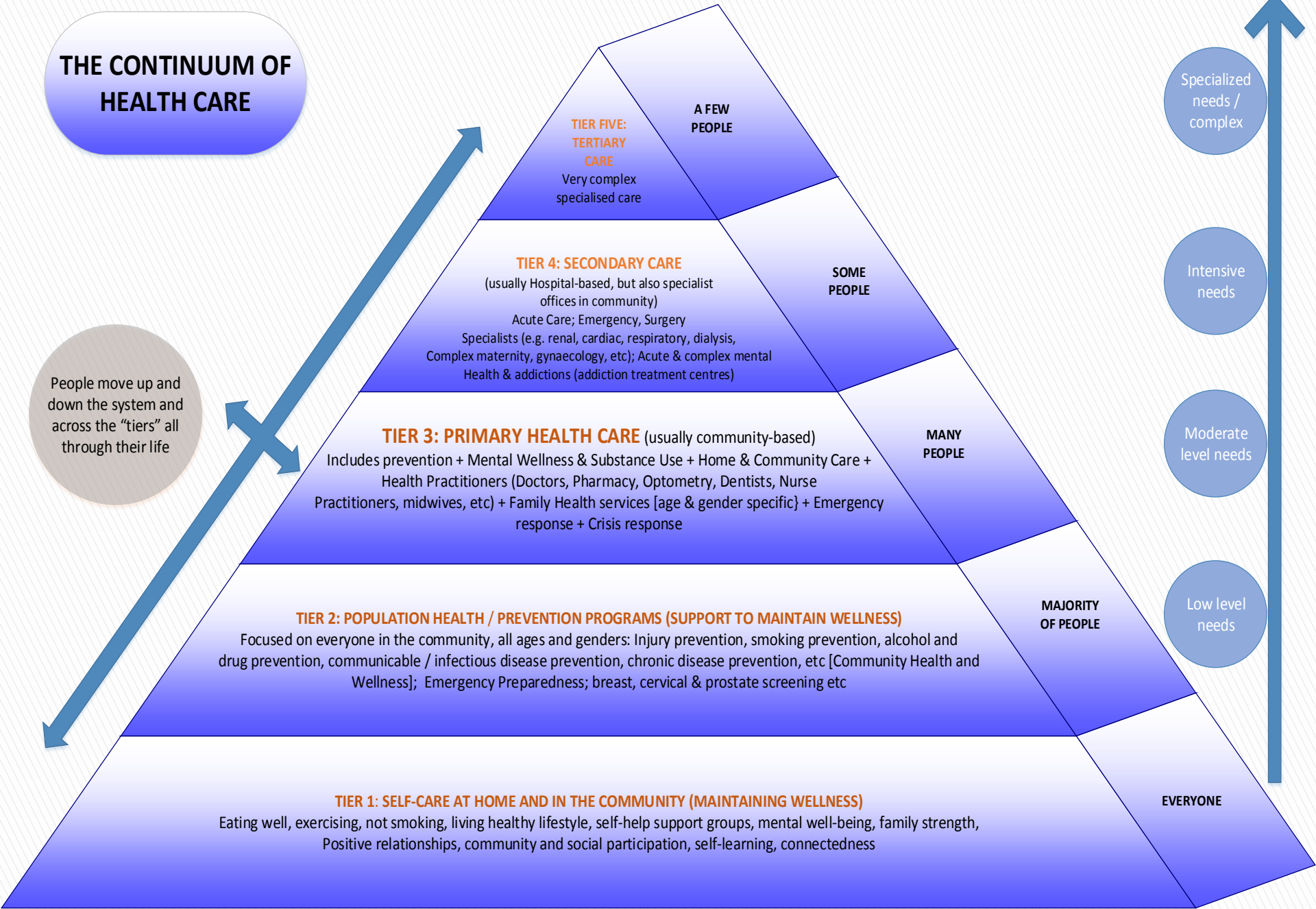


WHAT IS “PRIMARY HEALTH CARE”

- ▶ Refers to a wide range of ‘first contact’ services (and usually based in community not hospital)
- ▶ Care that is provided for people with chronic or complex health needs in the community
- ▶ Coordinating care with other service providers
- ▶ Services that help people stay well
- ▶ Service that help people manage their conditions
- ▶ Non-residential / non-inpatient / non-acute

THE CONTINUUM OF HEALTH CARE

People move up and down the system and across the "tiers" all through their life



When communities have good access to these services and programs – we can keep community members out of hospital and help them to maintain health and independence in the community and in their own homes



Definition: Primary Health Care in this model refers to the wide range of first contact services; care for people with complex health needs; coordination of care with other service providers and helping people to get well, stay healthy and to manage their conditions.

Inner circles = Primary Health Care (front-line processes, relationships, services): Integrated multi-disciplinary teams

Outer circles = Secondary care (referred through primary care): some hospital-based, some community-based

INTEGRATION = how services work well WITHIN a cluster and with OTHER clusters and with other service PROVIDERS

FIRST NATIONS COMPREHENSIVE PRIMARY HEALTH CARE TEAMS

WHAT	SERVICE CLUSTER	WHO (FN, FNHA, VCH, Private)
Traditional medicine & healing; Elders; Sacred spaces; language; ceremonies; traditional activities	TRADITIONAL, SPIRITUAL & CULTURAL WELLNESS	Elders, Cultural advisors, Healers
Physical activity & nutrition; Food security; Prevention of injury, Alcohol & drug; suicide; FASD; communicable diseases; smoking	COMMUNITY HEALTH & WELLNESS	Health Promoters / Educators, Community Health Workers, PH Nurses
Infant health, parenting, child health, youth; men's health, women's health, elders	FAMILY HEALTH SERVICES	Maternal Child Health Nurses, AHSOR workers, Youth & Elder Workers
Home Care Nursing (e.g. Assessment; case management, wound care, foot care); Personal Care; Medication reviews, Medical supplies & equipment; Rehabilitation (OT, PT, SLT)	HOME AND COMMUNITY CARE	HCC Nurses (RNs / LPNs), Personal Care Aides / Workers; Rehabilitation providers (OT, PT, RT, Dietitians, Podiatrists, Chiropractors, Physiotherapists)
Counselling & Therapy (individual, group, family) - clinical; social, psychiatric; vocational, social & recreational support; crisis support; access to residential (referrals & aftercare); suicide crisis response	MENTAL WELLNESS & SUBSTANCE USE	Counsellors (e.g. NADAP) – clinical, non-clinical, cultural; Psychologists; Social Workers; Psychiatrists
Medical & Clinical care; dentistry; optometry; pharmacy; alternative & complementary medicine	HEALTH PRACTITIONERS	Physicians, Nurse Practitioners, Dentists, Pharmacists, Optometrists, Alternative Practitioners
Patient advocacy; EMRs, Telehealth; Facilities; Education; Research; Quality	SERVICE ENABLERS	CHRs; Patient Advocates; Patient Travel Workers; Tele-health technicians; Researchers; Quality Managers

ACHIEVING THE 'IDEAL MODEL' IN COMMUNITIES

- ▶ 2012–2013: VCH worked with communities and mapped current services against the model in each community to identify what is working well, gaps & improvements needed
- ▶ Many examples of best practice and innovative arrangements by First Nations with local health practitioners and with VCH services
- ▶ Around 68% or just over 2/3 of the identified primary health care services are available to and /or accessible by the region's First Nations communities (but some of these services need to make quality improvements)
- ▶ Insufficient service to meet demand (prevention programs; traditional, cultural and spiritual wellness; mental wellness and substance use and rehabilitation services)
- ▶ Outright gap – the services or programs are not sustainably provided or available, or are non-existent:
 - Several prevention programs
 - service enablers that support services to work well (e.g. Electronic Medical Records (EMRs), tele-health, accreditation and outreach services)

LEGEND	 Service access / availability is good / acceptable; working relationships with VCH & others	 Service Gap: NO SERVICE in the community or accessible
	 Service access / availability is there, but with quality issues needing improvement	 Service Gap: INSUFFICIENT SERVICE or capacity or limited access

DASHBOARD (14 FN communities)

- 69 service lines assessed (7 clusters)
- **Green** – means good access to the service in the model
- **Orange** – means there is access but quality issues
- **Light red** – means there is an ‘insufficient’ service to meet demand
- **Red** – means there is no service (outright gap)

		Klaskan (Kwantlen)	Melittuk (Beilga Beilga)	Wuikiniy (Owekeeno)	Nuxak (Beilga Coala)	Sliammon (Tla'amin)	Seswilt	Lil'wat (Mount Currie)	Southern Sliw'it'it'inx (Paabberon)	Squamish Nation - North Shore & Squamish Valley	Tslelt'Wautath	Musqueam
SPIRITUAL AID TRADITIONAL WELLNESS	Traditional healers & practices	Orange	Green	Green	Green	Green	Light Red	Green	Orange	Light Red	Green	Orange
	Elders, Advisors	Light Red	Green	Green	Green	Green	Green	Green	Light Red	Light Red	Green	Orange
	Traditional / Spiritual spaces / facilities	Green	Green	Green	Green	Green	Green	Green	Orange	Green	Green	Green
	Cultural Ceremonies	Orange	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	Traditional Activities	Light Red	Green	Orange	Green	Green	Green	Green	Green	Light Red	Green	Green
HEALTH AID WELLNESS (Health Promotion & Prevention)	Use of Language	Orange	Green	Orange	Green	Green	Green	Orange	Orange	Orange	Orange	Orange
	Physical Activity	Orange	Green	Light Red	Green	Light Red	Green	Green	Light Red	Light Red	Light Red	Light Red
	Nutrition/Food Security	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Healthy Pregnancies	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Preventing smoking / smoking cessation	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Suicide prevention	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Violence prevention	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Communicable Disease prevention	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Injury prevention	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Alcohol and drug addiction prevention	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
FAMILY HEALTH SERVICES (Age & Gender specific)	Stress management	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Emergency Preparedness	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Infant Development	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Child health services	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Youth health services	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Women's Health	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Men's Health	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Parenting	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Seniors / Elders programs	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Referral / Discharge maternity	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
HOME AND COMMUNITY CARE	Referral / Discharge Assisted Living / LTC	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Referral / Discharges Mammography/Colp.	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Home Care Nursing	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Medication Reviews	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Clinical supervision and education	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Case Management	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Community Rehabilitation	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Adult day support	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Medical supplies and Equipment	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
	Palliative Care	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red
Personal care	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red	
Home Help	Light Red	Green	Light Red	Green	Light Red	Green	Light Red	Light Red	Light Red	Light Red	Light Red	

DASHBOARD (14 FN communities)

- 69 service lines assessed (7 clusters)
- **Green** – means good access to the service in the model
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LEGEND		Service access / availability is good / acceptable; working relationships with VCH & others	Service Gap: NO SERVICE in the community or accessible									
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		Kiasoo (Kiamu)	Haitasuk (Baita Baita)	Waiwikiaurū (Owakaero)	Nuxauik (Baita Cooba)	Silammon (Tia ramini)	Saecheit	Lil'Wax (Mount Currie)	Southern Strait/Inx (Pemberton) (4 communities)	Squamish Nation - North Shore & Squamish Valley	Ts'elil-Nanulth	Musqueam
MENTAL WELLNESS AND SUBSTANCE USE	Community-based counselling / therapy	Light red	Green	Light red	Green	Light red	Light red	Green	Green	Light red	Light red	Light red
	Outpatient Therapy and counselling (Social Worker)	Red	Green	Red	Light red	Light red	Red	Light red	Red	Light red	Light red	Light red
	Clinical psychologist	Light red	Light red	Red	Light red	Light red	Light red	Orange	Light red	Light red	Light red	Light red
	Psychiatrist	Light red	Light red	Red	Light red	Light red	Light red	Light red	Light red	Light red	Light red	Light red
	Crisis support	Orange	Green	Orange	Green	Green	Green	Green	Green	Light red	Light red	Light red
	Access residential care	Orange	Green	Orange	Green	Green	Green	Green	Orange	Light red	Light red	Light red
	Vocational training etc.	Green	Green	Green	Green	Light red	Light red	Green	Green	Green	Light red	Light red
	Support for families	Green	Green	Green	Green	Green	Green	Green	Green	Green	Light red	Light red
	Crisis response system for suicide	Red	Green	Red	Green	Orange	Light red	Red	Red	Light red	Light red	Light red
	Postvention support for families, friends	Red	Green	Red	Green	Orange	Light red	Red	Red	Light red	Light red	Light red
HEALTH PRACTITIONERS	Referral / discharge Resid. Treatment	Orange	Green	Orange	Green	Green	Green	Orange	Orange	Light red	Light red	Light red
	Referral / discharge Psych Units	Orange	Green	Orange	Green	Green	Green	Orange	Orange	Light red	Light red	Light red
	Referral / discharge Detox	Red	Green	Orange	Red	Orange	Orange	Orange	Orange	Light red	Light red	Light red
	Physician / Gen Med care	Green	Green	Green	Green	Green	Green	Green	Green	Light red	Light red	Light red
	Nurse Practitioner	Green	Green	Green	Green	Green	Red	Green	Green	Light red	Light red	Light red
	Pharmacy / pharmacist	Light red	Green	Green	Green	Green	Green	Green	Green	Light red	Light red	Light red
	Dental therapists / Dentists	Light red	Green	Green	Green	Green	Green	Green	Orange	Orange	Light red	Light red
	Emergency Services	Green	Green	Green	Green	Green	Green	Green	Green	Green	Light red	Light red
	Optometry	Red	Green	Red	Green	Green	Green	Green	Red	Light red	Light red	Light red
	Alternative Medicine	Green	Green	Green	Green	Green	Green	Green	Green	Green	Light red	Light red
SERVICE ENABLERS	Clinical supervision and education	Green	Green	Green	Green	Green	Green	Green	Red	Light red	Light red	Light red
	Visiting specialists	Red	Green	Red	Light red	Light red	Light red	Orange	Light red	Light red	Light red	Light red
	Referral / Discharge specialists	Orange	Green	Orange	Orange	Orange	Orange	Orange	Orange	Light red	Light red	Light red
	Community Health Representatives (CHRs)	Green	Green	Green	Green	Green	Green	Green	Orange	Light red	Light red	Light red
	Non-Insured Health Benefits (NIHB) / Patient Travel	Green	Green	Green	Green	Green	Green	Green	Red	Light red	Light red	Light red
	Tele-Health	Orange	Green	Red	Light red	Light red	Light red	Light red	Orange	Light red	Light red	Light red
	Quality Improvement - Accreditation	Red	Green	Red	Light red	Light red	Light red	Light red	Light red	Light red	Light red	Light red
	Research and Evaluation capacity	Red	Green	Red	Light red	Light red	Light red	Light red	Light red	Light red	Light red	Light red
	Training, education & workforce development	Light red	Green	Light red	Light red	Light red	Light red	Light red	Light red	Light red	Light red	Light red
	Service outreach, mobile services	Red	Green	Red	Light red	Light red	Light red	Light red	Green	Light red	Light red	Light red
Electronic Medical Record / Client system (EMR)	Red	Green	Red	Light red	Light red	Light red	Orange	Red	Light red	Light red	Light red	
Health facilities	Green	Green	Green	Orange	Green	Green	Green	Light red	Light red	Light red	Light red	

PRIORITIES

Meeting held with Health Directors from all 14 Vancouver Coastal First Nation communities on May 22–23, 2013 in Vancouver

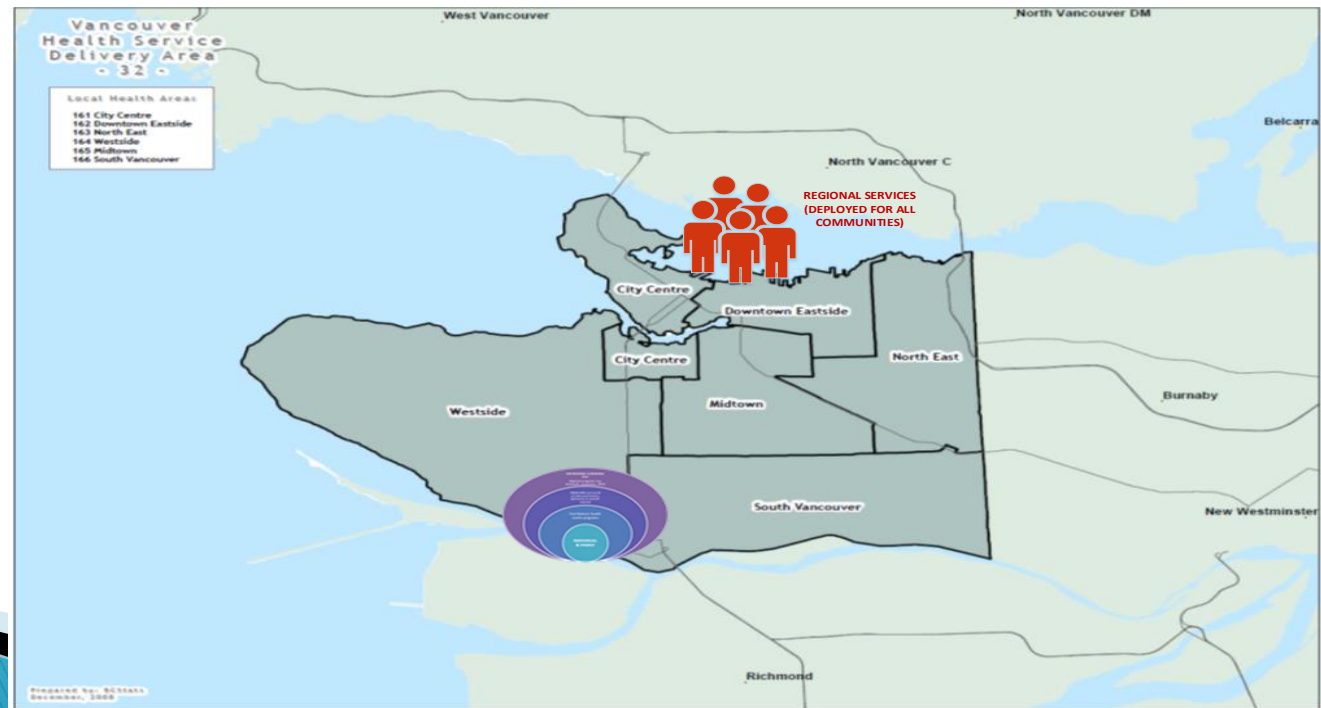
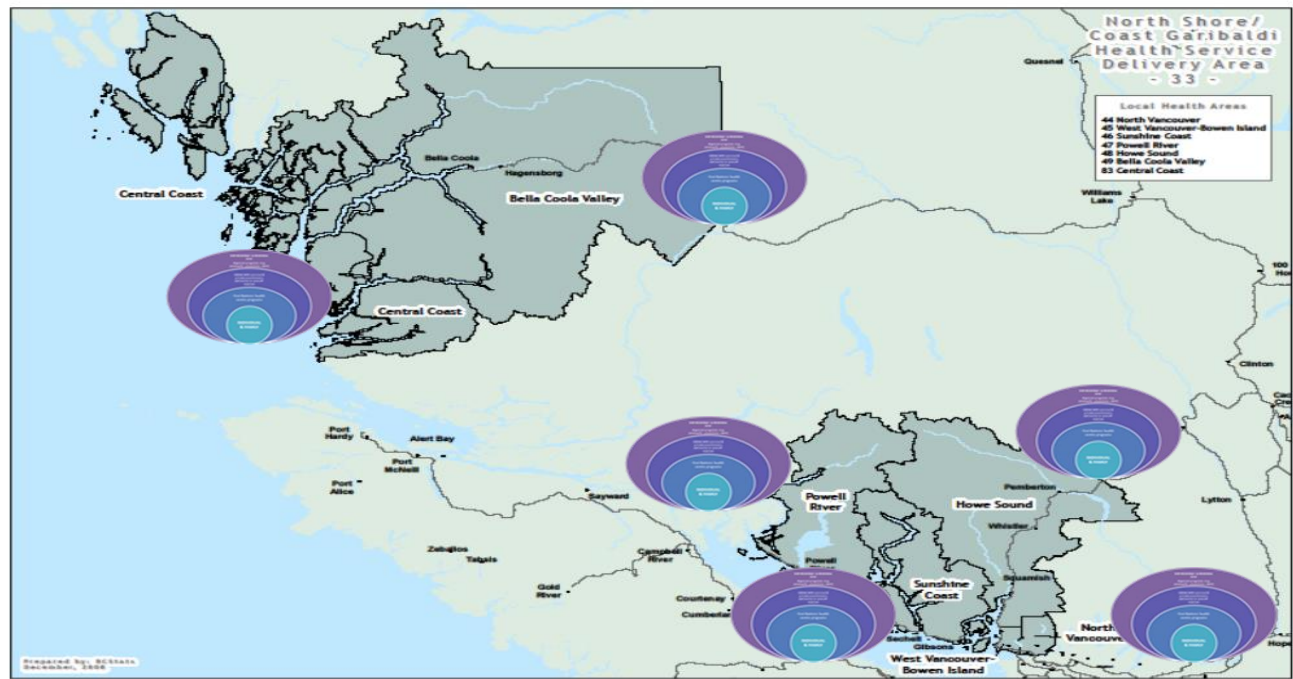


After discussion it was agreed to prioritize the Region-wide gaps:

- **Mental Health, Drug and Alcohol** (including Prevention) which includes addressing gaps in access to social work, clinical psychology, crisis support
- **Injury prevention** (accidental and intentional – suicide, violence prevention) – some Health Leads discussed that often injuries were a result from not addressing #1 mental health and addictions – very closely linked
- **Smoking cessation**
- **Service Enablers** – Electronic records, outreach, training / workforce, accreditation

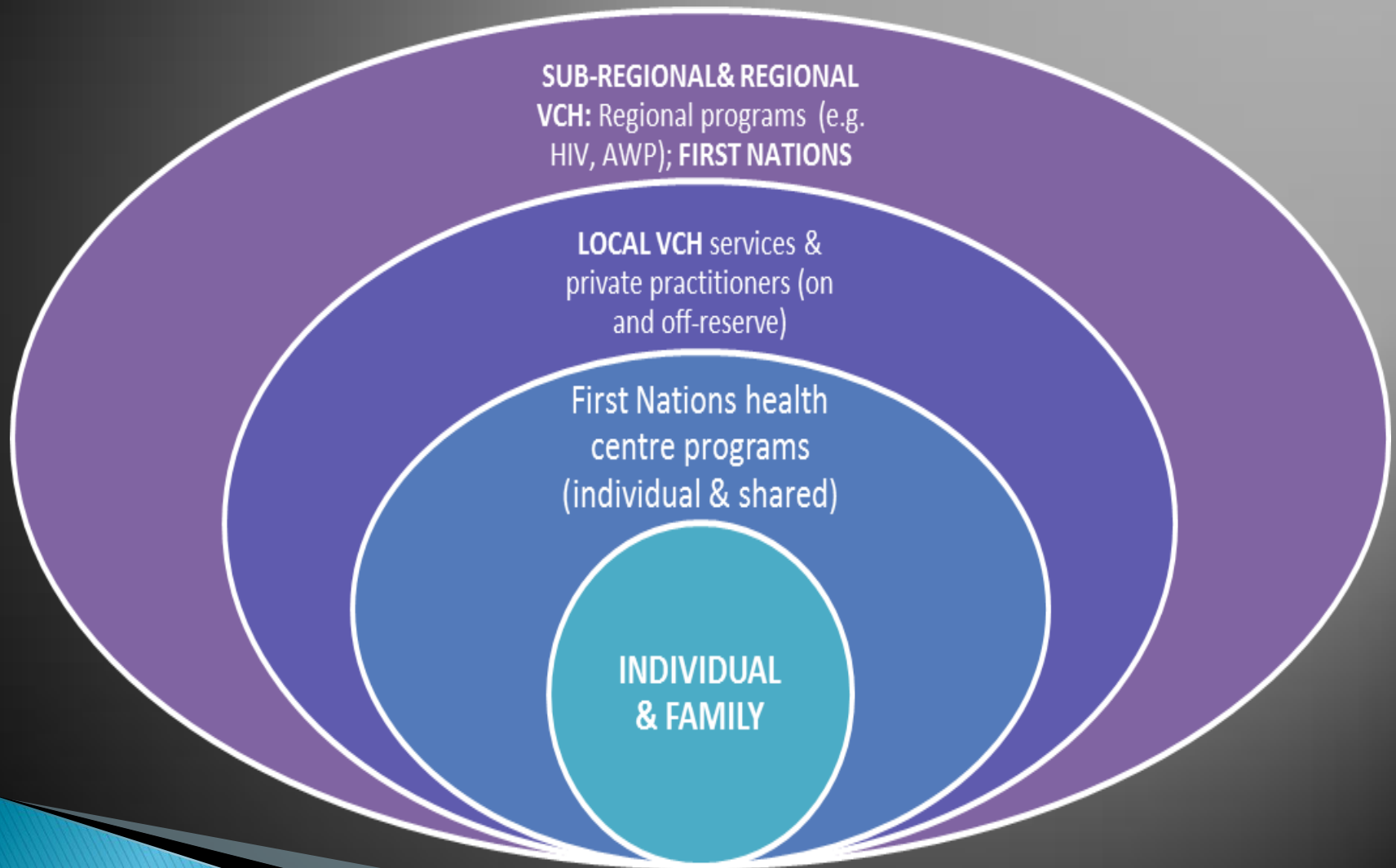
A foundation for Primary Health Care teams across the region

Building on current integration / partnership work (IPCC, partnerships, collaborations)



YOUR “PRIMARY HEALTH CARE TEAM”?

What does it look like? How is it working?



EXAMPLE OF PARTNERSHIP

collaboration, shared resources, integration

- ▶ Nuxalk (850 people): Integrated Home & Community Care Services
 - ▶ *“Our mission is to give care based on what you need, not where you live.”*
- ▶ Integration process developed over six years between the provincially-funded home and community care program offered off-reserve and the (then) federally-funded home and community care program offered within the Nuxalk Nation
- ▶ Both programs offered similar, but separate services including an Elders’ lunch program and blood pressure clinic, foot care services and personal care within the home.

EXAMPLE OF INTEGRATION

Partnering / collaboration, shared resources

- ▶ Integration of the two programs began arising out of challenges experienced in both programs: now one home care program in the Bella Coola Valley for all residents regardless of where they live
- ▶ Central management and supervision of home care by VCH Home Care Manager (based at hospital) and funded by both VCH and Nuxalk Nation. Manager has dual accountability to both
- ▶ Nation continues to employ two Personal Care Workers to provide in-home services exclusively on reserve – rest of the home care team are employees of VCH providing services both on and off reserve. Manager rosters, trains, supervises all of them as one team
- ▶ Program aligns with provincial home care standards and offers a variety of services including home care, wound care, palliative care, an adult day program, chronic disease education, care management and planning, discharge planning, and medication reconciliation.

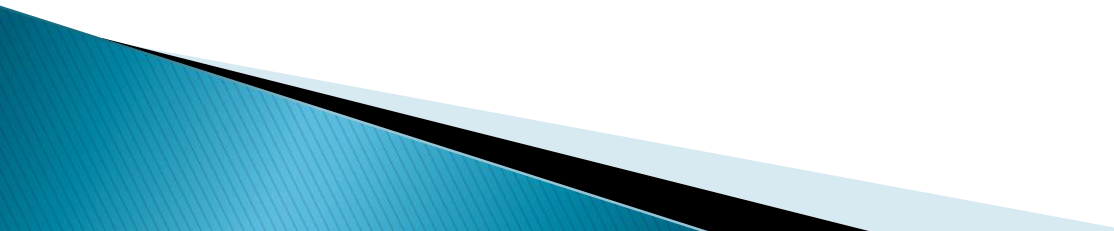
Synopsis of Program Changes as a Result of the Integration

Home Care Program Prior to Integration	Home Care Program After Integration
<ul style="list-style-type: none"> • 1 FT Registered Nurse (program manager) • 5 FTE Community Health Workers (2 exclusively on reserve and 3 exclusively off reserve) 	<ul style="list-style-type: none"> • 2 FT Registered Nurses • 2 Licensed Practical Nurses • 4.5 FTE Community Health Workers
Care 5 days per week 8am - 4: 30	Care 7 days per week 7am - 6pm including statutory holidays
2 Elders Lunches (one off reserve and one on)	1 Elders Lunch (every Wednesday located on reserve)
2 foot care clinics	1 foot care clinic held bi-weekly at the Health and Wellness Centre at Nuxalk Nation
Limited assessment or informatics – assessments described as informal and not systematic	<ul style="list-style-type: none"> • VCHA Primary Access Regional Information Systems (PARIS) used to register and track clients • Use of interRAI for complex cases
Basic wound care services	Daily wound care services along with specialized training for home care staff in wound care. <ul style="list-style-type: none"> • Pixalere wound care management system implemented
Program scope limited to in-home client care	Program scope broadened to include: <ul style="list-style-type: none"> • Elders Day Care (daily) at BCGH: bathing, blood pressure check, other required care, social activities and a meal • Wound Care • Palliative care at home (on request) • Designated Responders (Elder abuse) • Medication reconciliation


“We live in a small community and we have to be resourceful”

NUXALK: “Somehow with the funding we got separated (Indian and white) and things like the Elders Lunch help to bring us back together”

VCH: “It was shaky at first, but we are all one and we all need to work together and we need to be together and think with an open mind. We need to get out of that thinking.”



Challenges to work through

- ▶ Prior mistrust of hospital services by FN community
 - ▶ Persistent service gaps (e.g. respite, no long term care facility)
 - ▶ Combining two sets of standards (federal / provincial)
 - ▶ Change management takes time (high communication needs up front)
 - ▶ Having a champion to lead the work within each partner
 - ▶ Standardizing data collection
- 

Benefits / Improvements

- ▶ Increased interaction between home care clients on and off-reserve (compared to previous)
- ▶ More & broader companionship for Elders in the community
- ▶ Better efficiencies in the program for both partners
- ▶ Single set of standards the services work under
- ▶ Access to VCH tools, systems and expertise (Pixalere, InterRai)
- ▶ 7 day a week cover: greater use of human resource capacity
- ▶ Improved team support (both Nuxalk & VCH teams together)
- ▶ More training opportunities (for both)
- ▶ Improved wound care; clients with increased mobility
- ▶ More welcoming for First Nations when they use hospital (know the staff, have friends also in the program)
- ▶ Greater continuity of care
- ▶ Opportunities to expand to other areas of central coast (Heiltsuk, Kitasoo)
- ▶ Access to VCH regional specialist services easier

WORKSHOPS



- Opportunity to re-validate / update the gaps and needs so we keep working towards achieving all aspects of the PHC model in your communities
- Opportunity to look at creative approaches to invest so we can continue to strengthen the “PHC team” (you + your neighbor communities + VCH (local & regional) + local practitioners) operating together for your community

