AN ABORIGINAL HEALTH TRANSITION FUND PROJECT

Southern Chiefs' Organization & Winnipeg Regional Health Authority

# COLLABORATIVE STRATEGIC ACTION PLAN

SOUTHERN CHIEFS' ORGANIZATION INC.

Winnipeg Regional Health Authority
*Caring for Health*

Office régional de la santé de Winnipeg
*À l'écoute de notre santé*

# Thank You

The Southern Chiefs Organization and Winnipeg Regional Health Authority would like to extend thanks to those who contributed to this project:

Thank you to the many Elders, First Nations health care providers and Winnipeg Regional Health Authority health care providers who participated in the project.

Thank you to Elder George Matthew Courchene (Sagkeeng), Elder Esther Cameron-Laporte (Long Plain), and Elder Allan Cochrane (Winnipeg) who provided spiritual guidance for the project.

Thank you to the Communications Sub Committee who developed the communication work plan and produced the excellent communication tools for the project.

Thank you to the Adaptation Partnership Committee for their support and commitment throughout the project:

**Andrew Basham**, Manitoba Keewatinowi Okimakanak
**Michael Bear**, Southern Chiefs' Organization
**Gail Braun**, Four Arrows Regional Health Authority
**Allan Cochrane**, Elder Advisor
**Dr. Catherine Cook**, Winnipeg Regional Health Authority
**Donna Everette**, Southern Chiefs' Organization
**Shirli Ewanchuk**, Southern Chiefs' Organization
**Sylvia Flint**, First Nations Inuit Health
**Sandi Gendreau**, Manitoba Health
**Gwen Gillan**, West Region Tribal Council
**Cindy Hart**, Fisher River Cree Nation Health Centre
**Lyna Hart**, Southeast Regional Development Centre
**Josie Kent**, Interlake Reserves Tribal Council
**Amanda Mentuck**, Dakota Ojibway Tribal Council
**Jacqueline Nobiss**, Winnipeg Regional Health Authority
**Dean Parisian**, Assembly of Manitoba Chiefs
**Joanne Roulette**, Sandy Bay First Nation
**Darlene Sorin**, Manitoba Health

Also thank you our project funders, Manitoba Health and First Nations Inuit Health Branch.

The collaborative project was funded by the Aboriginal Health Transition Fund (AHTF), a federal funding initiative to enable governments and communities to devise new ways to integrate and adapt existing health services to better meet the needs of First Nations, Inuit and Métis people including those living off reserve and in urban areas.

The WRHA/SCO project falls within the Adaptation Envelope of the AHTF, which refers to the redesign, reorientation or modification of existing provincial/territorial health services and programs to improve both their availability and appropriateness in meeting the health needs of all Aboriginal peoples.

For more information on the Aboriginal Health Transition Fund, visit the Health Canada website, **www.hc-sc.gc.ca**.

## Table of Contents



# Introduction

In 2008, Southern Chiefs' Organization (SCO) and Winnipeg Regional Health Authority (WRHA) along with other partners, embarked on a collaborative journey to develop a model for adaptation of health care services within the Winnipeg Health Region as it affects First Nations people. For the SCO/WRHA project, a project office was set up, expert services retained and data was collected, processed and analyzed. First Nations were engaged at various levels to provide input in the process, and ultimately a framework for health adaptation was developed.

In consultations with various stakeholders, stories emerged about First Nations people not understanding the system that is available to help them or the policies in place to guide the service. While most people on reserve understand that their first entry point in the system is the nursing station or health centre, and from there follow-up arrangements get made, it is the experience once they leave the community, or encounter an urban institute such as a hospital, that some confusion occurs. Within WRHA, the department of Aboriginal Health Programs – Health Services exists to assist patients in planning treatment and discharge while they are in Winnipeg for health care at a WRHA facility. These health services include interpreter services, advocacy, referral and general counselling.

In spite of efforts of the stakeholders to make the health experience as safe and comfortable as possible, people still feel anxiety, and as a consequence do not seek the attention when they need it, or are not clear in their understanding of their condition and treatment. SCO and WRHA aspire to increase awareness among First Nations people about what services are available, when and where to access service, where to get information and support, and generally improve understanding in the broader community about the strengths and boundaries of the health care system.

The SCO/WRHA project explored and defined the experiences of health care from various stakeholders and developed a broad and comprehensive *Framework for Health Adaptation*. The project now defines strategies from that framework that might facilitate change at various levels. The strategies are broken down in this *Collaborative Strategic Action Plan* as guiding points for further development.

# Executive Summary

The *SCO/WRHA Collaborative Strategic Action Plan* is designed to be adaptable to the environment and context where partners will operationalize goals and objectives, and related activities. The scope of Primary Health Care and related health services is both broad and diverse, but in some cases specialized. Health services as they relate to First Nations have issues that are unique, due to jurisdictional factors impacting service as well as the health and social determinants of each population. Consequently, the broad strategic objectives will need to consider the segregated, fragmented reality in which all stakeholders operate, while at the same time aspire towards more mutual and common actions through innovative and forward-thinking processes.

Engagement sessions with stakeholders and Elders garnered stories and experiences within the health care system, including challenges and concerns. Elders told stories of fear, anxiety, stress and confusion about the system. Providers talked of some breakdowns in the system, including communication processes, and cited examples of gaps in the continuum of care at the community level, within institutions, and at the policy level.

In order to capture the essence of the system and begin to operationalize the elements of a plan to improve the system, it is important to lay out the variables.

The plan proposed here is not intended to be a step-by-step map of the change that is aspired. Rather, it is a template for further discussion and a tool to be used to open and guide a deeper dialogue on specific areas of mutual interest within the health system.

# Scope

The SCO/WRHA project has developed a *Framework for Health Adaptation* that is comprised of many parts. It outlines a general structure, symbolized by a tipi, through which changes to the health care system, at any level could be undertaken.

The overall structure of the Framework is comprised of 13 Principles that support the project Goal, the Strategic Objectives, and the Strategies. It is the key result areas, or theme areas in which issues were categorized, that make up this *Collaborative Strategic Action Plan*. The challenge is finding the interface mechanism between the system and the populations, each having their own unique characteristics, dynamics and sets of needs that are distinct to their domain, yet integrally linked with each other.

Health systems are macro-level entities that involve resources such as people, ideologies, sciences, machines, technology, knowledge, skills and tools, and methods for application. Populations break society down to a micro level that involve people as patients (recipients of services of systems), dynamics of individuals in their surroundings and dynamics between individuals and the systems around them. When there is breakdown at any level, the breakdown can be attributable to many things. Without clear definition of the parts and interactions, and steps and measures of actions, it can be difficult to pinpoint reasons for success or failure in systems as they operate, or in systems that have undergone change.

It is these multi-variant scenarios that pose challenges to any undertaking towards change or adaptation in any system. Using the range of factors at play in the health care system, this *Collaborative Strategic Action Plan* will provide options for programs and services to move forward. The plan will be broad enough to capture the various partners required to achieve change. However it will still be focused enough to be able to define the tangible results aspired towards through targeted action or result areas laid out in further work-plans.

The partners include the Southern Chiefs' Organization, representing 36 First Nations, the Winnipeg Regional Health Authority, representing the various service areas and institutions of health care within the city of Winnipeg, Manitoba Health, representing the Province of Manitoba and finally, First Nations and Inuit Health, representing the Government of Canada.

The scope in terms of time will be September of 2010 to September of 2015, and beyond. Beyond captures the work that will need to continue beyond 2015 but for which, in this plan, specific actions cannot be defined yet.

The scope in terms of resources is mainly current human resources, infrastructure/capital and technology that would be contributed in-kind towards implementation of the *Collaborative Strategic Action Plan*. Until such time as new resources, or re-profiled resources, are identified towards implementation of a focused action plan, this plan assumes that existing resources can be used and implies a minimal cash investment.

# Collaborative Strategic Action Plan

The *SCO/WRHA Collaborative Strategic Action Plan* (CSAP) builds on the strengths and findings of the AHTF project established in 2008 and carried out through to 2010. The project was established as a collaborative venture whereby partners with mutual interests in common issues came together to brainstorm and understand common issues; these common elements are laid out in the *SCO/WRHA Framework for Health Adaptation*. The Framework involves partners working together on a model of practice that would improve the health system overall and improve the health status of First Nations people. The CSAP builds on the Framework and it is anticipated that further work plans can be developed out of the CSAP.

The concept of collaboration is a common thread throughout the CSAP. It not only affirms the joint efforts that went into endorsing each plan and steps taken at each point of the SCO/WRHA project, but it implies that strategies will be implemented through joint actions. Foundational structures and processes were established early on in the SCO/WRHA project that guided activities, and reviewed the outputs. The CSAP builds on these lessons and aims to sustain the positive practices that were established.

# Structure

The CSAP will sustain the committees and project office established by the SCO/WRHA project. This includes the Adaptation Project Committee (APC) , the Report Review Committee (RRC) and Project Management Office (PMO).

It may be beneficial to retain an oversight committee to guide the development and implementation of the CSAP. The APC would be the most likely committee to assume the responsibility for oversight and guidance. The APC will be comprised of the same membership that consists of tribal and First Nations representatives, Manitoba Health, and First Nations and Inuit Health.

On an as-needed basis, review or Ad-hoc Committees could be established, comprised of members identified by each APC representative, but will consist of those who possess the expertise and background in each strategic area. The Communication Sub-Committee (CSC) established by the SCO/WRHA project will be retained to guide communication undertakings as well as serve as the Communication Review Committee. The CSC will also factor in the communication needs of each report and work plan laid out by each review committee.

As reports and specific work plans - with targeted priority areas - are developed, the APC will continue to serve as an oversight committee, but potentially could serve as a governance structure. This would be a specific strategy to be explored by the partners as it implies a great deal of change, change that would need to be managed, but also systemic change that perhaps could be entrenched by legislation or a regulation of existing health law. The purpose for such a governance structure would be to ensure that some collaborative entity exists within Manitoba that has insight and expertise to guide adaptive change within the system, and also has the authority to enable strategic initiatives to occur within the provincial and, if necessary, the federal system.

# Inputs

The CSAP is built on the premise that very little new cash investments will be needed for it to be implemented. It will draw from the existing human resource pool through in-kind contributions of staff, equipment and office/meeting space. In the first year however, it may require more time investments from targeted staff, such as up to 10 to 15 hours per month from each representative of each committee. This is to ensure the time to meet, as well as research and write on issues that will be targeted for action or work plans in each strategic area.

After the first year, meetings and work will scale down to approximately 5 to 10 hours per month for updates and strategic guidance of the Adaptation Partnership Committee, for about 12 to 24 months.

# SCO/WRHA Framework for Health Adaptation

The following goal has been set as an outcome of the SCO/WRHA project:
**Improved health status through the adaptation of existing health services.**

The four Strategic Objectives have been identified here in Figure 2:

| **STRATEGIC OBJECTIVES** | |
|---|---|
| Collaboration and Partnerships | New linkages, collaboration, and partnerships between health systems and at multiple levels that are achievable (i.e. Government, RHAs, Non-profit, lobbying {PTO} agencies, communities) |
| Reorientation of health services | Adjustments to better meet the needs of First Nations patients |
| Communication and Transition | Transition planning towards a sustainable best practice or promising practice model in each of the three areas – discharge planning, advocacy and cultural programs |
| Evaluation | To collect baseline data information and monitor for outcome results |

Figure 2. List of Results Framework Strategic Objectives with scope from the *Framework for Health Adaptation*.

For the *SCO/WRHA Framework for Health Adaptation*, the intent is to keep the Framework broad and foundational, thus not focusing on firm actions. Actions would instead be identified through the strategies around which the *Collaborative Strategic Action Plan* is developed.

Effective programs select evidence-based interventions, meaning services or behaviours known to have an impact on health status.

The five broad evidence-based strategies are: Access, Quality, Awareness, Structure and Communications. Figure 3 depicts the prospective results of the framework and related strategies which incorporate the key themes from the analysis of the data collected from the project. Examples of strategies that are simple, realistic and attainable are included.

| STRATEGIES | STRATEGIC ACTION EXAMPLES |
|---|---|
| Access to and availability of health services where links to health services are increased | • Community based services<br>• Joint community/system based case management<br>• Service access and delivery points |
| Quality of health services improved | • Improvement in health care provider capacity<br>• Strengthen service delivery<br>• Effective linkages between First Nations community and health system<br>• Develop a quality "culture"<br>• Ensure acceptability and respect for the differences in cultural norms |
| Increased awareness of health services | • Community mobilization and increased awareness<br>• Behaviour change communication |
| Structure | • Advocacy<br>• Governance/Policy<br>• Community capacity<br>• Leveraging of resources<br>• Partnering mechanisms<br>• Organizational development |
| Communication | • Applied technologies<br>• Improved Interpreter services |

Figure 3. Results Framework Strategies with example results.

Access and availability refer to the likelihood that the health consumer and a service will actually meet and that the necessary programs and services will be available. Access extends beyond geographic challenges and can encompass the social determinants of health, such as income, education and social networks, that impact on health status and pose challenges to health care.

The concept of quality is complex and refers not only to the technical quality of the services but also to patients' perceptions of quality and acceptability. Quality explores results aimed at assuring safety and security of all involved including the practitioner and patients.

Increased awareness of health services implies that once strategic actions are implemented, patients
will be aware of the services available to them regardless of where they reside. Patients will also have improved knowledge about the system and service overall to be able to confidently access when they need it.

Structural enhancement addresses the range of issues identified from the project in the research phase and examines methods and undertakings that might adapt the structures under which future health systems can operate.

Finally, at every step in the process, a defined communication system that ensures a dynamic and constant exchange of information between the partners should be in place.

The CSAP lays out a broad foundation that establishes broad strategies for which more specific strategic actions can be defined through mutual work-plans developed through collaborative efforts of all stakeholders.

## Principles

The *SCO/WRHA Framework for Health Adaptation* is guided by core principles. This ensures integrity in whatever process would be entered into, ties in the diversity perspectives of the stakeholders, and finally, incorporates cultural considerations from the various perspectives.

The principles are critical to the success of the Framework and are designed to guide effectiveness at all levels including individual, community, organizations and system overall. Thirteen principles have been highlighted in the Framework document to capture the values, beliefs and sentiments of both the stakeholders and participants in the consultation activities. The principles provided are broad and meant to serve as a guide, or grounding, for First Nations communities and health care providers in their endeavors to adapt health services; they factor in the needs and interests of the populations served, as well as capture the essence of the stories shared by all who were engaged in the project. The principles inter-relate and have been developed to guide all other areas of the Framework.

A working definition of Principles is: Agreed upon values which serve as roots or parts of a foundation, on which a health system adaptation can be built and through which stakeholders take ownership.

## Evaluation and Monitoring

Drawing from a results-based viewpoint, it is important to demonstrate that actions can be tied to results and that results can be measured to demonstrate things like effectiveness, efficiency, relevancy and practicality and ultimately sustainability considerations, such as program continuation, program investments or adaptation needs. At critical points throughout the implementation of each strategic area, benchmarks should be set early in the planning stages so all stakeholders know what to expect at the same time. Benchmarks demonstrate the systematic approach undertaken towards actions and outcomes, rather than arbitrary checkpoints that may be determined by one or more parties, but not all.

It is imperative that the Goal(s) and Strategic Objectives are clear and mutually agreed to, that activities are defined, resources earmarked and expectations and assumptions are disclosed. This ensures that bias does not influence the evaluation process and that the process of evaluation is fair, transparent and honest. Benchmarks help the stakeholders see how the CSAP is being managed, sets mutual targets and time frames for measuring progress, and sets a bar against which partners can measure progress. It would be up to each "review committee" to determine the benchmarks for their strategic area. Benchmarks will serve as markers to the APC only, and will not extend to community and/or RHA activities.

# Strategies and Strategic Actions
# Strategy 1 - Access

The result area of access implies that, through collaborative efforts, geographic access would be improved and systemic challenges reduced. Access to health care implies simply the ability for someone to seek medical attention when necessary. For many First Nations issues of access arise when an individual either does not have the ability to access health care, or that the service is either not available locally or regionally for a variety of reasons.

A number of scenarios were highlighted by project participants that painted a picture of frustration, fear, anxiety, stress, worry and general displeasure with the experience of accessing health services. Access to health services is facilitated through a myriad of programs and services at various levels, including the local band office, the nursing station, and various providers of transportation using a variety of vehicles such as snowmobile, ATV, boat, helicopter, taxi, bus, airplane, and ambulance. Each mode of transportation involves a different operator, and coordination of service is required in order to get patients from their homes to their appointments. There are many stories of breakdowns, misunderstandings and environmental circumstances that contribute to missed appointments or delays in getting between, to and from facilities.

### Strategic Action 1.1
### Community based services

A network of health care providers (First Nations/Regional Health Authorities) should be established to support the *SCO/WRHA Framework for Health Adaptation* in order to improve access to areas with limited access to specialized services. This would involve development of not only local community partnerships to advise on health programs and services, but also inclusive consultation processes to support the implementation of the adaptation of health services to First Nations and continued planning through the engagement of all stakeholders.

### Strategic Action 1.2
### Joint community/system-based case management

Regular meetings should occur between First Nations health care providers and external health services. Meetings could be done through a reorganization of existing networks of health care services for First Nations people particularly where collaboration is already apparent, maintained and could be built upon. It is also important to develop working relationships to access and share data on targets related to reducing social and health inequities. One mechanism to explore could be a data-sharing agreement between all partners that outlines the types of information to be shared, how it would be stored and who would have access to it. Information related to cases is critical in any health planning and is also a necessary piece to case organization and system management.

### Strategic Action 1.3
### Service access and delivery points

Logistics are required to get patients from their homes to the various entry points, which may or may not be health facilities. For example, from entry point to primary care centre and, at end of service or upon discharge, getting the patient back home. Through regular meetings between networks, important players across the various health sectors could share relevant information about patients. In this way they could also then identify formal mechanisms to engage the appropriate contacts required across the systems to ensure that patients are navigated safely through their experience.

# Strategy 2: Quality

Issues surrounding quality can arise for a variety of reasons including language barriers and unethical practice of providers in the health care system. Drawing from the SCO/WRHA Literature Review (2010), significant findings set the tone for the key objectives set out for the Quality Strategy.

Standards of care are explored by professional regulatory bodies such as the College of Registered Nurses of Manitoba. In the *Nephrology Nursing Journal* vol. 36, Ulrich (2009) listed standards of practice for culturally competent nursing care universally such as "leadership skills to advocate for socially just policies," "an awareness of how one's own values, beliefs and cultural heritage can impact culturally congruent nursing care", "understanding of the perspectives, traditions, values, practices, and family systems of culturally diverse individuals, families, communities, and populations for whom they provide care" and that "health care organizations should provide the structure and resources necessary to evaluate and meet the cultural and language needs of their diverse clients."(p. 367)

### Strategic Action 2.1
## Improvement in health care provider capacity

Health systems must support the need for culturally appropriate programming with full and equitable participation of First Nations people and health care providers. This would be done through the establishment of a network of health care providers (First Nations/RHAs) to support a strategy built to focus on quality. A network could identify a formal, but realistic, mechanism to engage the various health training categories required in First Nations communities to meet specific needs or conditions of the people. A network could also design and deliver innovative methods in health education and training to fast track skilled workers to the work force.

### Strategic Action 2.2
## Strengthen service delivery

Formative steps would need to be taken to build a strong foundation for addressing the area of service delivery. First the principles laid out in the Framework would need to be adopted and put into practice through various promotion strategies. From there, the systems should undertake to review existing health programs and services to identify and develop practices that would eliminate gaps in health service delivery.

After program reviews, systems would develop working relationships to access and share data on targets related to reducing social and health inequities, and plan training programs in line with health service needs. There would also be a continuation of health information sharing sessions.

A Quality Framework was developed by The Royal Australian College of General Practitioners (RACGP) (2008) in collaboration with practice representative organizations, consumer groups and health care improvement agencies in 2005 to 2006. The project explored the complex environment of general practice and is a tool for analysis of the current quality in the general practice environment, for planning quality initiatives in response to that environmental analysis, and for evaluating the effects of the activities and improvements that are implemented. The Quality Framework for general practice is a tool for systematic analysis of quality in the current general practice environment, and allows for planning of appropriate activities to address any gaps.

Some of the broad matters that the RACGP explored were: The need to follow a strict set of principles, benefit of oversight coordination of patients' care by the GP, and expanded role of GP into management of complex cases in collaboration with specialists.

Burley and Greene (2007) identify "core drivers" of quality within a remote setting. They offer four core drivers of an integrated conceptual model: The system, the organization, the community and the individual. Central elements of a model of quality care are: Observable attributes, structure, process and outcomes criteria, professional and managerial perspectives, context/environment and time/era. "Context" is defined as the environment surrounding the system, taking it from just a system that focuses on symptoms. "In the remote context, if quality care is to be assessed, a comprehensive understanding of the relationship between contextual variables, service provision and advanced nursing roles is required." (p. 3)

### Strategic Action 2.3

## Effective linkages between First Nations community and health system

In order to develop and maintain effective linkages, both internal and external to First Nations and the RHAs, it is necessary to build networks players. Networks imply that the related connections between systems are engaged and reinforced in order to establish and implement activities. Formal linkages could look at things such as defining and applying health care planning methodologies that includes equal participation from First Nations and the RHAs, and processes to establish monitoring, evaluation and reporting protocol to support the Framework. Regular reporting to the Chiefs'-in-Summit and government officials should also occur to ensure that leadership are informed and current in their knowledge and understanding of developments as they occur.

The *SCO/WRHA Framework for Health Adaptation* contains an illustration of core drivers along with their key factors; the integrated contextual framework should be revisited and adapted to apply to the Manitoba experience.

### Strategic Action 2.4

## Develop a quality culture

In terms of the principle of quality as a measure or guarantee of safety and good practice, many definitions and variables of quality come into play. It is important to reach mutual understandings and realities about patient and provider experiences and these should be defined through collaborative exercises. Teachings or lessons where issues were resolved and critical incidents reconciled should be built upon.

Quality in process, outcome and practice should be the critical areas explored first. Training initiatives that support health care providers in maintaining a level of skills and competence required to maintain the evolving health care needs and changes in program and service delivery should be promoted. Furthermore, targeted indicators of health to measure improvements and/or setbacks and to allow for adaptation of strategies as implementation plans are carried out should also be articulated.

Erdil and Kormaz (2009) cite ethical problems observed by student nurses in Turkey and validate stories such as: physical and psychological maltreatment of patients, ignoring patient privacy, not giving patients sufficient and appropriate information, and discriminating against patients according to their socio-economic or educational status . Factors impacting care were: Health personnel shortages; high patient-to-nurse ratios; inadequate institutional understanding of the importance of health care services and their quality; and insufficient resources and their unjust distribution. These factors cannot be overcome only by health care personnel because such problems require more comprehensive national policies and institutional regulations, apart from individual endeavors. (p. 594)

# Strategy 3 - Awareness:

Awareness within a collaborative health framework exists in the coordinated and mutual efforts made by parties to increase knowledge among the service populations. Awareness is established when patients navigate their way through the health system with relative ease; in this sense we expect that they know where they are supposed to go when they have a health concern, understand their condition and treatment plan clearly after seeing a health professional, and are able to get to and from their appointments with relative ease and comfort.

### Strategic Action 3.1

## Ensure acceptability and respect for the differences in cultural norms

The SCO/WRHA Literature Review (2009) states that when one embarks on a project involving Aboriginal people it is important to understand what culture means and how it fits into the project. Many studies or undertakings on work with Aboriginal people cite norms, practices and traits within the groups and communities. However culture is not just about beliefs and practices of groups of people with similar lifestyles or histories; culture also extends to environments where people come from and their different backgrounds, yet there are similar vocations, shared roles and responsibilities for delivering health care. Depending on the circumstances, it means different things to different people.

The relevance of culture in the Framework and CSAP is to emphasize the importance of coming to a common definition and understanding of what culture is, what it means, and its place in improving health care for Aboriginal people within the Winnipeg Health Region. The partners should seek methods to understand culture in health care as it applies to individuals but also as it applies to the surrounding environments of individuals such as the social, economic, political and historical experiences of the patient. In this sense activities might be undertaken to realize a restoration of the culture within health system adaptation activities and strategic efforts should be inclusive of First Nations way of life and mutual understandings about the history and experiences of the people.

### Strategic Action 3.2

## Community mobilization and increased awareness

Community mobilization is demonstrated through the efforts of people at the community level to organize and prompt action at all levels towards a set goal or objective. Often, people assume that others are taking care of their issues and concerns, but the reality is that health care providers are often over-worked and stretched to capacity to address the immediate issues, and certain matters do not get the attention they deserve. A workload analysis could be carried out to determine how much time nurses devote to the varying tasks related to their jobs, and from there findings could be shared with the public so that they understand the pressures and responsibilities within their immediate health facilities and programs.

It is important that creative and innovative practices be targeted and developed, that would explore the possibilities of non-health professionals to be engaged in improvements in the processes and systems surrounding patients and their families. This might occur through informal health networks of volunteers in every community that would come together to provide information and general orientation to those who are leaving the community for health care. It is also necessary to develop inclusive consultation processes between stakeholders to support the implementation of the planning and ultimate adaptation of health services to First Nations.

### Strategic Action 3.3

## Behaviour change communication

Stakeholders must identify gaps in health systems research, and support the development of essential health systems research to strengthen the health system in providing prevention measures, treatment and care.

Due to the sensitive nature of certain social, economic and health conditions, where lifestyle or behaviours might contribute to health status, it is necessary for a safe, trustworthy process to be established to begin exploring these very sensitive issues. Matters such as addiction, violence, and other preventable conditions have deep-

rooted causes and contributors that cannot be easily understood and where generalizations about interventions and effectiveness cannot be made. Stigmas do exist surrounding certain health conditions, and stereotyping and discrimination does occur. It is imperative that safe spaces are created when these matters are discussed and that any efforts to increase knowledge or test interventions, such as through research, are done collaboratively, engage cultural and spiritual experts, and that protocols are followed diligently.

## Strategy 4 - Structural Enhancement

Structural enhancement seeks to look at the players, their roles and responsibilities, and understand the systems in which they operate. Structures are in place to define the formal relationships between all employees of an organization and how everyone relates in their practice to the overall achievement of organizational or systemic goals and objectives. Structures take the form of governing bodies (including the leaders), decision makers and policy developers, but also includes the mechanism by which decisions get made, such as through policies. Policies within structures aim to guide practice and provide clarity and certainty about practice. They not only lay out the statements of authority about what will take place, they set boundaries and limitations of practice and provide for methods of recourse when boundaries become unclear or crossed.

### Strategic Action 4.1
### Strengthen existing advocacy practices

The field of advocacy is a sensitive one given the complex nature of health care and the various interactions that take place. The SCO/WRHA Literature Review approached the field of advocacy by examining the problems that may be encountered and the players that may be involved in a questionable health care event.

While formal mechanisms certainly should be explored and established to provide recourse for patients who have had negative experiences, ultimately it is incumbent on everyone involved in a formal system of service provision to conduct their relationships with respect. Health care professionals should work proactively with First Nations health care providers to not only address existing gaps and barriers to health services through meaningful dialogue, but lay out the common and mutual values and principles that will guide practice and to which everyone will be held accountable.

### Strategic Action 4.2
### Governance/Policy

Cultural competence as a matter of policy can only be achieved when leaders and decision-makers make it a priority and directly set out to institute it within the practice of everyone involved in the provision of health services. It is important to build effective relationships with leadership and government through on-going communication, and to lead, encourage and build upon mutual understandings in First Nations accessing quality health care.

Leaders must establish a monitoring and reporting process to support the Framework including annual reports to the respective First Nations and government. Leaders must also provide clarity about agreed responsibilities among Manitoba Health and FNIH (insured/non-insured), provincial and federal systems and First Nations for better care, patient safety and appropriate action to address health care system inequities. Overall, the governing bodies must work to promote principles laid out in the Framework into practice.

### Strategic Action 4.3
## Community capacity

Community capacity is recognized when members of the First Nations community contribute to the vision of improving health issues by finding effective solutions. This could be done through development of local community advisory partnerships to guide programs and services. Information is integral to any process aimed at achieving change, therefore it is advisable for communities to strategize about how they might achieve better understandings about the demographics, populations and health indicators of their community. Participation in collaborative or joint completion of Community Profiles with RHAs is a good start to understanding these statistics but also participation in annual censuses (Stats Can and Aboriginal Census) should be encouraged.

### Strategic Action 4.4
## Leveraging of resources

Recognizing that there is never enough money to provide for all the programs and services needed to address the multitude of issues impacting on health status, systems must be open-minded and creative in proceeding towards development and change without extensive investments or large cash injections. Resources currently exist at every level in terms of people, technology and knowledge.

Health research should be conducted in Manitoba First Nations communities, including aggregate level reporting on performance outcomes in service delivery, in order to better understand how practices and interventions are impacting on outcomes. Evaluations should take place to scan the general standing of programs at all levels. In 2008, the federal government initiated a research project that was jointly implemented by the St. Elizabeth Health Care and Assembly of Manitoba Chiefs' to explore dimensions of wait times for diabetes foot care within First Nations. The project was a collaboration involving various partners that worked to build capacity at the local levels, and a great deal of information was shared and knowledge gained.

Partnerships are necessary in a world of limited or over-taxed resources and systems should reorganize to accommodate existing networks of health care services for First Nations people where collaboration is apparent and maintained in order to assure that practices of working together are sustained and entrenched in everyday service delivery.

### Strategic Action 4.5
## Partnering mechanisms

The world views of each party involved in health care are unique and rooted in deep historical and cultural experiences as well as diverse value systems; achieving

Petrucka et al. (2007) offers the following definition of cultural competence: "Cultural competence in health care is the ability of the system to provide care to clients with diverse values, beliefs, and behaviours, which means tailoring delivery to meet their specific social, cultural, ethnic, spiritual and linguistic needs." (p. 172)

**Three attributes of cultural competence are:**

1) Cultural appropriateness 2) Cultural accessibility 3) Cultural acceptability

Given the findings on cultural competency, and identification of key themes, the authors offer that there is a "…need for health-care systems and providers to be aware of and responsive to the cultural perspectives of patients" and that the "… achievement of cultural competence depends on fundamental individual, collective, and systemic change." (p. 172)

congruence in a complicated health system requires open minds, flexible structures and trust. The principles laid out in the *SCO/WRHA Framework for Helath Adaptation* should assist to guide the partners in achieving trust, and protecting mutual undertakings.

Often in diverse systems, protocol agreements are necessary to lay out the terms of engagement between parties. Differences in mandates, authorities, systems and processes contribute to barriers towards agreements between parties; therefore, mechanisms are necessary to enable agreements or mutual understandings. Once understandings are reached, it is easier to lay out common objectives towards which planning can occur. Reliable, consistent and accurate information flow is necessary to ensure that stakeholders understand developments at every stage of a creative process in order to secure buy-in and facilitate change management.

Change is not easy; it is complicated and resistance can occur for a variety of reasons. Whatever meetings may occur, it is important for accurate records to be kept and information secured to ensure trust between partners but also integrity and quality of data. If there is to be collaborative policy development, not only are strong linkages important; healthy, productive debate should occur to ensure that all sides of an issue are explored and to avoid misunderstandings.

### Strategic Action 4.6
## Organizational development

Organizational development implies advancements or improvements within the institutes or agencies that represent the various populations in the health care system. It can include health facilities, health authorities at all levels including First Nations communities, administrative and/or regulatory bodies, and government entities. One way for development to occur would be to strengthen networks of officials across the various health entities, to ensure that information flow is steady and reliable. The linkages and collaborative initiatives should also encourage critical dialogues between the parties to ensure that all perspectives are shared, including theoretical and ideological underpinnings, so that each party has a clear understanding where decisions are rooted. From here, honest and respectful discussions can occur surrounding policies that could be addressed, the relevance, significance and appropriateness of policy change, and steps towards policy change.

Often, professionals are unclear as to roles and responsibilities in terms of limitations of practice; most know what they are expected to do however it is those scenarios, whether they are exceptions or on-going unresolved scenarios, that may lead to apathy or poor judgment in case planning and or treatment. Provincial, federal and First Nations systems should be articulated to assure clarity about agreed responsibilities among Manitoba Health and FNIH (insured/non-insured), for better care, patient safety and taking appropriate action to address health care system inequities. Near-misses, negligence, and discrimination can be prevented, but when they do occur, remedial action is necessary to repair damages and assure confidence in the system by the public. A transparent process should be developed that will reinstill trust in the health system, and be culturally appropriate and culturally acceptable.

# Strategy 5 – Communication

Communication emerged as a common theme in all activities including consultations, literature reviews, project and committee work. Communication involves relaying information between parties, quality of information, how information is processed and understood, and how it is disseminated. The SCO/WRHA project placed great emphasis on the communication factor of the project and early on instituted a communication strategy that was undertaken as a priority activity of a Communications Working Group. Many new items were developed along with an awareness campaign about WRHA Aboriginal Health Programs - Health Services, where information was distributed broadly at the community levels and around the Province. The CSAP aspires to build on the communication best practices of the project and formalize methods and processes in a more sustainable way.

### Strategic Action 5.1
## Communication Strategy

Efforts should be made to formalize and sustain the SCO/WRHA project communication working group as a preferred practice that would continue with structure and processes outlined. A strategy was developed by the group that laid out the steps and timelines of actions that took place in a joint campaign to raise awareness of AHP-HS offered by the WRHA. A similar structure and process should be sustained via a protocol arrangement, developed by the parties who will work on this strategic area. The communication protocol would look at information-related matters regarding delivery of existing and future health services, as well as develop an updated communication strategy based on mutual understanding and collaboration between First Nations and RHAs, with strong linkages and an outlined process.

As part of the communication strategy, First Nations leaders, senior executives and governing bodies would think strategically about how health care is provided, to ensure that systems are adapted to be more culturally and linguistically appropriate. Collaboration is an important feature of the overall CSAP. Networks across the various health sectors should be created and strengthened to ensure that relevant information obtained through meetings and workshops with key stakeholders gets shared both up and down the levels within the systems and across the sectors.

### Strategic Action 5.2
## Applied technologies

In order to understand the technologies available and needed for improving health services and systems, an inventory of information management systems at all levels would need to be carried out. This would include an assessment of interface mechanisms between systems used by the different jurisdictions. Also helpful would be integration of findings of e-Health project(s), activities and best practices into the CSAP.

Southeast Resource Development Corporation retained the services of Clear Concepts to prepare an "Information Management Needs Analysis" that examined the hardware, software, and internet connections, that are used when implementing the electronic health records for the patient wait-time guarantee; this needs analysis found that all community personal information was accessible to potential hackers, it was not secure and that it was not Public Health Information Act (PHIA) compliant. The merit of technology should be examined as it relates to First Nations who mostly lack the infrastructure and human resources to maintain complicated electronic and data systems. Nevertheless, information management, databases and record keeping are critical features of health planning and case management and require innovative and creative methods to be relevant and functional at all levels when it comes to First Nations health.

### Strategic Action 5.3
## Improved Interpreter services

Evidence compiled throughout the SCO/WRHA project indicates challenges for certain populations, such as Elders, in communicating health terminology, diagnoses, treatment, case and discharge planning. Challenges in communication occur due primarily to language barriers.

In order to determine Aboriginality of a client, a simple question upon the admission phase can be posed to the patient. The patient can voluntarily respond and where there is an indication that the client is Aboriginal, a further step could be for the client to agree to voluntarily participating in filling out an assessment tool. It would be

up to the RHA to determine the resources within its system to complete the assessment which includes patient language proficiency assessment. From here, the need for and type of interpreter services could be ascertained.

## Conclusion

Strategic plans are developed for the purposes of focusing in on targeted areas that require attention and outlining critical steps towards accomplishing a mission or vision. Together, the partners engaged in the SCO/WRHA project and confronted the issues that the health system, First Nations communities and individuals encounter in the course of both accessing and delivering health care. The Collaborative Strategic Action Plan is not meant to be an end; it is a means to an end. Much like the *SCO/WRHA Framework for Health Adaptation* was built to provide an outline of the parameters of change within a health system, the CSAP seeks to venture deeper into change, and spell out more clearly the parts of the system that require closer examination. From there, it is anticipated that collaboration and partnership will continue through the undertaking of work-plans in each result area, which will ultimately result in achievement of the overall goal which is:

"Improved Health Status through the adaptation of existing Health Services".

## References


**Burley, MB & Greene, P. (2007).** Core drivers of quality: A remote health example from Australia. Rural and Remote Health. 7:611.

**Erdil, F. and Korkmaz, F. (2009).** Ethical problems observed by student nurses. Nurse Ethics, 16:589, pp. 589 – 598.

**Petrucka, P., Bassendowski, S., & Bourassa, C. (2007).** Seeking Paths to Culturally Competent Health Care: Lessons from Two Saskatchewan Aboriginal Communities. CJNR , 39 (2), 166–182

**SCO/WRHA Literature Review (2009)**

**The Royal Australian College of General Practitioners.** The improvement of general practice primary care services. A submission to NHHRC.

**Ulrich, B. (2009).** Providing culturally competent nursing care. Nephrology Nursing Journal, Vol. 36, No. 4., p. 367.

# Appendix

A summary of themes, challenges and principles as they were developed and obtained through key informant interviews during the research phase of our project.

First Nation Health providers:

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 1 | Communication<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Lack of awareness of RHA program and service delivery<br>b) Insufficient or unclear linkages between health care programs/and First Nations communities<br>c) Clarity around referral system and information on how to access programs/services<br>d) Information on NIHB<br>e) Need for improved networking<br>f) Improved community involvement in processes at First Nations and RHA systems<br>"Contributing factors":<br>g) Federal/provincial jurisdictional issues<br>h) Inequitable funding distribution<br>i) Non-involvement of FN in RHA planning<br>j) Lack of networking between First Nations and RHAs<br>k) Limited collaboration between RHAs and First Nations<br>l) Lack of understanding of FN people<br>m) Issues of trust | **Communication**<br>**Collaboration**<br>**Awareness**<br>**Mutual understandings**<br>Access<br>Existing gaps<br>**Community**<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 2 | Primary Health and Public Health care needs<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | Public health issues:<br>a) Dietician<br>b) Immunization<br>c) TB testing<br>d) Mental health<br>e) Equipment and supplies<br>f) Prescription drugs<br>g) Pediatric care<br>h) Pregnancy care<br>Service Implications:<br>i) Quality improvement tools to improve<br>a. Service and delivery<br>b. Level of services<br>c. Linkages | Communication<br>**Collaboration**<br>Awareness<br>Mutual understandings<br>Access<br>**Existing gaps**<br>Community<br>Data reporting mechanisms<br>Workforce development<br>**Evaluation and monitoring**<br>Sustainability<br>Cultural appropriateness |
| 3 | Human Resources<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Need for doctors/nurses in communities<br>b) Need for collaboration between rural health centres and FN health centres<br>c) Culturally sensitive professional development for non-FN doctors/nurses | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 4 | Intervention care<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Concern of health professionals about health status of on-reserve population (i.e. diabetes)<br>b) Need for consultation and participation of both consumers and providers into treatment processes and prevention<br>c) Focus was on practitioner - interview and assess situation at three levels<br>a. Consumer<br>b. Practitioner<br>c. Practice system<br>d) Look at dialysis | Communication<br>Collaboration<br>Awareness<br>**Mutual understandings**<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 5 | Collaboration<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Continue and enhanced<br>b) Need for networking and partnerships – to address inequities of health care service delivery<br>c) First Nations representation on RHA Board | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

Four Arrows Regional Health Authority (FARHA):

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 6 | Communication<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Greatest challenge is remoteness<br>b) Breakdown of communication (with on-going struggle of jurisdictional issue)<br>c) Lack of information provided by overall health system (RHAs, hospitals, clinics) on programs/services offered<br>d) Miscommunication between providers and members (on-reserve)<br>a. Improvements needed between providers and consumers when dealing with RHAs off-reserve<br>e) Providers do not understand the social, cultural, economic factors<br>a. Factors that are central to individual life<br>b. Affect health and pose risks to health<br>f) Language barriers – members cannot convey concerns to providers unless interpreter present<br>g) Lack of linkages<br>h) No established communication process between providers and RHA staff however FARHA alleviates challenges if they are notified<br>i) Address language and information barriers to manage health care when they get home<br>a. Good understanding of health conditions<br>b. Take medication properly<br>c. Ensure follow-up if and when needed<br>d. Advocate for themselves | Communication<br>Collaboration<br>**Awareness**<br>**Mutual understandings**<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 7 | Jurisdictional Issues<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Island lake communities within BRHA but health connections are to Winnipeg<br>a. Referrals to specialists<br>b. Medivacs to hospitals in Winnipeg<br>c. Primarily access WRHA services<br>d. Flights/travel routes better to Winnipeg<br>b) Debates on who provides services – federal or provincial?<br>c) Barriers<br>a. Payment of medicine<br>b. Transportation<br>c. Accommodations<br>d. Out of pocket expenses<br>e. Travel to Winnipeg for dialysis, dental and other medical issues complicated<br>f. Distance compounds stress<br>g. Need for better coordination of services and appointments (members caught in between who will pay)<br>d) Health care systems need to understand unique needs and conditions of remote communities<br>e) No fit between policies developed in south that apply to north<br>f) Can't build trust with professionals - high turnover and resources spread so thin<br>g) Need to improve<br>a. Dental care<br>b. Home and community care<br>c. Role of Community Health Representatives<br>d. Access to physicians<br>h) Need advocates to navigate complex system, address payment of services, provision of information<br>a. Advocates would assist health providers by providing proper information to consumer PRIOR to travelling out of community<br>i) Issues affect quality and availability | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 8 | Transportation<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Depend on air travel or winter roads<br>b) Travel expensive and time consuming<br>c) Issues of reliability – weather and availability of flights<br>d) Leaving for appointments can take significant time away from families and places great stress on patient<br>e) Need for RHAs, doctors, nurses to understand challenges associated with living in isolated northern communities<br>f) Important to find solutions for effective and affordable transportation | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 9 | Access to health care services<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Access issues linked to distance, funding and jurisdictional divisions<br>b) Critical issues:<br>a. Transportation<br>b. Funding<br>c. Jurisdiction<br>d. Local availability of health services<br>e. Local availability of health professionals<br>c) Providers and support staff not aware are hardships (i.e. personal cost for accommodation and taxi, travel, stress) when scheduling appointments<br>d) Challenges at all levels: Local, Regional, Provincial<br>e) Need to work collaboratively | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

Elders:

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 10 | Advocacy<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Advocacy to provide a voice for seniors<br>b) Assist access to existing services<br>c) Assistance in discharge planning requirements by doctor<br>d) Assist in lack of level of services they receive in hospitals compared to mainstream population<br>e) Treatment Elders receive from hospitals and clinics is not equal and unacceptable<br>f) Stressed need for more advocates to assist health users/patients in overall health care system as they feel intimidated by the system | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 11 | Traditional medicines and interpreter services (languages)<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Need for interpreters in 5 dialects<br>b) Lack of awareness of interpreter services; service not readily available or offered by Aboriginal health services<br>c) Just speaking English is not enough – need to know medical terminology and doctors instructions<br>d) Importance of language use by health care providers and escorts<br>e) Elders do not understand medical terminology, ethnic doctors – medical terminology should be translated from English to each specific dialect<br>f) Need more language training for health care workers in community and system overall<br>g) Effect of diabetes, toll on community, stress of travel, change in lifestyles (food, eating habits, obesity in children)<br>h) Lack of knowledge and use of traditional medicines as alternative treatment<br>i) RHAs and health systems should consider using traditional medicines for health care users/patients | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 12 | Non-insured health benefits<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Basic health needs to be met<br>b) Transportation<br>c) Proper accommodation (hotels, boarding rooms)<br>d) Abuse of prescription drugs<br>e) Lack of financial support for escorts<br>f) Need for proper transportation in all communities<br>g) Financial difficulties<br>h) Lack of funding support for taxis<br>i) Hours of travel, hours of wait to see doctor<br>j) Lack of rooming houses, boarding rooms, hotels – damage deposits required | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 13 | Health care provider support<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) CHR to revert back to original role – to make home visits and ensure the health issues of the community members are addressed<br>b) More complex/acute a situation becomes, more care required – CHR has a role in this<br>c) Social isolation and emotional stress due to lack of information and home visits conducted by CHRs and health care providers (nurses, home and community care)<br>d) Lack/shortage of nurses and doctors in community<br>e) Services by professionals who are properly trained to work with individuals/families/and communities<br>f) Better management<br>g) Better follow-up<br>h) Hospital and clinic staff do not understand the culture of First Nations people<br>i) Health services in community okay but need improvement<br>j) Specialized nursing care, homemaker and adult day care not provided unless they live in personal care homes – usually family provides services | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

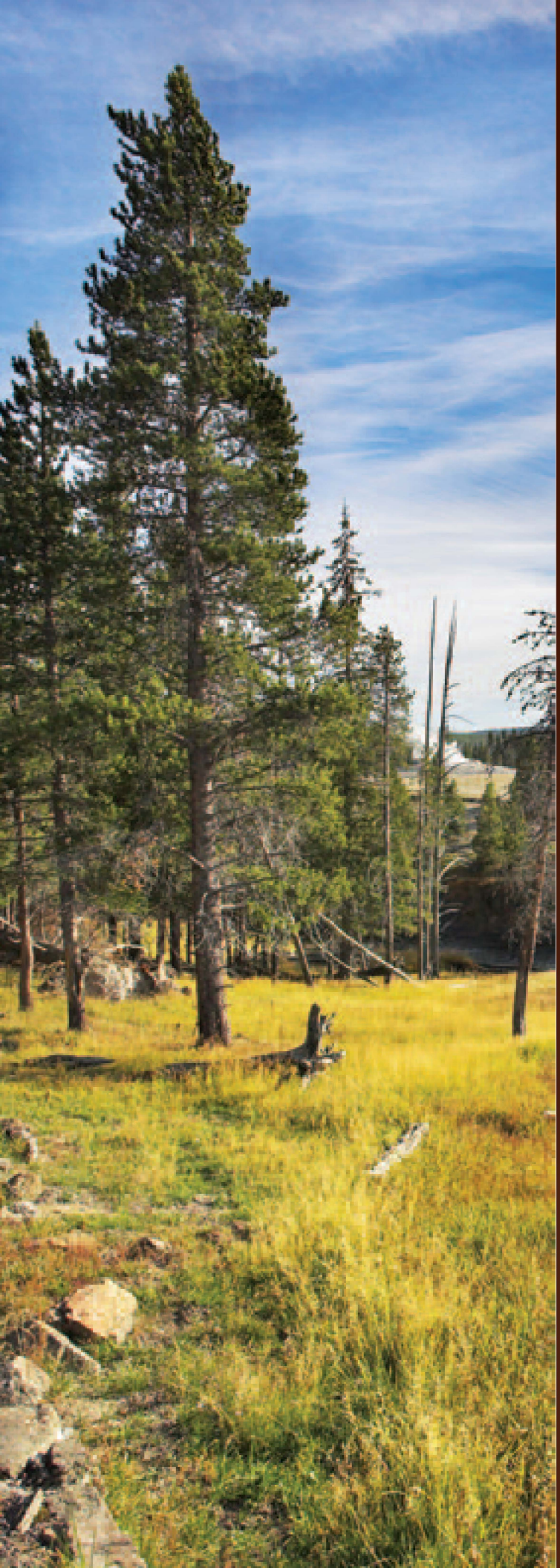
WRHA Health Care Providers:

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 14 | Communication<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Clear concise and accurate communication needs to take place<br>b) Not enough taking place<br>c) Communication between team members<br>a. Between hospital and community care<br>b. Gaps in service on discharge back to community<br>i. Due to limited or unavailable service<br>ii. Information not being communicated to hospital team<br>d) Inaccurate, not enough information communicated between hospital and home care team<br>e) Communication also responsibility of other parties such as other RHA's, First Nations Inuit Health Branch, MB Health) in regards to coverage for First Nations members (prescriptions, medical supplies and equipment)<br>f) Should be no assumptions made regarding continuity of care once discharged<br>g) Follow up needs to occur wherever patient is situation<br>h) Arrangements need to be communicated to the party responsible for individuals care<br>i) Example: Discharge Plan – Dressing change > facility staff to locate appropriate person in community for arranging home care<br>j) Communicate details of appointments<br>k) Responsibility at community level to be able to advocate to funding agencies if escort required<br>l) Interpreter services (Elders) – internal and external to medical setting | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 15 | Lack of Staff<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Adequate services = reasonable amount of staff<br>b) Increase of medical and non-medical staff needed<br>c) Representation of First Nations employees<br>d) Training to encourage higher enrollment by offering incentives or assist to maintain routine student accustomed to<br>e) Aboriginal Health services – 4 areas of service – outstanding in providing service, but understaffed<br>f) Unable to devote time due to overload of cases<br>g) Within hospitals services other than interpreting can be provided but not at community level – interpreter only service provided at community level<br>h) Advocacy at AMC<br>i) Discharge planning – time a factor – cases a complicated and maximum level of involvement required – AHS 2 F/T discharge planners; mobile to all sites but situated at HSC<br>j) Higher demand for spiritual/traditional care due to more information of service<br>k) Spiritual care worker doing excellent work but could use assistance | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 16 | Lack of knowledge<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Teams involved in patient and client care encountering a lack of information on resource available<br>a. Not knowing what resources are available<br>b. Those receiving or requesting info are not presented with all info<br>b) Staff not confident when releasing patients back to community<br>a. Feel it is responsibility of communities to do "quick reference for care teams" about what is available to patients upon return<br>b. Once staff aware, appropriate arrangements can be made with community staff and bridge gaps<br>c) Within urban setting, teams should be aware of what's available in city<br>d) Funding or certain services may not be available for those living away from community<br>a. Can cause delays in discharge planning<br>b. Suggestion to develop a resource guide<br>e) Participants not sure when they could use AHS and what they provided<br>f) Although posters/pamphlets available, workers should be available for rounds and around different sites<br>g) Community liaison worker be brought on to AHS<br>h) Options for care not same across the board – options to one ethnic group not offered to First Nations patients (i.e. amputations) | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 17 | Language and Cultural Sensitivity<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL<br>CHANGE | a) Mandate cultural awareness workshops for WRHA staff<br>b) Program managers say they cannot send staff due to budget/time constraints<br>c) Funding should be incorporated into program budgets under professional development or education<br>d) Workshops should help address issues/barriers (i.e. language barriers for Elders)<br>e) Overall lack of knowledge of First Nations<br>a. Misconceptions (i.e. women, prenatal care – substance, drug, alcohol abuse – idea held by some providers severely interferes with care – poor health care provided based on this belief<br>f) When designing or renovating health care structures, FN traditional and cultural practices should be considered (i.e. end of life accommodation for large families, smudging) | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 18 | Funding and lack of resources<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL<br>CHANGE | a) More funding needed = gaps to be filled<br>b) More funding for spiritual/cultural care<br>c) Half time position – work outside of hospital too<br>d) Traditional Wellness Clinic once a month<br>e) Improvements needed at FNIH and other funding agencies<br>f) Gaps occur due to funding and housing issues<br>g) No even distribution of resources available across various age groups<br>h) Within some rehab programs, there tends to be higher percentage of certain age groups<br>a. Upon discharge, individuals could benefit from community programs designed specifically for them to promote/assist individual to full recovery (i.e. abundance of programs for seniors with continued rehab but not for youth) | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 19 | Education<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL<br>CHANGE | a) People need to be informed about state of their health and what options they have to improve their well-being<br>b) Informed decisions = information presented<br>c) WRHA lacks in this area<br>d) FN not presented with all options (i.e. amputation of limb)<br>a. Providers have preconceived notions of FN not taking initiative regarding own health<br>b. FN intimidated by system<br>c. Health system not user friendly<br>e) AHS info needs to be communicated more broadly<br>f) Info about cultural awareness superior, but info about roles of AHS equally important<br>g) Gaps in transmission of info to patient coming from community<br>a. Patients not fully aware of procedures<br>b. Anxiety due to not knowing what to expect<br>h) Not enough promotion/prevention<br>i) Re-victimization – traumatic experience and although staff aware, choose not to provide any kind of support or sensitivity to case | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |

| | THEME | CHALLENGES | PRINCIPLES |
|---|---|---|---|
| 20 | Jurisdictional issues<br><br>ACCESS<br>QUALITY<br>AWARENESS<br>STRUCTURAL CHANGE | a) Health care jeopardized due to jurisdictional issues<br>b) Participants experienced jurisdictional barriers regarding FN patients health care<br>a. Medical supplies<br>b. Equipment<br>c. Transportation<br>d. Home care<br>c) Delays in discharge because not all necessary services/ equipment in place<br>d) Patient susceptible to other illnesses when there are delays<br>e) Jurisdictional issues seen in coordination of services from one region to another<br>f) Not all efforts made by health care staff to ensure for smooth transition from one region to another<br>g) Patient or family had to make necessary arrangements to ensure continuation of service | Communication<br>Collaboration<br>Awareness<br>Mutual understandings<br>Access<br>Existing gaps<br>Community<br>Data reporting mechanisms<br>Workforce development<br>Evaluation and monitoring<br>Sustainability<br>Cultural appropriateness |
| 21 | Determinants of Health | a) Income social status<br>b) Social support network<br>c) Education and literacy<br>d) Employment and working conditions<br>e) Physical environments<br>f) Social environments<br>g) Biology and genetic endowment<br>h) Personal health practices and coping skills<br>i) Healthy child development<br>j) Health services<br>k) Culture<br>l) Gender | |



For more information on this report, please contact

**Winnipeg Regional Health Authority**
650 Main Street
Winnipeg, Manitoba R3B 2C1

1-204-926-7119

**Southern Chiefs Organization**
225-530 Century Street
Winnipeg, Manitoba R3H 0Y4

Office: 1-204-946-1869
Toll Free: 1-866-876-9701