



AN ABORIGINAL HEALTH TRANSITION FUND PROJECT

Southern Chiefs' Organization & Winnipeg Regional Health Authority

FRAMEWORK FOR HEALTH ADAPTATION



Winnipeg Regional
Health Authority
Caring for Health

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THANK YOU

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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.



How to use the good for four aspects of life (Mind, Body, Feelings, Spirit) by:

Eyes: See all things in good, or fall sick

Ears: Hear all things in good, or hear bad

Mouth: Speak in good voice and not swear or fall in the negative ways of life

(Source: Elders stories, SCO/WRHA Elders Focus Group, 2009, p. 78)

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**“WORK WITH COMMUNITY HEALTH SERVICES TEAM
IF SOMETHING NEW IS WANTED TO BE TRIED.”**

(SCO/WRHA, WRHA HCP REPORT, 2009, P. 53)

**“IF YOU’RE WILLING TO WORK WITH THEM, THEY
WILL WORK WITH YOU.”**

(SCO/WRHA, FN HCP REPORT, 2009, P. 48)

EXECUTIVE SUMMARY

The *Southern Chiefs’ Organization and Winnipeg Regional Health Authority’s Framework for Health Adaptation* draws from the shared experiences of health care providers and consumers, as well as the expertise of the collaborative team who worked on this Aboriginal Health Transition Fund Project (AHTF). The Framework lays out a structure through which the partners may continue to work together, as well as identifies key processes under which reorientation of mutually agreed upon systemic changes can occur. It offers key definitions to ensure a common language, and to ensure validity in the methodologies that will be applied towards each systemic change.

The Framework is described in two components. First, an analytical framework that considers the literature on critical topics associated with Primary Care with diverse cultures and on specific service areas, and how they apply to Manitoba. Secondly, an adaptation operational framework that identifies the overarching themes and sets the context for which a range of strategies at individual, community and organization levels could be developed. The Framework is intended to serve as a functional framework for First Nations health care providers seeking to adapt existing health services within a health system by first identifying why gaps exist and second, how to improve them.

While the *SCO/WRHA Framework for Health Adaptation* borrows from other results based models, it was adapted to conform to a variety of unique conditions specific to this project, such as Aboriginal cultural influence, the broad geography and population covered by the project and the preferred practice to incorporate a holistic and circular based model.

Two other frameworks were drawn from to explore other dimensions of an adaptation process, namely quality and integration. Quality encompasses those characteristics in health care that not only assure safety and accountability in the provision of service, but establishes trust, an integral trait to relationship building. Integration is explored because it considers the unique multi-jurisdictional roles and responsibilities in providing health care to First Nations people. Regardless of residency, First Nations people require care that factors in their unique experiences and status in that they are adjoined to a history of discrimination and oppression. Furthermore, their care involves various levels of government namely, federal, provincial and First Nations.

INTRODUCTION

In 2004, at a First Ministers Meeting in Kelowna, British Columbia, an announcement was made for the establishment of a Blueprint for Aboriginal Health, and a federal funding investment of \$700 million towards an Aboriginal Health Transition Fund (AHTF). With this announcement came anticipation for new and vigorous change within a health care system that, as iterated by First Nations professionals and citizens, has not kept pace with the growing needs of the populations served.

Evidence exists that demonstrates the scope and scale of the problems encountered by First Nations people, regardless of where they reside. Governments at all levels collect various data on health users including service usage, and delivery costs; researchers and academics process the data and produce revealing reports. Within such reports, two things are known to be true: 1) Over the past few decades certain health status indicators among First Nations people are not improving and in some regions, with certain conditions, and in specific populations, health status is getting worse, and 2) the gap in health status between the First Nations and Non-First Nations population is growing.

In Manitoba, the response to the funding announcement was welcomed and Aboriginal groups began initiating activities towards achieving the broad objectives of the AHTF. Over the long term the AHTF is intended to result in:

- improved integration of federal, provincial, territorial (F/P/T) funded health systems;
- improved access to health services;
- health programs and services that are better suited to Aboriginal peoples; and
- increased participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services (Health Canada, 2006, p. 6)

In response to the call for proposals, Southern Chiefs' Organization (SCO) embarked on a collaborative journey with Winnipeg Regional Health Authority (WRHA) in 2007 to identify gaps and challenges impeding First Nations access to existing health care systems and services. The SCO/WRHA project was designed to achieve mutually identified objectives. Through engagement with various stakeholders in the system, the SCO/WRHA project was designed to achieve mutually identified objectives, which were: explore the challenges encountered in three main service areas -

discharge planning, cultural and interpreter services and patient advocacy; to work on a communications strategy; to explore gender specific considerations; and to work towards human resource strategy.

The ultimate objective of the project is to adapt existing health systems in a manner that is inclusive of First Nations participation in the assessment, planning and evaluation phases and that is transferable to other health systems, providers and stakeholders creating suitable, sustainable and meaningful practices (SCO-AHTF work plan, 2008/2009).

To realize these objectives, the partners agreed to bring forward suitable mechanisms that would include the following:

1. A goal expressed for the adaptation of existing health services to First Nations communities and the health consumer.
2. A statement of principles to guide the approach for collaborative action to support the recommended activities.
3. A framework for action at the local and provincial levels that would result in a sustained systematic approach to adapt existing health services.

SCO and WRHA conducted focus group sessions and key informant interviews with First Nations health care providers, community members (Elders and health consumers) and WRHA staff, producing four reports as well as both specific and comprehensive literature reviews that explored preferred practices in the project priority areas. The findings in the reports identified numerous recommendations to improve and enhance access to existing health services. This Framework builds on the data and research collected and compiled in the reports and literature review.

The *SCO/WRHA Framework for Health Adaptation* explores as many dimensions as possible in its design to provide a firm foundation on which new systems can be built or critical features of a system adapted. The dimensions include: Principles, Goals, and Objectives, on top of which strategies can be developed to address issues, such as gaps or fragments in systems. Related processes and structures can be factored in and adapted in any re-design, such as other models and preferred practices.

PURPOSE

The purpose of the *SCO/WRHA Framework for Health Adaptation* is to provide a model of care that is “conductive” to the needs of the First Nations communities and improves access to health care services.

As a foundational tool, this Framework is meant to provide an overarching structure under which a strategic action plan could be developed. The rationale for developing the Framework is to incorporate the key findings of the SCO/WHRA project into a practical mechanism through which other health providers or authorities could use as promising practice towards change. Its purpose is meant to be broad and generic enough to capture only key goals, strategic objectives and ultimately strategies towards results. Further work on a strategic action plan can be undertaken once the core foundation is laid and mutually agreed upon by the partners.

Theoretically, the preferred practice in the application of both the SCO/WRHA Framework and subsequent strategic action plan is for a collaborative process to take place between multi-jurisdictional stakeholders to identify both the common issues and areas of mutual interest that would be targeted for improvement, or in this case, adaptation.



EVIDENCE BASED PRACTICE

Evidence suggests action needs to be taken on improving access to existing health services for First Nations health consumers. In 2005, the Assembly of Manitoba Chiefs' Inter-governmental Committee on First Nations Health, published a report with key findings such as that in infant mortality for First Nations people was up to 2.9 times higher than the rate for other Manitobans, First Nations people live approximately eight years less than other Manitobans, the incidence and prevalent rates of diabetes, circulatory and respiratory diseases, and some cancers are increasing in First Nations and that First Nations persons experience higher rates of injuries, poisonings, and suicide.

The SCO/WRHA project consulted with various groups, including First Nations Health Care Providers, WRHA Health Care Providers, and First Nations Elders, by hosting focus group sessions and engaging consumers and providers into the process by asking them to identify specific health challenges, gaps and barriers. From each focus group session, theme areas were identified as follows:

Four Arrows Regional Health Authority Focus Group:

- Communication
- Transportation
- Jurisdictional issues
- Access to services due to isolation of communities

Elders Focus Group:

- Advocacy
- Traditional Medicines
- Non-insured Health Benefits
- Health care provider support

First Nations Health Care Providers:

- Communication
- Primary Health and Public Health care needs (dietician, immunization, maternal)
- Human Resources (doctors, nurses, training, professional development)
- Intervention Care (dialysis, foot care)
- Collaboration among First Nations health systems
- Education

Winnipeg Regional Health Authority Health Care Providers:

- Communication
- Lack of Staff
- Lack of Knowledge
- Language and Cultural Sensitivity
- Funding and lack of resources
- Education
- Jurisdictional issues
- Determinants of Health

LITERATURE REVIEW

Many themes overlapped such as communication, quality, jurisdictional challenges, coordination and collaboration. A number of issues were highlighted as examples of either breakdowns in the systems, fragmentation of systems, and providers working in isolation from one another. Essentially what the themes tell are anecdotal experiences from different perspectives. Health providers spoke of specific challenges in direct patient-focused practice, as well as frustrations with lack of coordination between systems. Elders emphasised a need for special focus on Elders in terms of cultural factors, and the need to restore traditional practices into care systems. Other perspectives were the on-reserve versus off-reserve experiences, as well as experiences of those from remote/isolated communities.

With each story told, theme areas emerged, and it was these theme areas that translated into core values of the project. These theme areas or core values were developed further into 13 principles that guide the Framework. This ensures integrity in whatever process would be entered into, as well as ties in the diversity perspectives of the stakeholders and incorporates cultural considerations from the various perspectives.

The literature review was framed and defined by specifications relating to culture, language and the use of interpreters, communication processes, discharge planning, primary health care, safety and quality of care, and advocacy to identify and assess health practices in rural and urban settings. The focus of the review of “practice” was based on specific types of health care providers and delivery settings. The scope included Canadian jurisdiction and one international jurisdiction (Australia). What emerged from the review was a confirmation of challenges encountered within three main service areas of the health system: patient advocacy, discharge planning & cultural/interpreter services. But overall, preferred practices do exist that can be drawn from in the adaptation of health services within Manitoba.

The bulk of the literature reviewed focused on the importance of culture, multi-disciplinary practice and the importance of communication in health care service delivery. General trends from the Canadian and international literature included: use of multidisciplinary approaches and practice to delivery of primary health care (PHC) services; expanded concept of culture for health care providers; language and the importance of health care providers understanding its place in the health care system; advocacy and discharge planning applications.

Other major trends that emerged from the literature review included: technology, models of primary health care services, the importance of the development of communication processes; the role of the health care providers to deliver effective Primary Health Care services to Aboriginal people; the role of families; development and use of discharge planning tools and to increase access to health services, particularly in remote or isolated communities; and other initiatives. The importance of culture and its affect and impact in the health care system was evident from the literature and formed the base of the review.

USING A RESULTS FRAMEWORK

Program developers and researchers have different agendas, serve different stakeholders, and use different terminologies. Yet, to answer First Nations people's most difficult health challenges, they must and do collaborate. Results Frameworks are simple models that both disciplines can understand and use. Results Frameworks can serve a range of social programs, agencies, and levels. The Framework serves two critical functions. By describing the steps toward the program's ultimate goal, it indicates the general direction to achieve that goal through stepwise results. Second, by outlining a hierarchy of results, it will prompt health technicians and managers to specify indicators to track progress.

A Results Framework is a tool to assist with achieving and measuring specific objectives at the sector, country or regional level – usually laid out in diagrammatic form. It uses the objective tree approach to link high-level objectives through a hierarchy to program-level outcomes (and ultimately individual activities) and then sets out a means by which achievement at all levels of the hierarchy can be measured. (Australian Agency for International Development, 2005)

The Results Framework has many advantages:

1. The framework is simple and can be easily understood by health care providers who can use the framework.
2. The framework model can be applied throughout the life cycle of programs and services.
3. The framework model focuses on life-benefitting results for individuals and the health consumer.

In the SCO/WRHA Framework, a situation analysis (qualitative and quantitative) was used to characterize the existing First Nations health environment, inclusive of the health system, the levels of indicators of use, availability and demand and the gaps based on the responses and data presented in the reports.

SCO/WRHA FRAMEWORK

The Results Framework applied to the SCO/WRHA project is a simple, overarching model that proposes a broad, common structure under which partners can work together. It also provides for open, flexible processes through which strategic actions can be set.

The symbol that emerged as the SCO/WRHA Framework was being developed was a Tipi (Fig.1). The *SCO/WRHA Framework for Health Adaptation* has three levels. The top layer identifies the program goal: **Improved Health Status through adaptation of existing health services**. The middle layer identifies Strategic Objectives which are the most influential statements toward a result that can reasonably affect a program and for which an implementing organization would be held accountable. The Strategies level provides strategies and actionable tasks. This level is further developed in the strategic action plan. Thirteen Principles guide the effectiveness of all three levels and serve as the foundation for the Framework.

Throughout the *SCO/WRHA Framework for Health Adaptation*, symbols are used to capture various elements of the Framework. It is implied that through creative expression and symbolic interactionism, key themes and issues communicated from stakeholders, and critical linkages will be captured.



Figure 1. The SCO/WRHA Framework for Health Adaptation

A tipi serves not only as shelter from the elements and as residence, but also for food storage/preparation, governance, celebrations, and in this context, healing. The basic structure of a tipi is 13 posts bound together with cord or string, a canvas over top, an opening as a door and an open top for ventilation. It is transferrable because it can be taken apart, moved, and set up again in any climate and season. It is strong, reliable and durable.

The Strategic Objectives have been identified here in Figure 2:

STRATEGIC OBJECTIVES	EXAMPLES
Collaboration and Partnerships	New linkages, collaboration, and partnerships between health systems and at multiple levels that are achievable (ie: Government, RHA's, Non-profit, Lobbying {PTO}, agencies, communities)
Reorientation of health services	Adjustments to 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. The Four Strategic Objectives

For the SCO/WHRA Framework, the intent is to keep the framework broad and foundational, thus not focusing on firm actions. Actions would instead be identified through the bottom layer of the Tipi, the strategies around which a collaborative strategic action plan can be developed. Effective programs select “evidence-based interventions” meaning services or behaviours known to have an impact on health status.



The bottom layer of the Framework has five broad strategies which, when applied, lay out essential steps toward achieving the objectives. The five broad strategies are: Access, Quality, Awareness, Structure and Communications. These are developed in further detail in the *SCO/WRHA Collaborative Strategic Action Plan* but Figure 3 depicts the prospective results of the strategies layer 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	<ul style="list-style-type: none"> • Community based services • Joint community/system based case management • Service access and delivery points
Quality of health services improved	<ul style="list-style-type: none"> • Improvement in health care provider capacity • Strengthen service delivery • Effective linkages between First Nations community and health system • Develop a quality “culture” • Ensure acceptability and respect for the differences in cultural norms
Increased awareness of health services	<ul style="list-style-type: none"> • Community mobilization and increased awareness • Behaviour change communication
Structure	<ul style="list-style-type: none"> • Advocacy • Governance/Policy • Community capacity • Leveraging of resources • Partnering mechanisms • Organizational development
Communication	<ul style="list-style-type: none"> • Applied technologies • Improved Interpreter services

Figure 3. The Five Strategies

RESULTS FRAMEWORK MODEL

The top view of a tipi is a circle. The circle is another helpful symbol as it offers a sense of continuity and recognizes life and processes as a cycle more than a linear path. When looking at the *SCO/WRHA Framework for Health Adaptation* it was determined that a hierarchal model was not sufficient enough to capture the unique nature of the project. The undertones of the project are based on the spirit of holism and striving toward more comprehensive services based on the unique and challenging circumstances facing First Nations individuals both on and off-reserve.

The results framework model has been revised to reflect the needs of the *SCO/WRHA Adaptation Framework*. The model as depicted represents the Goal, Objectives and Principles through which strategies can be implemented. The framework addresses critical questions posed by participants regarding issues confronting both the communities and the system around matters such as community participation.



Figure 4. Top-view of Tipi Results Framework Model. SCO/WRHA Framework for Adaptation Model with 13 principles - illustration #1.

The Results Model Framework can be used to assess the performance with regard to the four strategic objectives however other more specific issues and strategies can be addressed by borrowing from other applied frameworks such as the Quality Framework examined by the Royal Australian College of General Practitioners, as well as the Integrated Contextual Model (see page 27 and 28).

RESULTS BASED PRINCIPLES

The principles as presented 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 to capture the values, beliefs and sentiments of both the stakeholders and participants in the consultation activities. The principles provided are broad and are 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 strategies, strategic objectives, and the overall goal of the project 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.



Figure 5. SCO/WRHA Framework for Adaptation Model with 13 principles - illustration #2.

Principle 1

CULTURAL APPROPRIATENESS

Culture emerged as a significant determinant of health and was referenced and/or cited as a critical consideration for any project that involves First Nations peoples. Culture is a broad term and means different things to different people. It is important for all partners to be working under the same common definitions and understanding of the place culture has within the health care system and for First Nations health status. It is especially critical to consider the literature that provides evidence of serious cultural issues affecting the delivery of health service, such as racism and discrimination, but also as a quality indicator where there are issues about language barriers or other barriers that exist due to culture and the impact that these issues have on care and health practice.

The literature review highlighted different dimensions of culture. Browne (2009) argued that perceptions, attitudes and assumptions of nurses affects practice. Browne differentiates between concepts of discourse, culture and dominant culture and the influence they have on practice. "Discourse" she defines as "a coherent way of describing and categorizing the social world through patterns or words, figures of speech, concepts, values and symbols...it is through discourse that social reality comes into being." (p. 169)

The definition offered for culture is shared values, beliefs, norms and practices but that can be understood as "shifting, relational process, as deeply enmeshed in power relations and in economic, political, historical contexts." (p. 169-170) Finally, "dominant culture" is defined as "deeply rooted sets of understandings...experienced as a set of common sense, taken for granted truths...". This is defined further as being non-static, but fixed, unitary and ascribed to by everyone, and shifts according to one's context, such as local issues and political/economic contexts.

Browne offers though that change may occur when "different life experiences or individuals, conditioned not only by their individual biographies but also by their varied positions within structures of inequality...give rise to different perceptions that challenge the legitimacy of a dominant culture" (p. 169). Browne offers that there are three overlapping discourses that shapes nurses' interpretive

perspective and understanding: 1) discourses about culture, 2) professional discourses about egalitarianism, and 3) popularized discourses about Aboriginal people.

Applied to the Manitoba experience, dominant culture would then be those taken-for-granted truths that are held by individuals within their immediate locales, such as home or the workplace, but that can change depending on where the individual is situated and particularly where they might relocate. Dominant culture as a backdrop for the SCO/WRHA project, matters for two reasons: First, it requires that stakeholders, such as health professionals and patients, should be aware of the environment in which they work or live and the discourses within them, and second, that it could be challenged by those who take check their perceptions and become conscious of it, and then take steps/actions to adapt or change it for a better fit. At the point of intersection three main observations are highlighted. First, that it is challenging when culture does not factor in power relations or social/economic circumstances or else it perpetuates stereotypes.

"These narrow understandings of culture, which are pervasive in health care, constrained the nurses analyses of the wider structural, historical, and social contexts that shape peoples lives, life opportunities, and access to the resources for health." (p. 180)

Second, the concept of egalitarianism is defined as "all people should be treated the same regardless of their social, ethno-cultural or gendered location." (p. 180) The health care system is supposed to be fair and treat people equitably, however it should tailor services and cares to specific groups to rectify past injustices and present inequities. Individual biases, Browne argues, feed into wider social discourses which still exert influence on nurses' interpretive perspectives, despite commitments to egalitarianism/professionalism.

Third, within popularized discourse, thinking can be organized by racialized assumptions. Brown states: "...it is apparent that the critical issue is not the individual beliefs expressed but the extent to which the nurse's thinking is organized by racialized assumptions. The image of the "drunken Indian" is one of the most enduring colonizing images pervading Canadian society." (p. 182)

According to Flowers (2005), “if the goal of critical care nurses is to provide the best possible care for these clients (American Indians), the nurses must understand the cultural differences that may create conflict and result in less than optimal outcomes. In addition, the nurses must have expertise and skill in the delivery of culturally appropriate and culturally competent nursing care.” (p. 49)

Information that she finds necessary for facilitating the administration of culturally competent care include: Demographics, health problems or health indicators, avoidance of stereotyping including between tribes, religion and spirituality and advocacy for adaptation of critical care practices to allow for practice within units, importance of communication and understanding non-verbal cues and behaviours, and if there is presence of traditional Indian medicine and healers in the lives of patients.

The relevance of culture in the Framework is to emphasize the importance of coming to a common definition and understanding of what culture is, what it means, and what is its place in improving health care for Aboriginal peoples within the WRHA. Understanding culture in health care respects individuality but factors in the diverse experiences of the individual, the environment in which they live or in other words, the social, economic, political and historical context of the patient.

Principle 2

COMMUNICATION

Communication is essential to the Framework and must be reflected in a culturally appropriate manner that is consistent with the needs of each individual First Nations community and Regional Health Authorities. Learning how to provide culturally sensitive care to a diverse population of health consumers is a fundamental responsibility for all Regional Health Authorities. The health care provider and key informant reports (SCO/WRHA, 2008) stated differences in communication and culture are viewed as challenges faced by the First Nations communities and existing health authorities. The lack of response by the overall health care

system to the needs of First Nations health consumers in language access (communication) is an indication that there is a continuing need for systemic change. More effort is needed to develop roles and responsibilities that provide cultural interpretation and communication to develop specific health initiatives that respond to First Nations community needs.

Communication emerged as the most recurrent theme throughout the process of engagement with both stakeholders and focus group participants. Communication implies more than just language, written and spoken word; it encompasses not only process or dialogue but overlaps with other matters for consideration, such as culture and the values and beliefs of different cultural groups and populations, such as youth and Elders. Each consultation group spoke of communication within their own contexts: For Health providers within WRHA, they felt the need for clear concise and accurate communication and that not enough was taking place. WRHA providers also felt that more communication was needed between team members, as well as between hospital and community care and that there were gaps in service on discharge back to community.

Issues cited by First Nations providers were lack of awareness of RHA program and service delivery, insufficient or unclear linkages between health care programs/and First Nations communities, lack of clarity around referral system and information on how to access programs/service, such as NIHB and a need for improved networking

Issues cited by Four Arrows Regional Health Authority, a First Nations organization established to provide community programming to four remote First Nations in the Island Lake region of Manitoba were: Remoteness and its contribution to breakdown of communication, lack of information provided by overall health system (RHA's, hospitals, clinics) on programs/services offered, miscommunication between providers and members (on-reserve), lack of understanding from off-reserve providers about on-reserve social, cultural, economic factors, language barriers where members cannot convey concerns to providers unless an interpreter's present and that to date, there is no established communication process between providers and other health authority staff, although FARHA deals with issues when they are notified.

Finally Elders do not speak specifically on communication however their concerns had to do with a lack of awareness

of interpreter services; they perceived that the service was not readily available or offered by Aboriginal Health Services. The Elders felt that just speaking English is not enough – they need to know medical terminology and doctors instructions, and spoke of the importance of language use by health care providers and escorts. Elders do not understand medical terminology, and there were challenges noted about working with doctors whose first language was neither English nor First Nations.

Diamond, L.C., Schenker, Y., Curry, L. Bradley, E. H. & Fernandez, A. (2008) suggests that to increase professional interpreters use requires interventions at both individual physician level and practice environment. At the Physician level there is a need to educate about challenges of caring for patients with Limited English Proficiency (LEP), including adverse outcomes with untrained versus trained Professional Interpreters (PI). Their emphasis is on accurate communication and improved understanding of cultural differences. They recommend that professional standards regarding appropriate use of second language skills by Resident Physicians should be established and finally, that residents need role models to reinforce appropriate use of PI.

Diamond et al. offer suggestions to address challenges in cultural differences and communication. At the Physician Level it is implied that Physicians should be educated about challenges of caring for patients with LEP, including adverse outcomes with untrained vs trained Professional Interpreters to assure:

- Accurate communication
- Improved understanding of cultural differences

Two final suggestions offered by Diamond et. Al, are 1) professional standards regarding appropriate use of second language skills by Resident Physicians should be established and, 2) residents need role models to reinforce appropriate use of Professional Interpreters.

Lowell (2001) offers three points in her paper on communication and cultural knowledge in Aboriginal health care. The first addresses communication in Aboriginal health care and indicates that ineffective dialogue equals adverse outcomes. Ineffective dialogue takes the form of:

- Cultural/language difficulties
- Inadequate use of interpreters
- Inadequate social/linguistic knowledge of hospital staff

- Extensive comprehension difficulty

Lowell cites that consequences of miscommunication can result in a patient "...being returned home with a serious condition." (p. 8) The importance of documenting events is highlighted, for example patients who are often unaware of the purpose of medication. "In order to give meaning to medical instructions and reasons for than it is necessary to find concepts which overlap the two cultural systems". (p. 10)

Cultural influences on communication are complex and extensive, and an understanding of how perceptions – both Western and Indigenous – of health and sickness are culturally constructed is essential to ensure effective clinical and educational interactions. Beliefs about causation are just one cultural feature that can critically influence health communication, particularly the way in which information is interpreted. ... providing warnings – or even statistics – about potential health problems could be construed as a 'threat', because predicting an illness can imply involvement with sorcery to cause the illness in the first place (Lowell, p. 10).

Principle 3

AWARENESS

Creating an awareness of existing health services offered by the Regional Health Authorities is essential for First Nations communities to appreciate current Aboriginal health care programs and services. Increased efforts should be made to promote awareness among First Nations health program and service delivery centers, First Nations health-care providers and the Regional Health Authorities and staff by effectively engaging all stakeholders with relevant information and updates on the status of existing and future health programs and services.

Principle 4

MUTUAL UNDERSTANDINGS

Mutual understanding of health policies, political and socio-economic environment challenges is a requirement to link the broader health care and health planning systems with First Nations communities and health centers. Understanding and addressing the socio-economic determinants of health inclusive of employment, income,



working conditions, education, housing and poverty is a key element because they have a greater impact on health outcomes than do individual choices and the health-care delivery system. The critical point is that action is required by leadership, government and health care providers to ensure the health care benefits delivered through positive programs and services.

Principle 5

ACCESS

Access to quality health care inclusive of language services and culturally appropriate services by First Nations health consumers has been limited and is supported by little responsibility on the part of the existing health care system. While accessibility is a fundamental principle of Canada's health care system, to date access has been defined most often as the financial barriers to care.

To effectively engage the diverse First Nations communities served by the current healthcare systems requires commitment from First Nations leadership, senior management and government officials that are representative of, and respond to, First Nations communities. By becoming responsive the community will become a crucial partner in developing and providing quality healthcare – not just as consumers or recipients of healthcare services.

Engage senior management and government officials to develop and maintain open dialogue with the First Nations communities, through interaction and identifying key issues and effective strategies, to improve First Nations health challenges and develop community resources.

Principle 6

RELATIONSHIP BUILDING

First Nations health providers spoke of non-involvement of First Nations in RHA planning, lack of networking between First Nations and RHAs and limited collaboration between RHAs and First Nations. Four Arrows Regional Health Authority highlighted the issue of trust, and that trust is hard to establish with human resources shortages that manifest

through an overburdened workforce, which then translates into compromised care. The SCO/WRHA embarked on an unconventional journey by entering into a joint venture to examine key issues in the system and explore options for change; it is not easy for two completely different systems to come together and work congruently when they operate under unique circumstances and systemic conditions. However, the project was complete, relationships were formed and maintained throughout the process and challenges were worked through. It was the spirit of working together and the recognition that systems have to come together to explore overlapping issues impacting similar service populations, and that optimal solutions cannot be found working in isolation of one another.

Principle 7

MEANINGFUL ENGAGEMENT

The development and implementation of First Nations community health plans that provide direction and vision, set priorities and target community resources is a key element in engaging policy makers and decision makers (stakeholders). Essential to the engagement process is the inclusion of transparency and responsibility to facilitate the consistent flow of meaningful information among all stakeholders.

Principle 8

ACCOUNTABILITY

Most health-related decisions are based on information collected by the provincial and federal governments. First Nations need to be responsible for the collection of data that reflects their distinct populations, geographic makeup, unique health issues and include/encourage community participation. Data reporting is critical in understanding community health expectations and prevention measures.

The *SCO/WRHA Framework for Health Adaptation* results framework although generic is designed to incorporate both the mutual and priority changes identified by the stakeholders towards achieving the overall goal of an improved health system. Indicators of change will be coded and tracked, benchmarks set, and an evaluation framework laid out to assist in systematic monitoring of not only the

process, but the outcomes. Recognition must be given to the adaptation framework and must be informed with the best possible information and linked to the broader health care system. This will involve continued collaboration, consultation and sharing. Ongoing evaluation processes will be used to inform all stakeholders of health care policy and changes and impacts of changes on all of the system, communities and patients.

Principle 9

REPRESENTATIVE WORKFORCE

There were issues of turnover and staff shortages that First Nations health providers spoke of. Common cohesive action among the stakeholders (First Nations/WRHA) is required to ensure the health work force is sufficient, skilled and competent. This may involve identifying current and future employment and training needs of the First Nations work force and providing training suitable to the needs of the community while using diverse and inclusive curricula. Consideration of accelerated entry into the health workforce may be necessary.

The Elders felt a need for more language training for health care workers in the community and system overall. They state: "All health workers must have cultural training. They need to know about the culture and traditions and need to be respectful." (Elders report, p. 37)

Principle 10

QUALITY

The Australian Commission on Safety and Quality in Health Care (2008) offers the following on quality:

Safety and quality design principle: There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement. Consumers are central to identifying safety and quality issues and the solutions that need to be implemented.

For improvement to occur information is critical: of the gaps between care recommended and care received and of the occurrence of adverse events and complications. In addition to ensuring safe practices and that consumers receive effective and appropriate health care. Attention to both access and efficiency of service provision is also essential for good quality care (Executive Summary).

The results of a paper published by Erdil and Kormaz (2009), indicate ...that the quality of service provided by health care professionals is affected by many factors. The most important of these are: 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).

Quality, as a design principle within the SCO/WRHA Framework was highlighted because it instills a level of trust and confidence amongst patients. Quality implies that all facets of the care continuum have been examined and that practice reflects consideration of the varied health indicators among First Nations populations.

Quality was alluded to in every theme area within the SCO/WRHA Literature Review as not only a feature of front-line clinical work practice, which is examined closely by the Australian Commission on Safety and Quality, but a feature within governance, management, and planning practice amongst the various players in the systems.

Principle 11

SUSTAINABILITY

As the system adapts to strategic actions taken in a collaborative approach, efforts will be made along the way to ensure that outcomes or successes are maintained for the long term, regardless of the status of a project, changes within the project structure, or key partner personnel. The Elders spoke of Treaty rights and the importance of being aware of this as a basis for working together; treaties imply sustainable partnership and are appropriate references for future planning and implementation.

Principle 12

COLLABORATION

Collaboration between First Nations health care providers and the Winnipeg Regional Health Authority Health Services staff must be better integrated through the support of effective lines of communication and to build relationships based on trust, that allows for the pooling and leveraging of existing and future human resources, expertise and to foster synergies that benefit all stakeholders in responding to the unique needs of First Nations health consumers.

Four Arrows Regional Health Authority spoke of lack of linkages between First Nations and the health system and feel that better collaboration would contribute to reaching better understandings around jurisdictional issues and the unique conditions impacting First Nations, particularly in remote locations.

Principle 13

OWNERSHIP

Ownership lends itself to a vested interest by individuals into the systems that they are a part of. This means individuals as patients, as owners of their personal health, as well as practitioners as key participants in the primary health care system, as employees or professionals. From the consultations, ownership is referenced most appropriately by Elders who urge for a restoration of traditional practices and medicines in order to achieve the optimal level of health for individuals; these are practices that need to be restored and integrated into the mainstream system, and the ownership comes into play when actions are taken to adapt systems to accommodate involvement of everyone, at all levels and according to their roles and responsibilities, into the health care continuum.

The Results Framework model has been revised to reflect the needs of the SCO/WRHA Framework. The model as depicted represents the Goal, Objectives and Principles through which strategies can be implemented. The Framework addresses critical questions posed by participants regarding issues confronting both the communities and the system around matters such as community participation,

QUALITY FRAMEWORK

Appendix 1 (p. 27) provides an illustration of a Quality Framework utilized by Royal Australian College of General Practitioners (RACGP) (2008), which may be considered for use in the Results Framework, particularly as it applies to the area of human resources. It was developed for use for General Practitioners and perhaps could be applied to other professional and allied professional services as well. It could also be applied to the area of discharge planning due to its relevance in the continuum of primary health care, or at the end of service. The report of the RACGP (2008) states the following of the Quality Framework:

...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.

The Quality Framework...ensures that planners, evaluators, designers, funders and providers of health care consider a wide range of factors in considering health care interventions. The Framework provides a structured way of reflecting on the success and failure of past programs. The RACGP uses the Quality Framework within its programs and has consistently found that it leads to a better understanding of the environment, the complexities and interactions. (p. 10)

Elements of the Quality Framework would need to be adapted in at least two ways to focus on the relevant issues to be addressed by both SCO and WRHA. Currently, the Quality Framework is designed to focus on factors related to General Practitioners. Its domains include: Knowledge and information management, Competence, Capacity, Financing, Patient focus and Professionalism. In order to be applied to a collaborative process that undertakes adaptation of a health system, and explores quality within the context of health providers and First Nations technicians, the domains would need to be redefined and clarified. What is relevant about the Quality Framework, though, are the levels of application. It does not just focus on adaptations that would need to occur at the practitioner level; rather it provides a wider context by looking at national, regional, setting of care and consultation mechanisms that need to be explored. For the purposes of SCO/WRHA, a specific sub-framework would need to be further explored to both integrate the Quality Framework into the overall *SCO/WRHA Framework for Health Adaptation*, and to redefine the domains and their features that would apply.

INTEGRATED CONTEXTUAL MODEL

Another useful tool for consideration for application within the SCO/WRHA Framework, is the Integrated Contextual Model. Burley and Greene (2007) undertook to study core drivers of quality within a remote setting. In their paper they suggest that there are four core drivers of an integrated conceptual model identified in a remote area nursing context which are: The system, the organization, the community and the individual. The authors cite definitions of quality. 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. They also cite that there are five factors influencing outcomes: the person receiving care, the professional providing care, the context, the type of care provided, and the timing of outcomes expected from the care provided. "Context" is defined as the environment surrounding the system, taking it from a system that only 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) Appendix 2 on page 28 is an illustration of the core drivers along with their key factors.

The original model has a relationship focus between individuals and community and a task focus between the system and organization. However for the purposes of the SCO/WRHA Framework, the relationship focus is between the community and the organization, given the nature of the collaborative partnership formed through the AHTF project and to be sustained in development and implementation of a Strategic Plan. Thus, the task focus rests with the individual and the system.



EXAMPLE OF APPLIED INTEGRATED CONTEXTUAL MODEL

Objective 1: Access

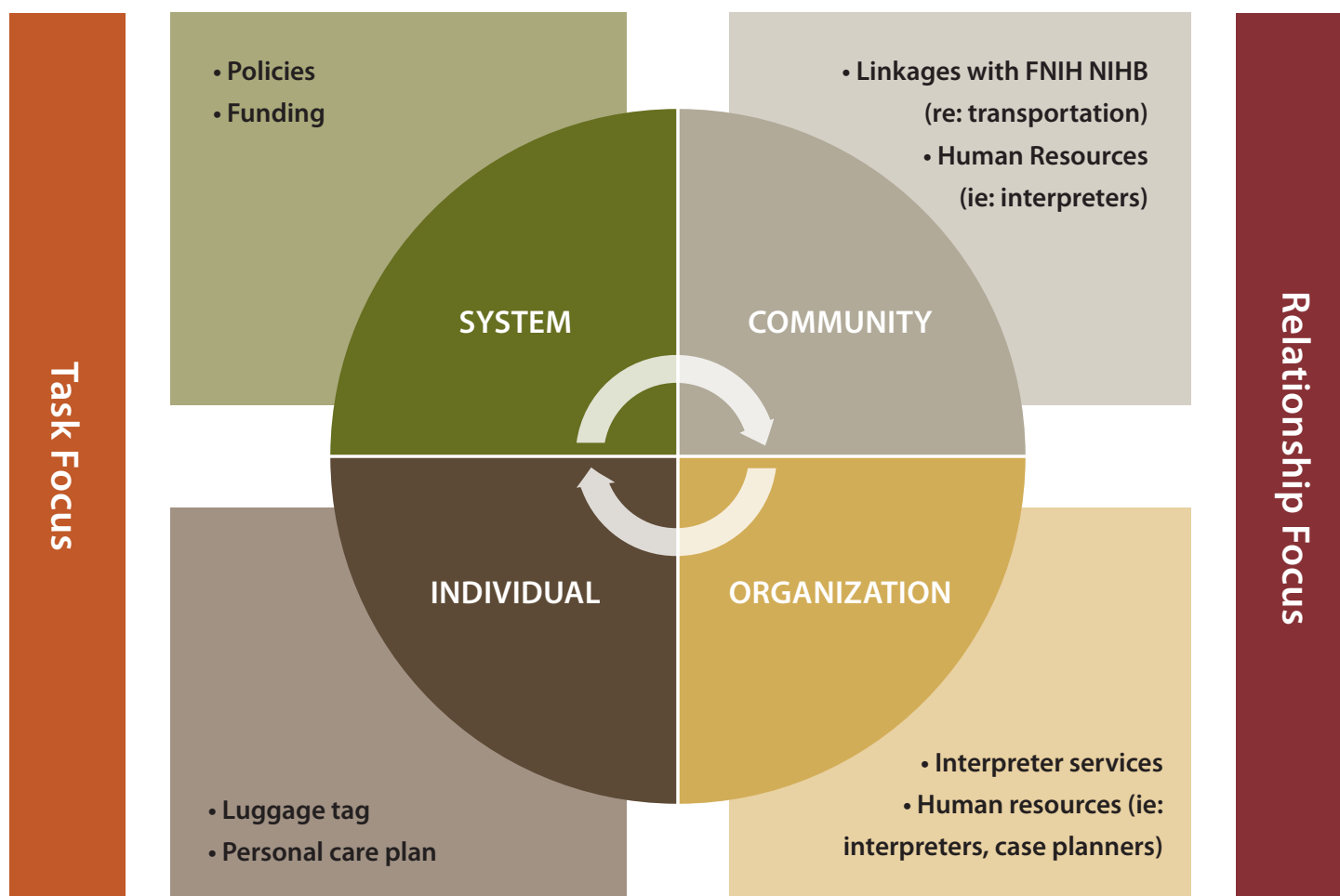


Figure 6. Example of Applied Integrated Contextual Model

Source - Burlery, MB & Green ,P. (2007). Core drivers of quality: A remote health example from Australia. Rural and Remote Health 7:611

SUMMARY

It is not a matter of a single framework or program producing positive outcomes or results but rather recognition that the 63 First Nations communities in Manitoba have differences in their ability to participate in a changing health care system. Together effective change can occur with modifications to the use of culturally appropriate methods that respect First Nations peoples and one that supports First Nations people to take the lead in becoming stewards of improving health care in their communities.

The framework presented in this document is intended to help the partners and key stakeholders to use a more adaptable and strategic approach based on existing knowledge and experiences to deal with health and health gaps. In the short term, this Framework is being used by SCO and WRHA to guide the development of a process to improve health and reduce health disparities. The Framework is adaptable and transferable for other health authorities or organizations to utilize. In the long term, this Framework can help in multiple ways:

First, the Framework can help enhance the understanding of policymakers, health care providers and leadership about the action that must be addressed in developing policies or programs that affect First Nations populations. These are identified as the major action items in the Framework.

Second, the Framework can help strengthen understanding about the many ways in which the actions relate to one another. These relationships are multiple and multifaceted, but the Framework has been designed to make it easier to articulate these multifaceted relationships, as they involve specific situations within First Nations communities and the urban setting.

Third, the Framework will make it easier to identify issues that need more input—whether by improved communication, data collection, improvement in cultural competency and provision of services or training of health care providers—if progress is to be made in improving health and reducing health disparities. Fourth, the Framework can improve, both in its structure and in its details, through the full participation and collaboration of the stakeholders at the First Nations, regional and national levels.

Finally, the Framework can increase systematic planning and use evidence-based strategies and practices that really work. Because of its simplistic nature, the Framework makes it clear that progress in developing and using evidence-based strategies and practices can arise from any number of sources. The Framework can provide health care providers and stakeholders with a better understanding of the exact challenges and issues to be addressed, the kinds of strategies and practices that may best contribute to effectiveness, the measures of outcomes and impacts that are appropriate and feasible and the kinds of goals and objectives that are realistic and achievable.

Improving access to health care systems by First Nations peoples and reducing and, ultimately, eliminating the problem of health disparities will require a multi-faceted process sustained over many years. This process must be guided by strategic and efficient approaches.

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DEFINITIONS

Acceptability - Services provided meet expectations of service users, community, providers and government.

Accessibility - People are able to obtain services at the right place and right time based on needs.

Appropriateness - Services provided are relevant to service user needs and based on established standards.

Competence - Knowledge, skills and actions of individuals providing services are appropriate to service provided.

Continuity - The system is sustainable, comprehensive, and has the capacity to provide seamless and coordinated services across programs, practitioners, organizations, and levels of service, in accordance with individual need. The services provided are aligned with the needs of the patient.

Effectiveness - Services, intervention or actions achieve desired results.

Efficiency - Organizations / programs achieve desired results with the most cost effective use of resources.

Safety - Organizations / programs avoid or minimize potential risks or harms to consumers, families, healthcare staff and the community associated with the intervention / lack of intervention or the environment.

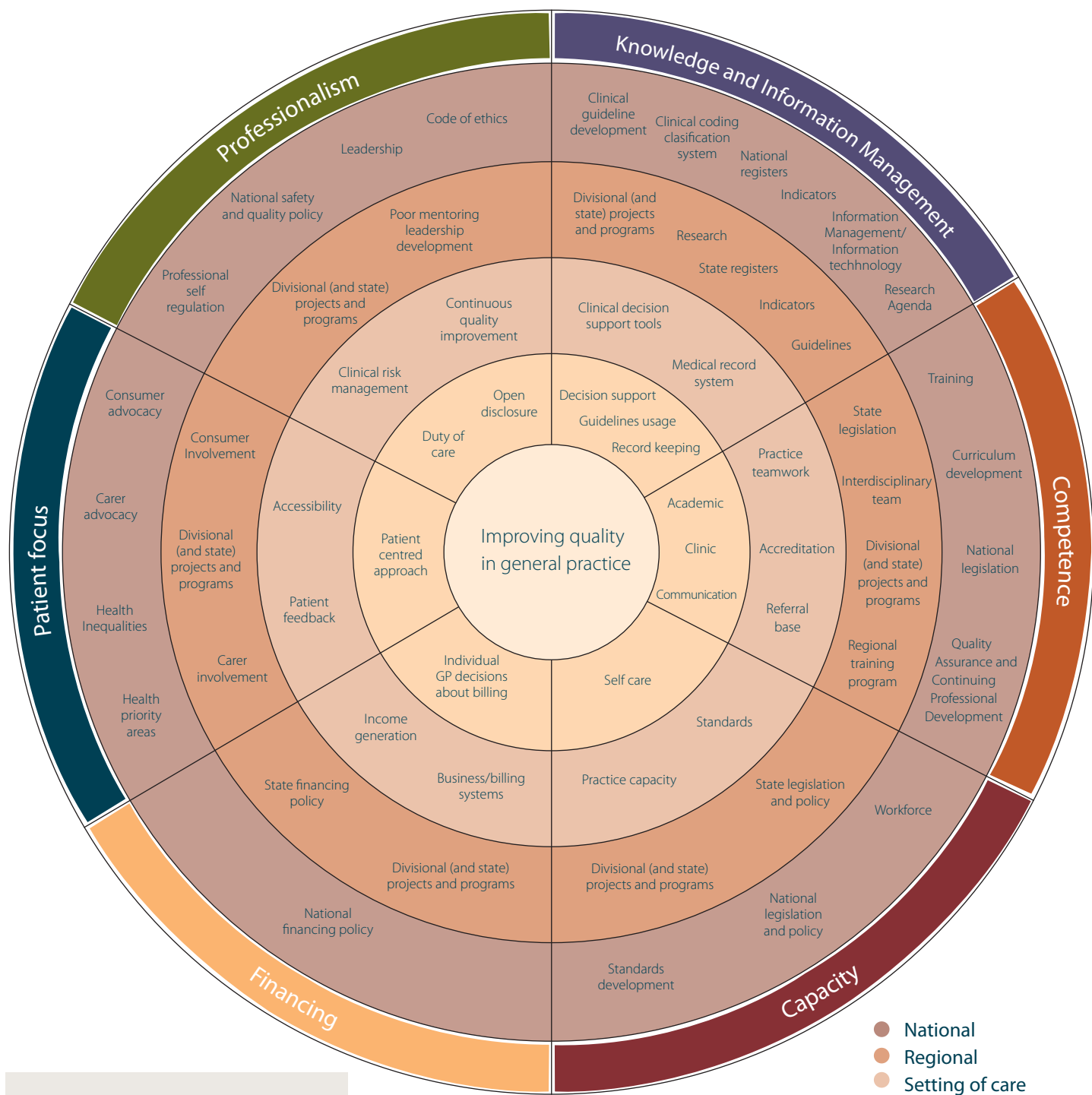
“Cultural sensitivity” is used in its broad sense (i.e., sensitivity to race, culture, and also to gender, disability, etc.).

“Early intervention” refers to both first episode intervention and services and supports that prevent exacerbation of existing mental illness.

“Best practices” refers to “... activities and programs that are in keeping with the best possible evidence about what works...”

(Source: Mental Health Accountability Framework, 2003, Ontario)

APPENDIX 1: QUALITY FRAMEWORK, ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS



Source - The Royal Australian College of General Practitioners. (2008). The improvement of general practise primary care services. A submission to NHHRC.

APPENDIX 2: INTEGRATED CONTEXTUAL MODEL; CORE DRIVERS AND KEY FACTORS

System

- political party, policies & programs
- Legislation
- Credentialing/registration
- Workforce issues
- Regional governance & health service priorities

Community

- Service access
- Cohesiveness & connectedness
- Socio-economic status
- Transport & environment



Organization

- Strategic plan
- Health service alliances
- Health service provision model/s
- Policies & procedures

Health Care Professional

(Centre Circle)

- Experience
- Knowledge, attitude & skills
- Understanding of community/client
- Qualifications
- Authorization/designation or registration

Individual

- Experience with illness/ill people
- Personal beliefs, preferences & expectations
- Ability to be a 'partner' in care decisions
- Availability of support network

Quality of Care

Outcome of Interactions - Interrelationships - Health Professional Competence - Service Access

Integrated contextual model - four drivers of quality health care.

Source -Burlery, MB & Green ,P. (2007). Core drivers of quality: A remote health example from Australia. Rural and Remote Health 7:611

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