Evaluation Findings

Improving the Provision of Home Care for
First Nations People Living on Reserve in Nova Scotia

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Cape Breton Home Care Discharge Planning Program

Evaluation Findings

Aboriginal Health Transition Fund Project:

Improving the Provision of Home Care for First Nations Living on Reserve in Nova Scotia

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A Report of the Nova Scotia Aboriginal Home Care Steering Committee
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Introduction

The evaluation of the Cape Breton Home Care Discharge Planning Model is one of three key components of the Nova Scotia Aboriginal Home Care Aboriginal Health Transition Fund (AHTF) project[1]. The evaluation focused on documenting a program history, gathering information from the Cape Breton pilot experience to demonstrate what worked and what didn't, and identifying issues to consider when rolling out the program province-wide.

The context of this evaluation is important to understand. In the general population, protocols have been developed for provincial home care personnel, who work closely with hospital-based care coordinators to ensure that appropriate services are in place when the individual returns home. Due to a profound policy gap between federal and provincial jurisdictions, however, the discharge planning needs of First Nations people living on Reserve have been unaddressed on the Nova Scotia (NS) mainland.

Many of those who return to their home on Reserve after a hospital stay do not have their care needs communicated to Band-employed nursing staff by discharge planners, because no such protocols exist. Moreover, discharge planners and provincial home care providers are generally unaware of the service capacities and gaps in First Nation communities. As a consequence, care plans are either not developed or could be better informed. This lack of coordinated discharge and care planning may also

[1] *The other two components are: the development of a Trilateral Policy Forum and the development of a province-wide Home Care Framework to serve First Nations people living on Reserve.*

lead to unnecessary long waits in hospital, avoidable readmission and complication rates with obvious impacts on the broader health care system, patients and families.

An Aboriginal discharge planning pilot project that began in 2002 and has become normal practise in the Cape Breton Health District offers a solution that could be implemented province wide. In the sample from 2005-06, approximately 29 First Nations people from 4 Cape Breton communities were assessed by the provincial continuing care staff and referred to the First Nation Inuit Health Continuing Care (FNIHCC) Program after a hospital stay. These four communities represent approximately 60% of the province's on Reserve population.

While anecdotal evidence suggests that the Cape Breton Home Care Discharge Planning program has been very successful, until now there had not been a formal evaluation of the program since the year of its inception.

It must be stressed that this evaluation is part of a broader piece of work that culminates in the articulation of a Provincial Home Care Framework for First Nations People Living on Reserve. As such, this document constitutes one chapter, specific to discharge planning systems, in the larger body of work that speaks to wider issues of community-based service capacities and deficits, mechanisms for collaborative planning between First Nations communities, District Health Authorities and the Province.

The recommendations in this report must therefore be considered in the context of both immediate/short-term tactics to improve discharge planning based on the pilot experience and medium/long-term strategies to create and strengthen home care delivery to First Nations people living on Reserve across Nova Scotia.

Research Approach

The evaluation followed a mixed qualitative research design consisting of two streams of data collection and analysis: [1] document review and [2] key informant interviews.

Document Review

The document review included an analysis of all documentation on the Cape Breton Home Care Discharge Planning Program. The main sources of material included emails and letters sent during the set up and design of the program, a six-month evaluation of the pilot project (2002), the Memorandums of Understanding between the communities and the province outlining the terms of agreement for the program, and program statistics.

Key Informant Interviews

The key informant interviews included general interviews and targeted interviews (please see Appendix B for key informant role descriptions). The interviews were based on an iterative format whereby those being interviewed had the opportunity to comment on the findings. Client interviews were not conducted due to privacy and confidentiality issues; clinical key informants were able to provide anonymized anecdotal scenarios to inform this dimension of program review.

General interviews:

The general interview was designed to solicit information regarding the administration and delivery of the program. A list of people to interview was developed with input from the AHTF Home Care Steering Committee. We completed ten individual interviews and two group interviews. The group interviews included a department with limited involvement in the program that decided to respond together, and a group of individuals who all occupy similar positions within their organization. Only two people from our original list did not respond.[2] The interview questions were pre-screened by the Steering Committee prior to the interviews (please see Appendix A for a list of interview questions).

A summary of interview themes was presented back to the group-based participants for feedback and discussion. At this time a series of follow up questions were asked of the group regarding gaps in the original interview findings.

Targeted interviews:

The targeted key informant interviews were intended to solicit more specific information about the program. These interviews were less formal and often took the form of a general discussion around specific aspects of the program. In all cases, interview notes were sent back to the potential informants to verify accuracy and to add further comments. Four targeted key informant interviews were conducted.

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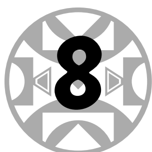
[2] *Those who did not respond received at least three reminder emails and a follow up phone message. Michele Landry also sent a direct email request to the potential informants.*



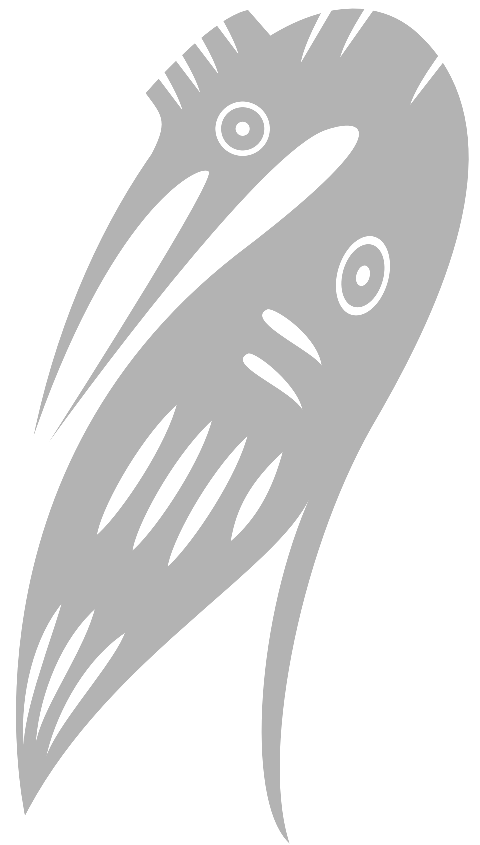
Evaluation Results

The results are organized into three sections:

1) **Program description:** a history of the program and a description of the Cape Breton Home Care Discharge Planning Program operations.

2) **Interview themes:** a review of the major themes which emerged from the interviews. Interview summary findings are included in Appendix B.

3) **Service gaps and challenges:** critical areas which emerged as part of the evaluation which need to be considered by the steering committee to inform the roll out of a discharge planning program serving all First Nation (FN) communities in the province.



1) Program Description

The objective of the program is to provide a home care discharge plan to those FN clients who require one when they leave the hospital. The hospital-based care coordinators complete a 2-page functional assessment about mobility and other key issues around a client's capacity to function out of the hospital setting. This identifies enough information about the client to activate short-term service in the home until the community-based care coordinator conducts a home assessment to develop a home care plan[3]. Once the client is discharged from the hospital, the case management and services are provided by the FN community.

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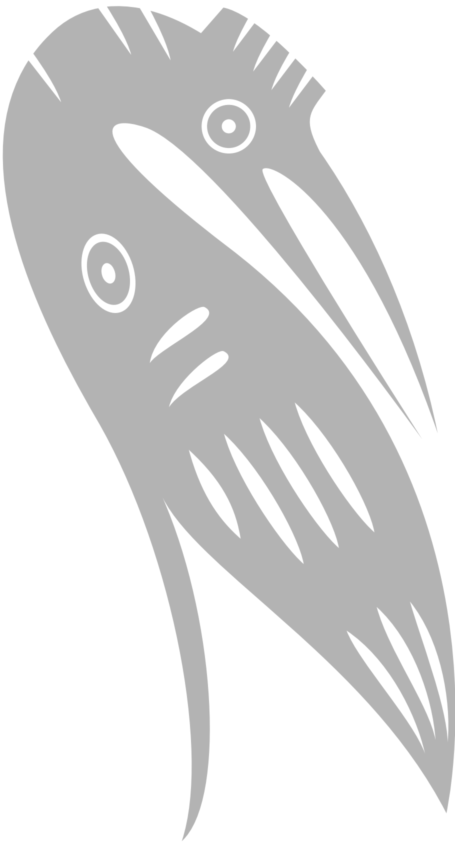
[3] *The hospital-based care coordinator does not develop a service plan for the client unless they are going to receive 'acute' services. What they do is identify unmet needs and make note of the services that they would require.*

Cape Breton Pilot Program impetus

This pilot program was initiated to improve the procedure for handling the discharge of FN clients living on Reserves in the region and to fill a gap in the provision of care that both FN communities and the District Health Authority (DHA) identified as being important.



More specifically, the impetus for the program was the result of an incident in 2001 in a FN community where a client was discharged from the Cape Breton Regional Hospital under very serious circumstances and no one at the local health centre had been notified. It was not the first time this type of scenario had unfolded. This particular incident, however, was documented and shared with the Cape Breton District Health Authority (CBDHA) CEO, John Malcom. A subsequent meeting took place between the community, the Union of Nova Scotia Indians (UNSI) and the DHA to explore ways to prevent this type of event from occurring in the future.

A joint letter was submitted to the Nova Scotia Department of Health on behalf of the Cape Breton FN communities and the Cape Breton District Health Authority, requesting approval to allow care coordinators based at Cape Breton Regional Hospital to provide discharge plans for FN clients.

The province supported the initiative and a pilot program was launched in July 2002 for a six-month trial period to include the communities of Eskasoni and Membertou. The initial setup and communication work was carried out by Michele Landry of UNSI. Due to pilot program's success, it was expanded to We'koqma'q and Wagmatcook in 2003 and to Potlotek (Chapel Island) in 2008, now serving all five FN communities in Cape Breton. It has continued to date.

2) Interview Themes

There were a number of prominent themes identified through the interview process, which provide critical insight for informing the expansion of the Home Care Discharge Planning Program province-wide. Appendix B provides a more detailed inventory of feedback.

Initial program success

The initial success of the program reflects several key factors including:

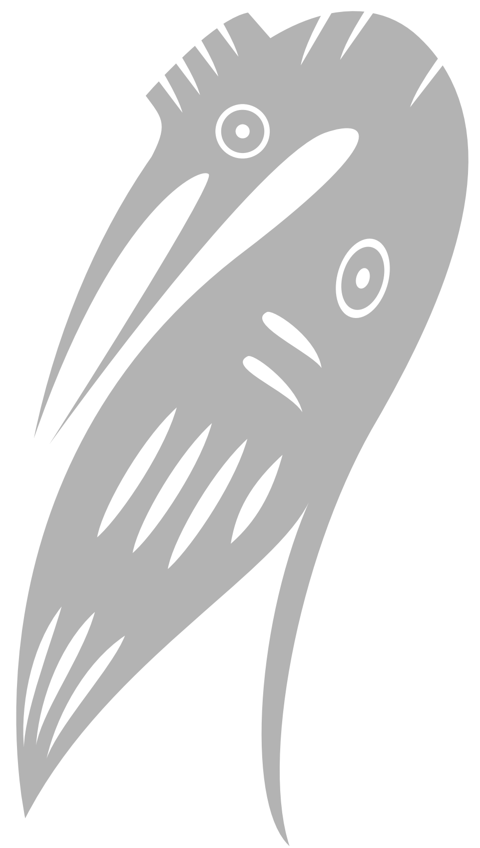
- the program did not require significant resources;
- the program integrated into the existing system smoothly;
- the program achieved a win-win for FN communities and CBDHA;
- the program was supported by all partners involved;
- the Memoranda of Understanding (MOUs) were important to embedding roles, responsibilities and expectations within organizational structures; and,
- all partners involved have demonstrated good will and in-kind support.

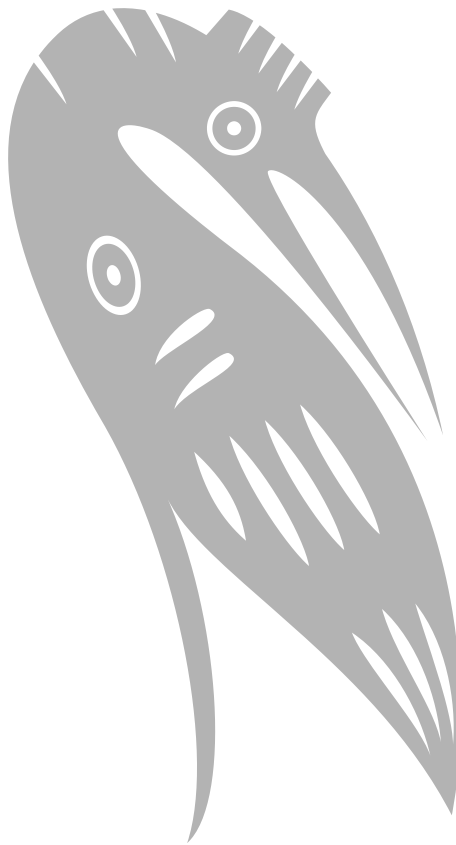
Lack of data

When planning the program, there was a concern that the number of FN clients requiring the service might overload the existing discharge planning program at the hospital. There was no data to suggest what the increase in volume might be. In practice, the number of FN clients needing a discharge plan was quite small. Since the inception of the program, the annual total number of discharge plans provided to FN clients has ranged between twenty-five and thirty-five per year.

Program operating resources

It was uncertain if the program could operate successfully without any specific resources dedicated to it. The program has largely been able to succeed on minimal resources due to the goodwill of those involved and the low number of FN clients accessing the program. The existing services in place at the hospital were not overwhelmed and the program has been well integrated into the discharge planning process at the Cape Breton Regional Hospital. In addition, the home care nurses in the FN communities have been very supportive of the service. Michele Landry of UNSI has also assumed the role of central coordinator which has been vital to the program's ongoing success.





Linkages

The necessary linkages and relationships to ensure the success of the program were made early on in the process and were vital to both the expansion and the extension of the program. The program had the buy-in from the FN health directors and the community-based home care coordinators, the DHA CEO and Continuing Care Regional Director, as well as the Unit Managers and social workers at CBRH. The program was also supported by UNSI and First Nations Inuit Health (FNIH).

Strong program design, setup and relationships

Strong linkages were created during the program design and setup based on a successful team effort. At the beginning, there were regular working group meetings to address gaps, concerns and the orientation of those who were going to be involved in the program. The early meetings and collaboration created an effective working environment and a legacy of strong relationships.

Respect and good will

The various team members were very complimentary of the other health providers involved in the program. Several respondents also indicated that the success of the program hinges on the goodwill of those involved.

Communication

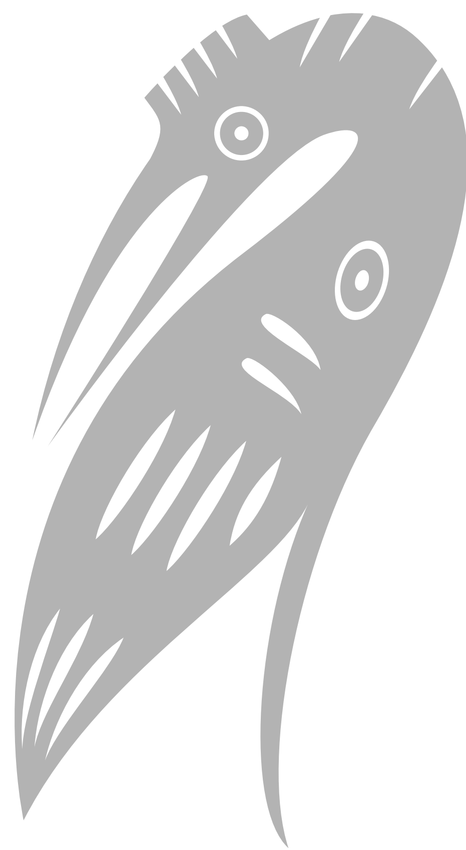
Effective communication among the various program members was consistently identified as a strong point of the program and a driver of the program's success. Good communication was identified at some point in all the interviews. While effective communication among program providers is clearly vital, there is also a need to ensure good communication with the client and family. This requires cultural sensitivity, knowledge of the services available in each of the communities and the context in which clients and families live.

Opportunities to meet

Those involved with the program have met once per year. The annual meeting was felt to be very useful. There was a strong opinion that the

various partners need to meet at least once per year to fine-tune the program and address gaps. Several community front-line staff highlighted the importance of meeting their respective counterparts, in spite of the fact that the logistics of finding a common meeting time is tremendously challenging.

One respondent suggested that holding meetings by teleconference might help with scheduling difficulties. Other respondents indicated that they prefer face-to-face meetings.



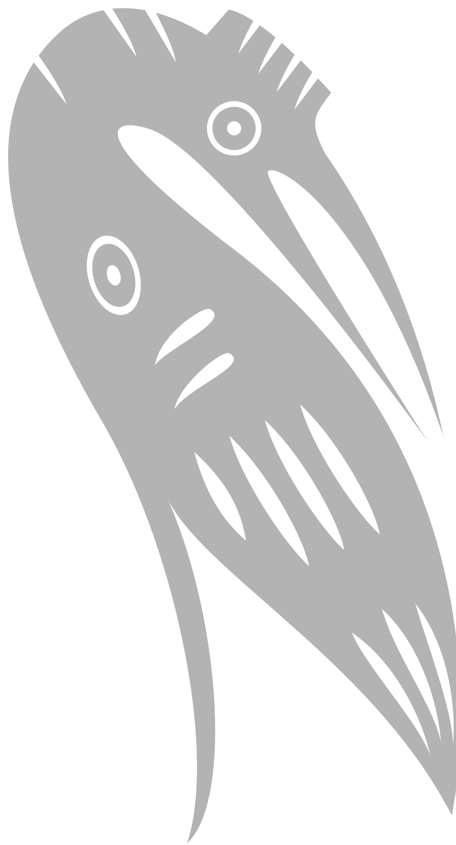
Need for FN-dedicated hospital-based care coordinator

There was some suggestion that a care coordinator dedicated to FN clients working directly in the hospital could better facilitate the discharge process and provide a direct link to the communities. Several respondents also suggested that a direct presence in the hospital would facilitate program education, ensure that information posted in the hospital was up to date and provide orientation for new staff. A dedicated FN hospital-based care coordinator could also address any potential culturally sensitive issues, track program data and act as a liaison for all aspects of the program. It was noted, however, that an annual 35 client case load doesn't warrant a full time position.

Value of FN interpreter role

The role of the FN interpreter was highlighted as being critical by several respondents. There was some suggestion that the FN interpreter role could be expanded to support the discharge planning program including updating information and providing education. The FN Interpreter provides relevant community supports with information about FN residents in the hospital and gives home care coordinators a heads-up as to when the clients will be discharged. The FN interpreter also communicates directly with clients and their families to ease worries about what is in place with regard to care at home and informs them about what services are available to them through the Non-Insured Health Benefits program (NIHB).

There was, however, concern that the FN interpreter position is already too busy and may not possess the competencies necessary to support the



discharge planning function. Furthermore, it was expressed by respondents that, in addition to having a strong understanding of the community infrastructures (formal and informal), anyone who is going to be involved in the discharge planning process in a navigation role may be advantaged by some relevant health care training. It was also suggested that the proposed cancer care navigator position could be combined with a discharge planning support position.

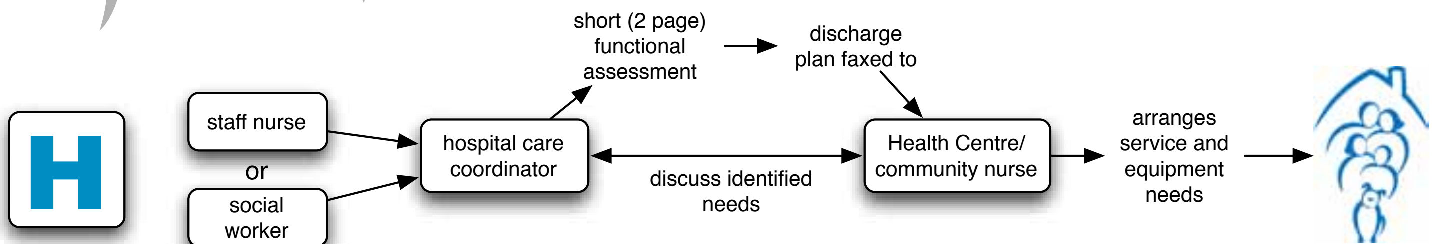
Strong support networks in FN communities: real or perceived?

There was a sense among hospital staff that First Nation communities have very strong social support networks, which helps facilitate better care. They also expressed the perception that FN clients seem to have better support services than non-FN rural communities in the surrounding area, which interestingly is not entirely consistent with the perceptions of health staff providing care in FN communities. Indeed, some local feedback cites the dire circumstances in which many FN families live as conspiring against successful convalescence, notwithstanding that extensive local social networks exist. This issue will be explored in more detail through the development of the local service profiles and broader Home Care Framework.

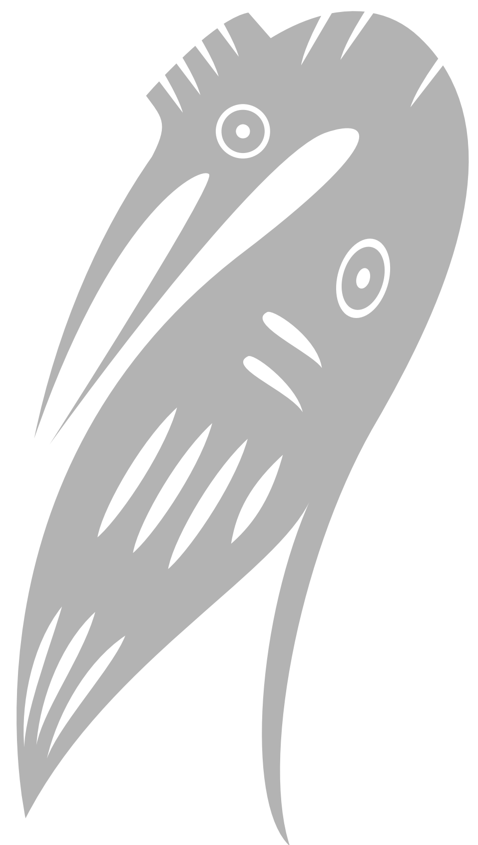
Referral and discharge process

Several respondents indicated that the referral and discharge process could be improved in light of the fact that there is concern that some referrals are being missed – although there is no formal mechanism in place to capture this information. Informal networks have been created to deal with unresolved service issues.

Home Care: Discharge Client Flow



Gaps include those clients who are ambulatory but could benefit from a coordinated discharge plan for home support and those clients who, for whatever reason, are not provided with a discharge plan but could benefit from same. There is also no process in place when hospital nurses don't think that the client needs home care but requires another referral to be carried out in the community.



Community-based home care nurses noted that they would like more time between the assessment at the hospital and discharge so they can ensure the appropriate services are in place before the client returns home. It was acknowledged that providing a longer lead-time between communicating the discharge plan and release from hospital would be challenging, owing in no small part to how busy the hospital-based care coordinators are.

In addition, often times unit managers don't contact community-based home care staff until the client is about to be discharged. One FN community home care nurse noted that when she is aware that a member is in the hospital, she will contact the unit directly to facilitate a discharge plan getting done sooner rather than latter.

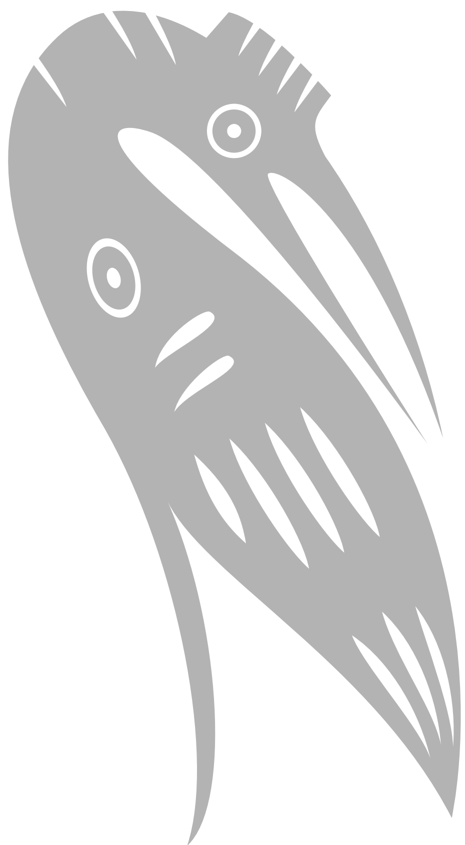
Linkages

Making the right linkages between the client/family, hospital, community based services and local primary care providers was essential to the success of the program and will be critical when extending the program to other communities.

Cultural training

While the program is serving FN communities well, several respondents alluded to the need for cultural awareness and training to improve the quality of service that care providers' deliver to FN clients. The Cape Breton Regional Hospital is providing cultural competency training starting July 2008.

Also, among some FN clients, there is a reluctance to accept hospital care and support. It was noted that FN clients in the hospital will often say whatever it takes to get out of the hospital sooner. They will even say family or the community will provide care when in fact the family is unable and/or the services are not provided by the community. This partially reflects a larger issue of culture and language especially among elders where they do not feel comfortable in the hospital setting. It also reflects a communication issue where hospital staff is not aware of services available in the communities.



3) Service Gaps and Challenges

Service availability on Reserve

Some respondents noted that it is difficult to reach home care services in the communities during holidays and on weekends. This is especially a concern when there is an unexpected shut down due to a death in the community or for other reasons. One respondent noted that the unexpected shut downs would be easier to deal with if they were notified or if the message on the answering machine indicated that the centre would be closed. It was also noted that it is important for hospital-based care coordinators to recognize that care providers in the smaller communities often have multiple roles making them hard to reach.

Some respondents noted that the communities do not have access to longer term services or specialized services. For example, most Reserves do not have long term care facilities. Individuals requiring this level of care are reluctant to leave the Reserve even though their family or community-based health care system may not have the capacity to care for them. Also, younger populations who have disabilities and other health problems may be best served in a group home setting but that type of setting is often not available so it falls on home care to fill the service gap.

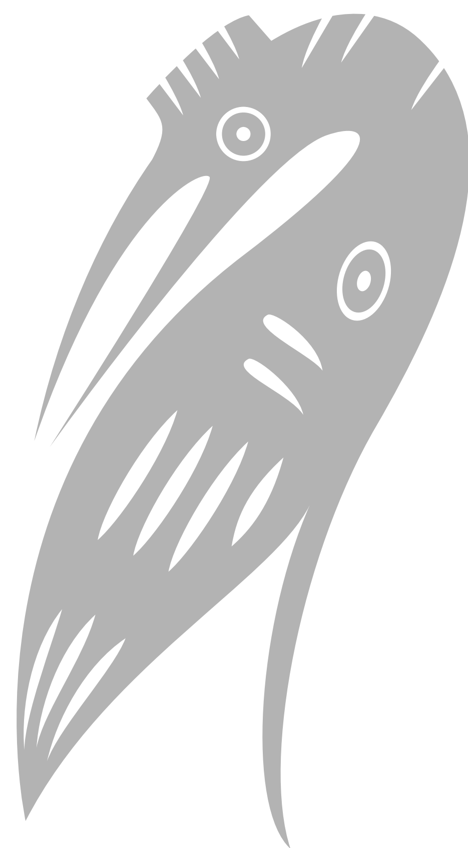
It was also noted that not all of the communities have the same level of resources and services available, demanding an intimate understanding of

community-based infrastructure including formal and informal systems of care.

Off hours care

There are service gaps regarding the provision of 24-hour care and care on evenings, weekends and holidays. Communities are not funded for weekend, holidays and evening care. Representatives from FNIH noted that they will not be funding care during these times at any point in the near future.

Currently, FN clients who can be discharged from hospital on a weekend are held back until Monday. This is hard on the client and their family. Moreover, this is an inefficient use of hospital resources. It contributes to bed shortages for patients who are acutely ill and has a ripple effect throughout the system.

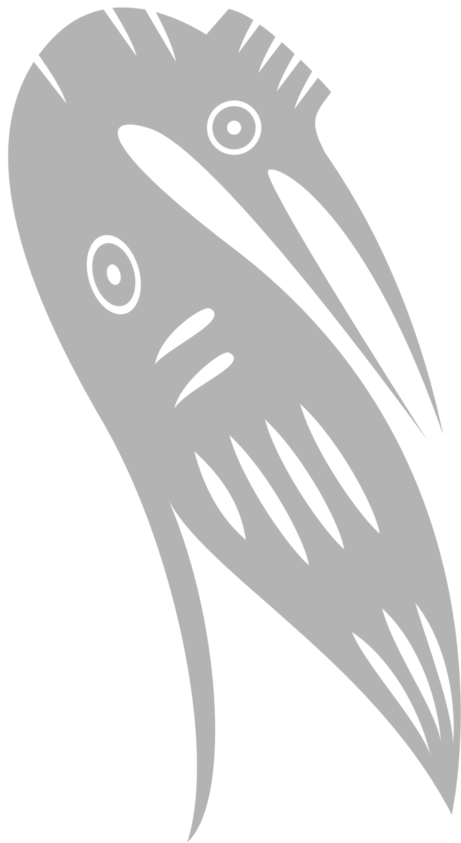


Another major gap in service is that those clients already discharged are technically not able to access home care during off hours. The Cape Breton FN communities have informal arrangements in place to address this gap in service. The community of Membertou contracts out the provision of care during off hours at a direct cost to the Band. In Eskasoni, home care nurses try to teach family members what to do but staff will intervene in emergency situations. In We'koqma'q and Wagmatcook, care is not provided during off hours. In emergency situations the community nurse steps in. If the nurse is not available, the client must go to the Emergency Room.

Synchronizing services

As residents of a FN Reserve, Aboriginal people have access to two streams of health services: one funded and delivered by the province, and one funded and delivered by the federal government. Both levels of government are keen to ensure that there is no overlap of service responsibility, but in the case of home care, significant gaps in coverage have become apparent. Moreover, both the provincial and federal governments assumed themselves to be the provider of last resort. While

this issue is central to the development of the broader Aboriginal Home Care Framework, and is explored in greater detail in that larger body of work, for the purposes of discharge planning for such clients, the policy disconnect can be paralysing.



Burden of care

A major challenge facing the communities involves clients who require extensive and complex levels of care that exceed the capacity of formal and informal community-based resources. While many of these clients are candidates for placement in a long term care facility, many of them – especially elders – understandably refuse to leave the community and their family and social supports. FN communities have traditionally placed high value on their elders and functioned with a local extended family network that is less characteristic of more scattered mainstream nuclear communities. It should also be noted that there is a significant population of younger aboriginal people living on Reserve with complex medical needs and disabilities, who represent another growing client constituency for long term home care programming.

Overlooking potential clients

There is concern about the risk of overlooking potential clients for discharge planning. The program largely hinges on hospital staff in the various units being aware of the program. For example, during the evaluation of the program it became evident that key Emergency Room staff did not know about the FN discharge planning pilot program and may therefore have missed opportunities to link clients with this service.

Data tracking

Currently the hospitals keep track of the number of FN clients requiring a discharge on paper and forward the tally monthly to the Department of Health Care Coordinator monthly as FN clients are not entered into the provincial computer system. While this makes it impossible to track if the FN client is a new or repeat referral, the current (and rudimentary) data collection approach appears to pose no challenges to respondents. This may be due to the relatively small client load involved in the program.

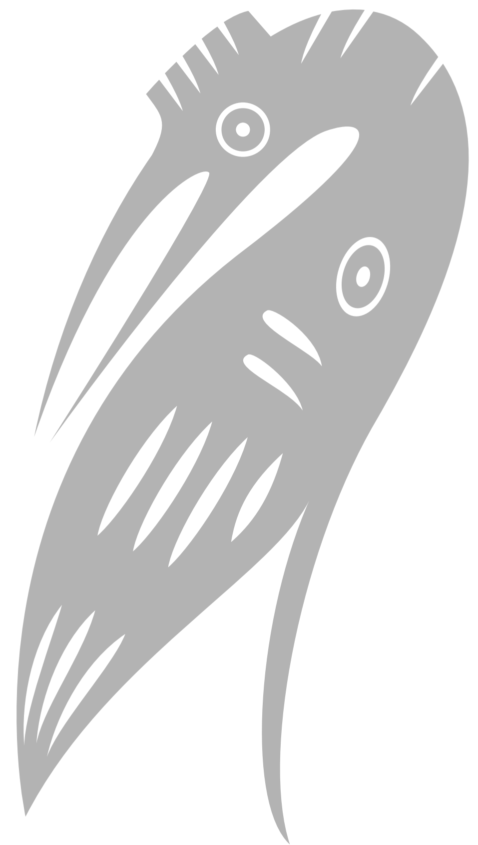
Lack of operating resources

There is no specific funding to support the discharge planning program, although the NS Department of Health is providing in kind support as the hospital-based care coordinators are completing assessments for the 30-35 clients per year. The program is fueled entirely by goodwill from all those involved with patient care and program coordination support from Michele Landry. In addition, the extra workload for the discharge planning nurses (30-35 clients per year) and the administrative supports required are provided by the hospital on an in-kind basis.

Gaps in resources are primarily around human resource time (coordination) and program support.

- Ongoing communication with those involved (in hospital and communities)
- Targeted education for unit managers
- Updating community information sheets and posters
- Data roll up and tracking
- Annual meeting

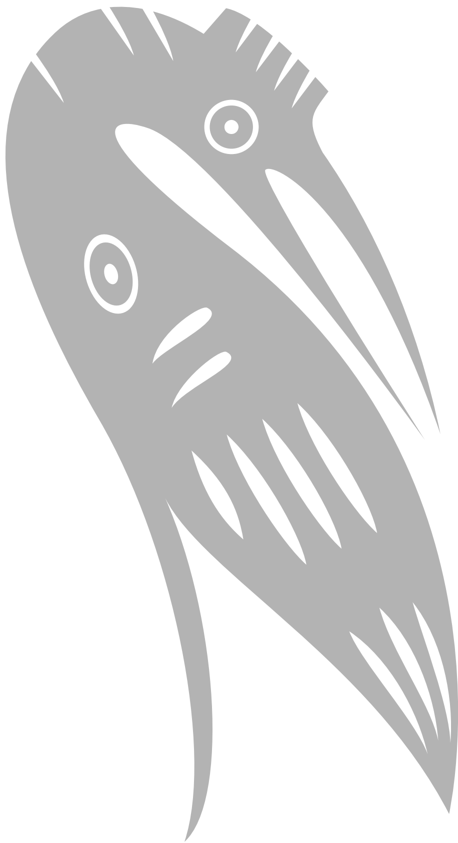
Gaps in resources are also apparent at the community level for the delivery of home care services (after hours, weekends, and specialized care). *This issue will be explored in more detail through phase two of the Aboriginal Home Care Project Community Service Profile.*



Special needs (children)

Special needs care is a different level of care and often very clinically specific. The communities do not receive the necessary funding to offer such a specialized level of care and practical issues of critical mass would need to be considered in any program coordination function.

Recommendations



Based on the evaluation findings, the following recommendations are intended to inform a roll-out of the Cape Breton First Nations Discharge Planning Program across the province.

1. The Cape Breton First Nations Discharge Planning Program should be implemented across Nova Scotia, using the Memorandum of Understanding process to detail discharge planning roles, resources and protocols (as designed for the Cape Breton First Nations communities) and customized to the needs of each community and district.
2. The Nova Scotia Department of Health Continuing Care Branch should facilitate a process of joint planning with DHAs and FN communities to design and operationalize the roll-out strategy.
3. Successful implementation will require strong local linkages, which may require facilitation to become established where they do not currently exist.
4. Local FN and DHA discharge planning mechanisms will require some modest infrastructure to support their work (such as regular meetings of stakeholders, information sharing, community service profile updates and associated coordination resources).
5. A discharge planning coordination function is critical to success and there are several models that should be considered. The feasibility of expanding the FN interpreter role to include a discharge planning component could be explored (currently there is one FN interpreter to serve the mainland and one to serve Cape Breton), noting the competency requirements to support the discharge planning coordination function. Alternatively, the feasibility of expanding a patient navigation role to include FN discharge planning functions could be explored. The feasibility of any coordination model must obviously take into consideration the critical mass required to sustain such positions and include contemplation of shared positions across DHAs.

6. All staff involved with discharge planning to FN communities should be supported with cultural competency training.
7. Communication protocols must be established between the appropriate First Nation community contact and hospital-based care coordinators regarding irregular health centre closures.
8. Discharge planning should commence upon client admission to hospital.
9. Emergency department and mental health program staff should be informed and educated about home care supports for FN clients living on Reserve.
10. Community-specific service profiles must be developed and updated regularly in order that care coordinators and discharge planners are aware of service limitations/capacities at the local level (such as hours/days of care availability) in designing care plans.
11. Formal mechanisms to track and resolve service issues and gaps should be established within the context of a quality assurance / risk management framework.
12. Orientation processes for hospital-based care coordinators should include participation by FN community nurses, to promote cultural competency and professional relationship building.

Issues for further consideration

In addition to the previous recommendations, the following list includes some key observations that should be reflected in the development of the broader home care framework, currently in development.

- Even with the most effective local linkages, broader system-wide policy issues require a forum of multi-jurisdictional partners whose role it is to address gaps where they might exist and to optimize the collaboration of prevailing programs in meeting the needs of FN clients on Reserve.
- Timely information sharing between local health directors and their DHA will ensure that FN home care needs are clearly articulated and reflected in health authority business plans (anticipating the transfer of home care delivery to the DHAs in April '09).
- A better understanding of community home care needs will help to inform programming decisions that acknowledge the burden of illness for complex care case management.
- Clarity is required regarding coverage of special needs children needing home care services on Reserves. This information should be collected as part of the home care framework development.
- It is critical to ensure that those providing community-based services are competent to deliver the level of care required. Failure to do so raises significant liability concerns and undermines the credibility and confidence of services overall.
- There is an opportunity for the Aboriginal Health Human Resource Initiative (AHHRI) to explore additional training supports for First Nations students to become qualified home care service providers.

- Pay equity for FN staff providing home care services on Reserves with their provincial counterparts has been raised as an issue, most notably by a number of FN Health Directors.
- Emerging models of primary health care delivery requires that there be discussion about Nurse Practitioners working in FN communities being granted privileges at admitting hospitals, to facilitate continuity of care/information sharing.
- Small options homes may be explored as part of a broader home care strategy in FN communities.
- Telehealth could hold promise as a home care tool. The Tui'kn Partnership management team (a partnership of the Cape Breton First Nation communities) is presently involved in a telehealth initiative and may be able to provide leadership in this regard.
- Some FN people live in satellite Reserve communities, for whom service delivery plans may be required.

Appendix A: Interview Questions

General Interview questions

What is your role in respect to the Home Care Discharge Planning Program?

How many clients do you interact with per year as a result of the program?

What do you think has contributed to the success of the program?

What do you think the strengths of the program are?

Can you provide any specific examples of how the program has successfully served clients?

What are the limitations of the program?

Please identify any gaps in service or specific areas where you think the program could be improved?

If this type of program was going to be extended to all First Nations Communities in the province what recommendations would you make?

What changes to the program would make your role easier?

What linkages are required to facilitate the Home Care Discharge Planning Program?

Is there anything else in respect to the program that you would like me to note?

General interview – follow up questions

How does the home care coordinator use the discharge plan?

What clients are we potentially missing?

What are the implications of subsequent referrals being treated as a new referral?

How could we improve data tracking and what data do we need to track?

Is it feasible to expand the First Nations interpreter role to improve discharge planning? If so, what would be included in the new role?

What happens to clients on holidays or when the community health centres are closed?

What type of funding is needed to support the program?

Appendix B – Interview Rollup

KEY INFORMANTS AND ASSOCIATED PROGRAM ROLES

- FN program facilitator: oversight, liaise with communities and DHA, program maintenance.
- community-based home care coordinators: receive reports from the hospital, schedule assessments, visit the client at home, set up services for the discharged client, provide a follow up plan.
- District manager: oversee programs and liaise with community and DHA.
- Care coordinator supervisor (NS Department of Health): supervise hospital-based care coordinators, administration.
- hospital-based care coordinators (CB Regional Hospital): complete functional assessments on FN clients that have been identified by hospital staff as needing Home Care on discharge. The assessments are discussed with the FN Home and Community Care staff and are forwarded to them by fax.
- Social work (inclients): Various roles – have interface with home care coordinators.
- First Nation Interpreter

How many clients do you interact with per year as a result of the program?

- approximately 30-35 per year
- 10-15 per year (Membertou)
- approximately 20 (Eskasoni)
- 108 discharges from hospital (Wagmatcook)
- very few – deal mostly with elderly frail clients (hospital) (not many elderly FN clients)

CONTRIBUTORS TO SUCCESS / STRENGTHS OF PROGRAM

Relationships

- ***Excellent communication*** between FN program facilitator and communities and good communication between care coordinators at CB hospital and home care nurses in the communities;
- ***Team work:*** the various partners work well together, sense of belonging;
- ***Collaboration:*** FN community partners work together (band leadership, health directors, and service providers);
- ***Respect*** among team members;
- ***Commitment and good will*** on the part of everyone to provide excellent care.

Program operation

- ***Simplicity*** of the program;
- ***Manageable*** number of people passing through program;
- ***Clear rolls****:* The MOU clearly outlines roles;
- ***Well maintained***: contact numbers for communities in the hospital are updated regularly, annual meeting;
- ***The First Nations interpreter*** is a very important role. The interpreter provides First Nation health centres additional

information and acts as a direct link to community.

Program roll out
- ***Inclusion*** of all partners during program development;
- Good ***orientation*** process at start of the program.

Improved outcomes
- ***Smooth transition to home:*** Clients and their families have been able to return to their community in an efficient and less stressful manner;
- ***Ability to provide the appropriate resources*** (equipment) for successful outcomes at home;
- ***Link to other resources*** that may be required i.e., social work, MFCS, housing, welfare.

PROGRAM LIMITATIONS

Resources
- Don't have specific ***funding***
- Ability to find a ***time*** for everyone to meet (annual meeting cancelled last year)
- ***Data collection tool*** is rudimentary (calendar)

Communication
- ***Lack of knowledge regarding services provided by communities****:* Most of the DHA staff and NSCC do not know what services communities can provide;
- ***Verification of needs***: Clients will sometimes mislead Social Workers that they have adequate care arranged in community so they can be released. This is often not the case and subsequently the burden falls on the community home care provider.
- ***Communication with client***: Communication with client is paramount with good service delivery. This requires sensitivity to client needs and background.

Program structure
- **Discrepancy in services**: The home care program offered on Reserves (federally funded) differs from the Provincial Continuing Care program. Also not all of the communities have the same resources and services.
- ***Limited access to DOH continuing care services***: First Nation communities only have access to acute home care services;
- ***Availability of service*****:** First Nation Home and Community Care are usually closed over holidays. Voice mails just say the office is closed, leaving Care Coordinators caught in the middle between Cape Breton Regional Hospital discharging the client and no service being available in the community.

GAPS IN SERVICE

Education
- High staff turnover requires ***ongoing orientation;***
- ***Ongoing education*** is essential for all

partners to ensure that the program runs smoothly.
- ***Client and client family education*** is essential. Family education is sometimes missed.
- ***Service availability:*** There is confusion about what services are offered in the communities. The FN and Inuit Home and Community Care Program and Provincial Continuing Care program differ. For example, the FN Community Care program is not funded for evening and weekend care per the program framework and funding structure. Though the service hours are posted on the communication sheets, it still causes some confusion at the hospital end.

<u>Referral process</u>
- ***Streamline process*** to ensure appropriate referrals;
- ***Do not track the number of referrals*** that don't end up on the home care door step. If there are other referrals, where are they going?
- ***Need process*** for when hospital nurses don't think that the client needs home care but requires another referral to be carried out in the community.

<u>Discharge planning process</u>
- ***More time between assessment and discharge:*** Many times FN home care nurses receive the assessments the day of discharge and don't have time to arrange the appropriate services in the home;
- ***Comprehensive team approach:*** For complex clients a team approach could improve discharge planning process;
- ***Clients that use emergency services are missed***. This happens with the public at large and is not a unique FN issue.

<u>Cultural training</u>
- **Need for cultural training** targeting FN experience to be available to hospital staff.
- **Mistrust** among some FN clients towards hospital and hospital staff.

<u>Lack of facilities</u>
- ***Nursing home or elderly care facilities*** are typically not available on Reserves. There is reluctance among individuals to leave the Reserve even if their families do not have capacity to support them in the home.
- ***No targeted support facilities*** for younger populations that cannot be served in home.

What changes to the program would make your role easier?

- Electronic tool to track program data;
- Dedicated person to track and monitor program data, update contact information in hospitals, provide orientation and ongoing education and act as a direct liaison between hospital and

communities;

- Financing for communication posters and staff person to support program;
- Expand role of FN interpreter to support program;
- More opportunity to meet those involved with program (At least 1 or 2 meetings a year);
- Teleconference versus a face to face meeting;
- Clear understanding and communication of the days/hours of operation of the FN Home and Community Care programs and direction as to responsibility of service provision during closures.

What linkages are required to facilitate the Home Care Discharge Planning Program?

- Linkages with the DHAs, unit managers in hospitals, frontline hospital staff, and communities (band council, Health Directors, service providers);
- Most important link is between hospital-based care coordinators and counterparts in the communities.

Recommendations to extend program to all First Nations Communities in the province

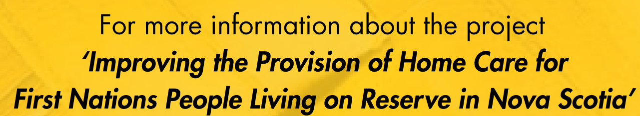
- Increase time between assessment and discharge so community providers have more time to set up home care;
- Focus on communication and relationship building;
- Ensure community information is up to date at all times, i.e. contact person, phone numbers.

Is there anything else in respect to the program that you would like me to note?

- There is concern about what will happen when the districts assume responsibility for home care. Will the program differ by region? Will it be feasible to roll out a discharge planning program to serve all FN communities?

For more information about the project
'Improving the Provision of Home Care for First Nations People Living on Reserve in Nova Scotia'
please contact:

Department of Health, Continuing Care Branch
Tel: (902) 424-7807
Fax: (902) 424-0558



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