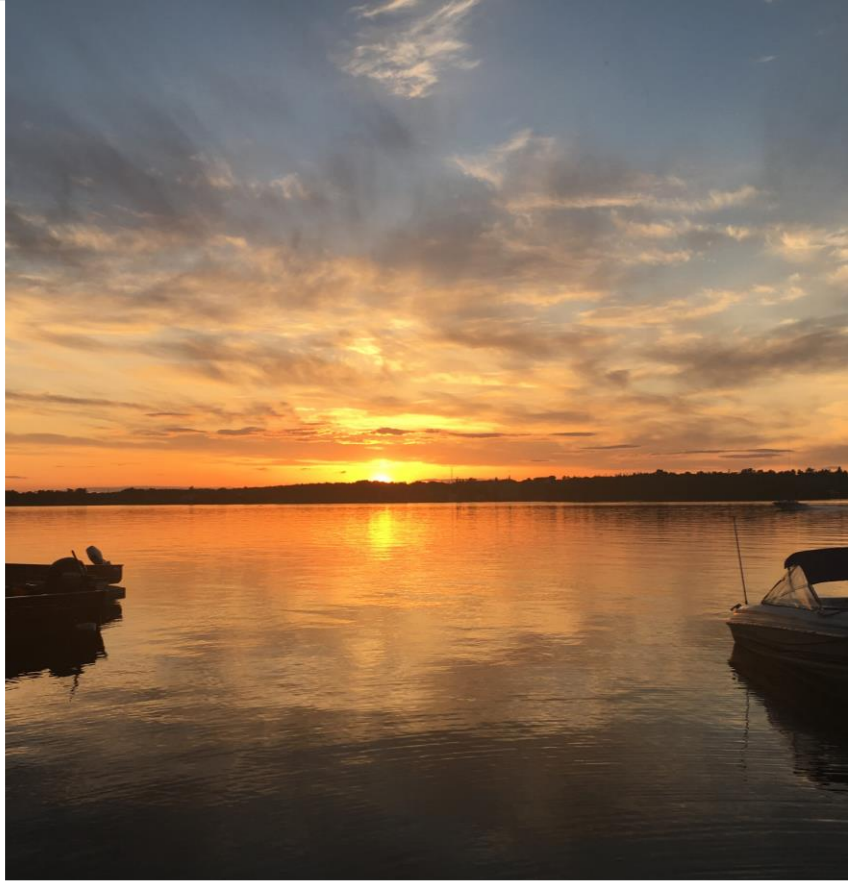


EXPANDING PRIMARY CARE FOR FIRST NATIONS COMMUNITIES IN THE KENORA AREA

Dr. Jillie Retson B.A. MD. MM.

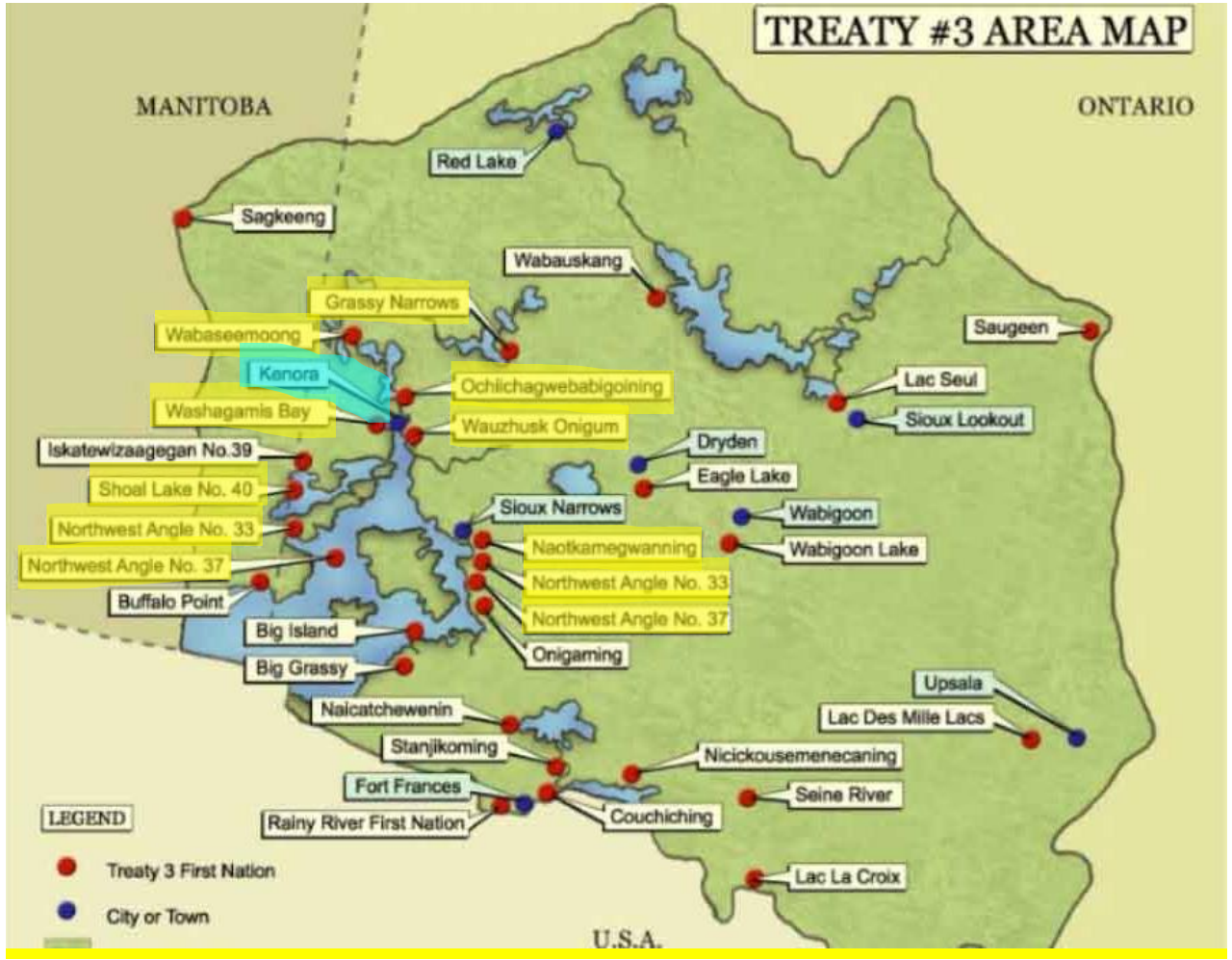
In partnership with the Kenora Chiefs' Advisory

INTRODUCTION AND BACKGROUND

- **The Truth and Reconciliation Commission of Canada released its final report in 2015 with 94 calls to action, several pertaining to health**
- **Indigenous and Municipal leadership (2016) signed a resolution to work together in partnership towards solving the healthcare issues in the area and work towards the creation of an All Nations health care system and hospital**
- **Discussion around the need for more family doctors and more primary care services in First Nations communities**
- **Barriers around social determinants of health**
- **Higher incidence of morbidity and mortality and overall poorer health outcomes**

Indigenous Services Minister Seamus O'Reagan joined community stakeholders in Kenora on May 30, 2019, to announce a $375,000 investment to develop an All Nations Health-Care system (kenoraOnline.com)

The Nine First Nations Communities of the Kenora Chiefs' Advisory



QUESTION

- How can Indigenous and Mainstream people work in partnership to develop an expanded model for primary care services that is culturally appropriate and meets the needs of all communities and is also recruitable for family physicians and health care providers?

AIM AND SCOPE OF THIS PROJECT

- The first step and scope of this project will be to engage with First Nations communities to determine what they would like to have in terms of access to culturally appropriate primary care services and family physicians on reserve

OBJECTIVES

1. Identify **perceptions around access** to primary care providers and services.
2. Identify **current gaps in access** to primary care providers and services from the First Nations perspective
   - perception of what currently exists and the perceived future primary care needs
3. Identify current **perceived barriers** to accessing primary care on reserve and how these might be overcome
4. Identify what it means to have care that is **“culturally appropriate**”
5. Identify if there is a **perceived need for Family physicians** in communities and how family physicians might have an **impact**

METHODS

Participatory Action Research Approach

Core working group

- two youth, one elder, health director, two KCA managers and KCA health assistant.

Quantitative research -

Survey group A: Patients – youth, families, elders

Survey group B: Key informants – health directors and health staff, band council, various service providers

Qualitative research

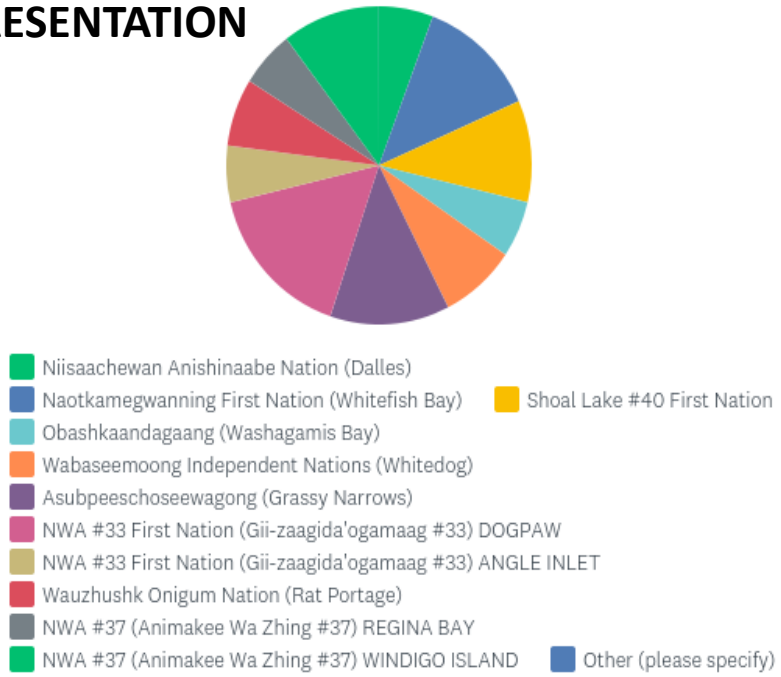
Focus group sessions in each community – patients and key informants

152 survey participants and 80 focus group participants

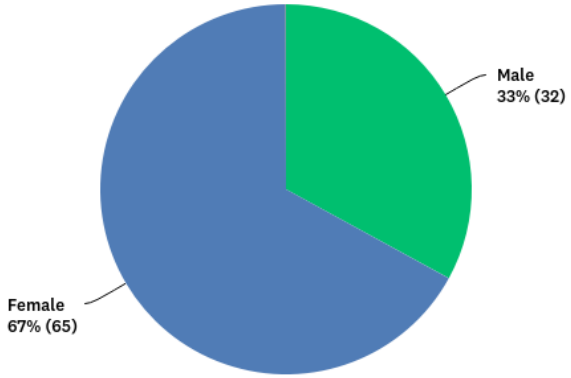
PARTICIPANT DEMOGRAPHICS

Survey group A: Youth, Families, Elders

COMMUNITY REPRESENTATION



GENDER



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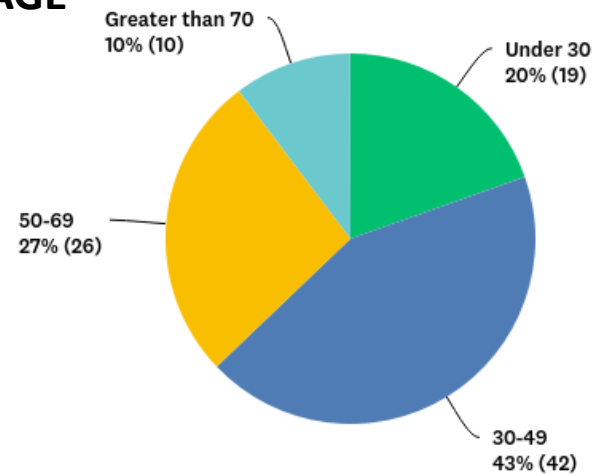
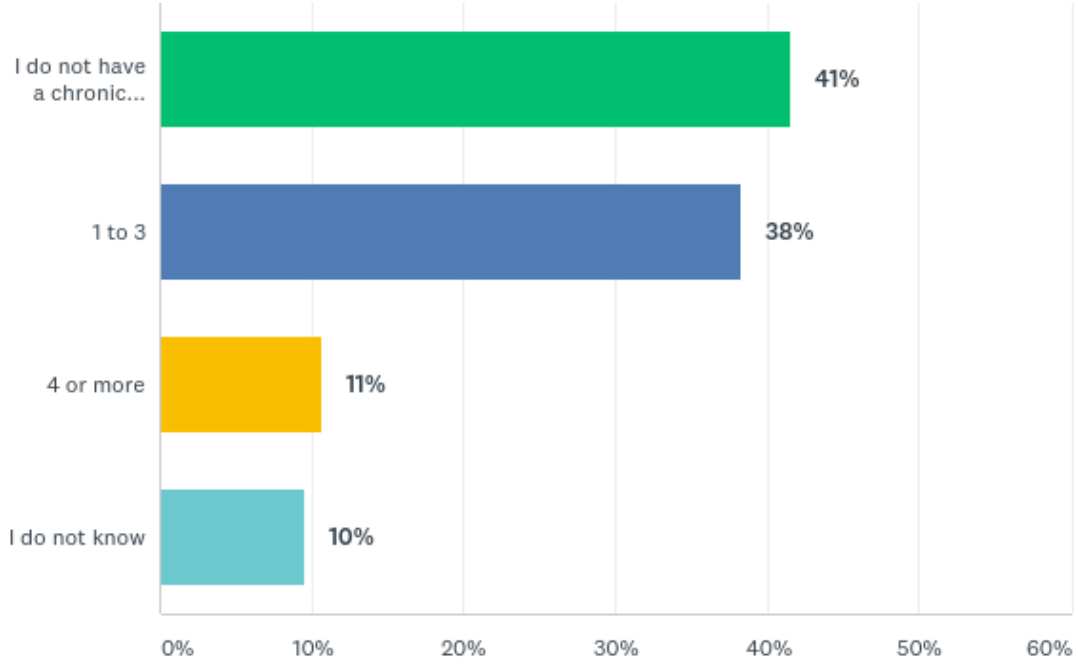


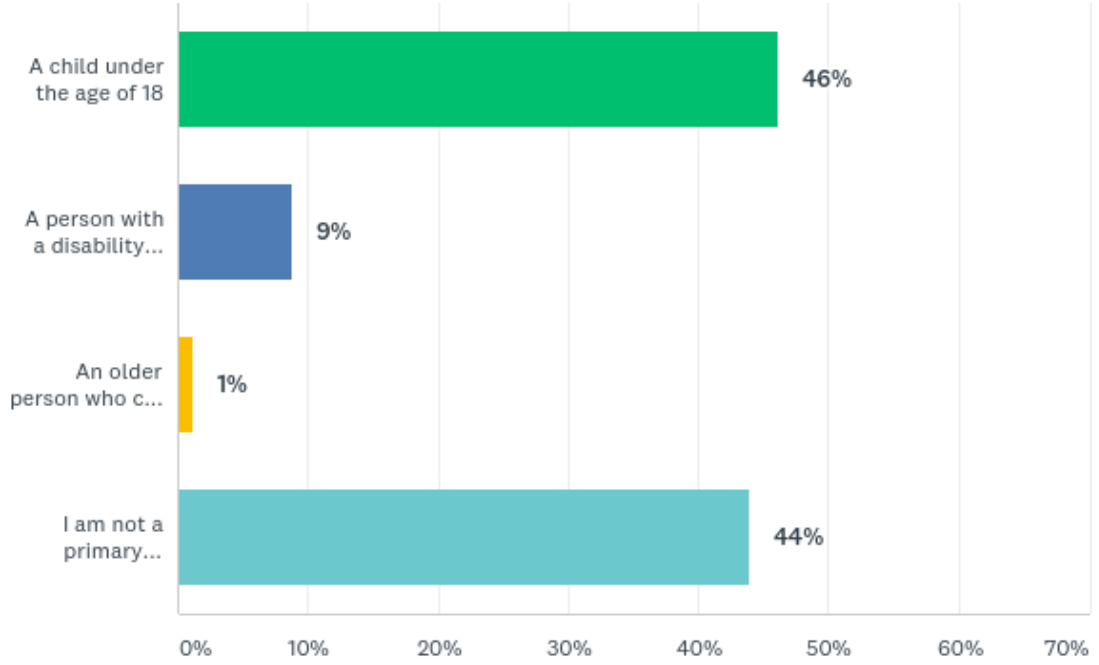
PARTICIPANT DEMOGRAPHICS

Survey group A: Youth, Families, Elders

CHRONIC ILLNESS



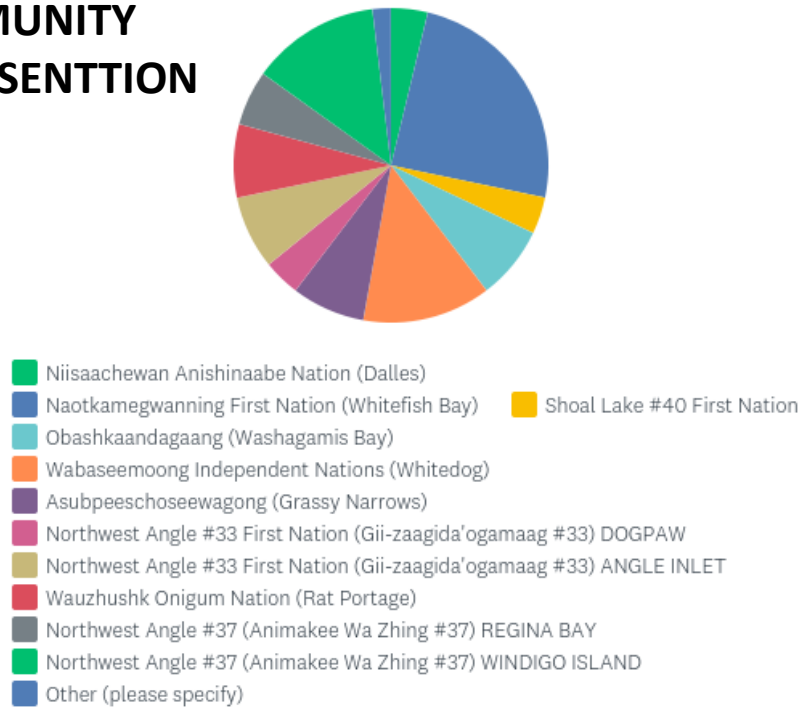
CAREGIVER RESPONSIBILITIES



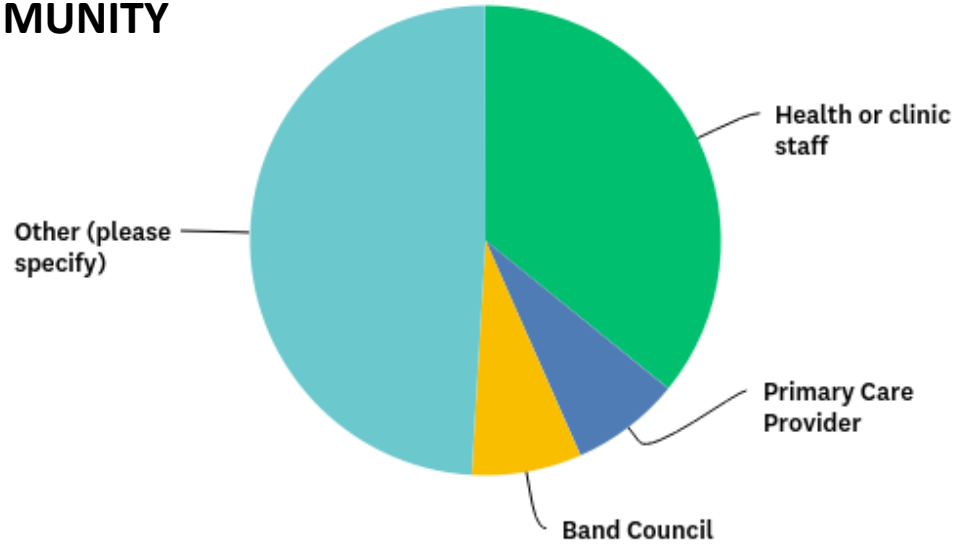
PARTICIPANT DEMOGRAPHICS

Survey Group B: Key Informants

COMMUNITY REPRESENTTION

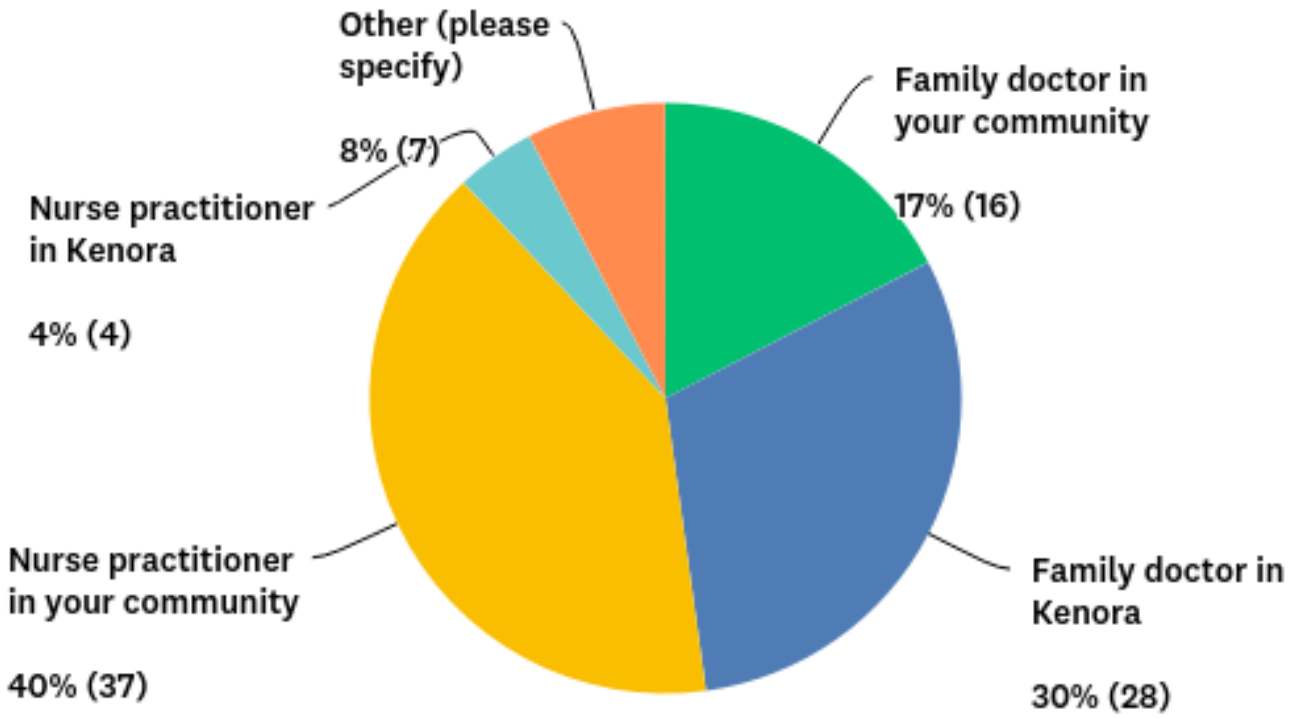


ROLE IN COMMUNITY



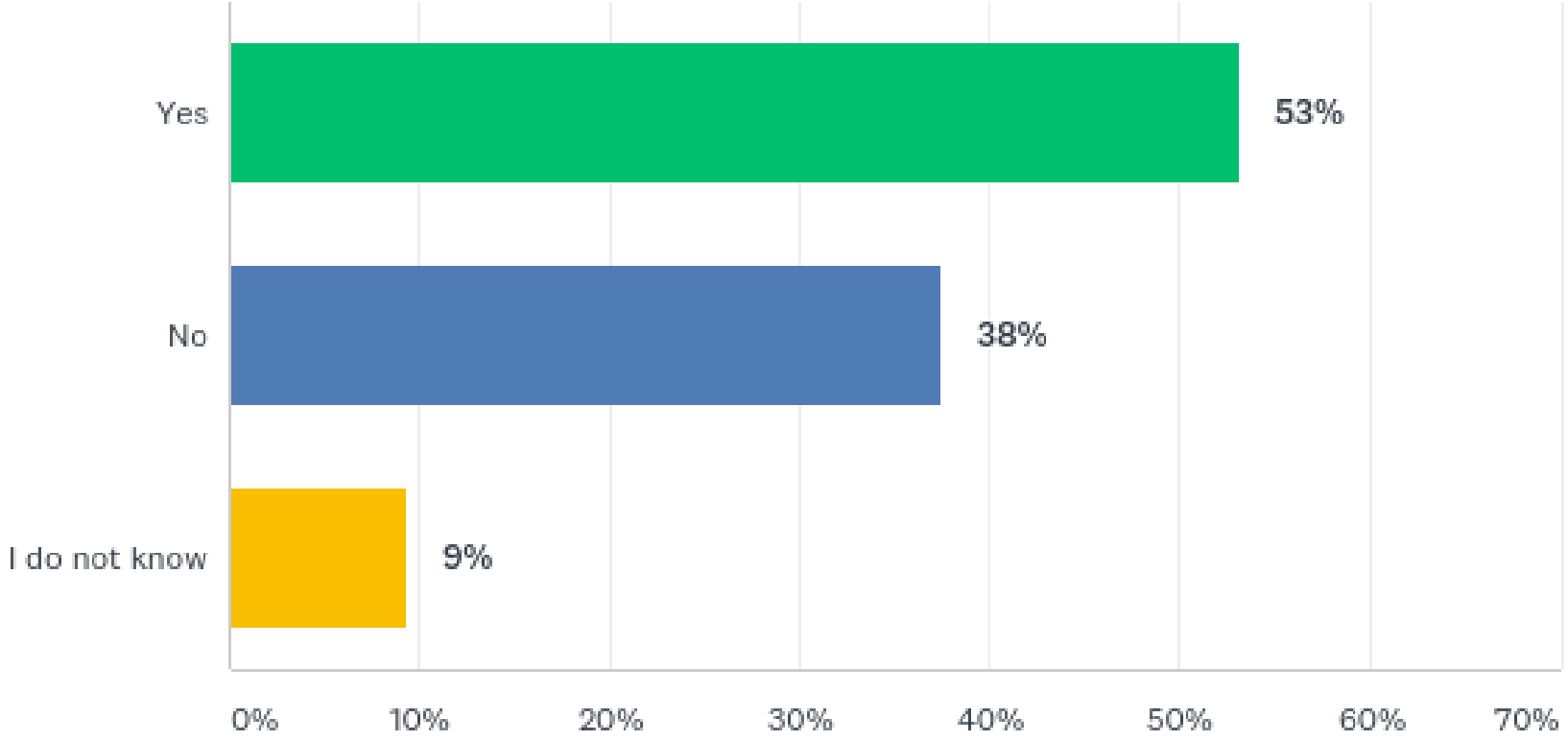
ACCESS:
Which type of primary care provider do you see most often?

Answered: 92 Skipped: 7



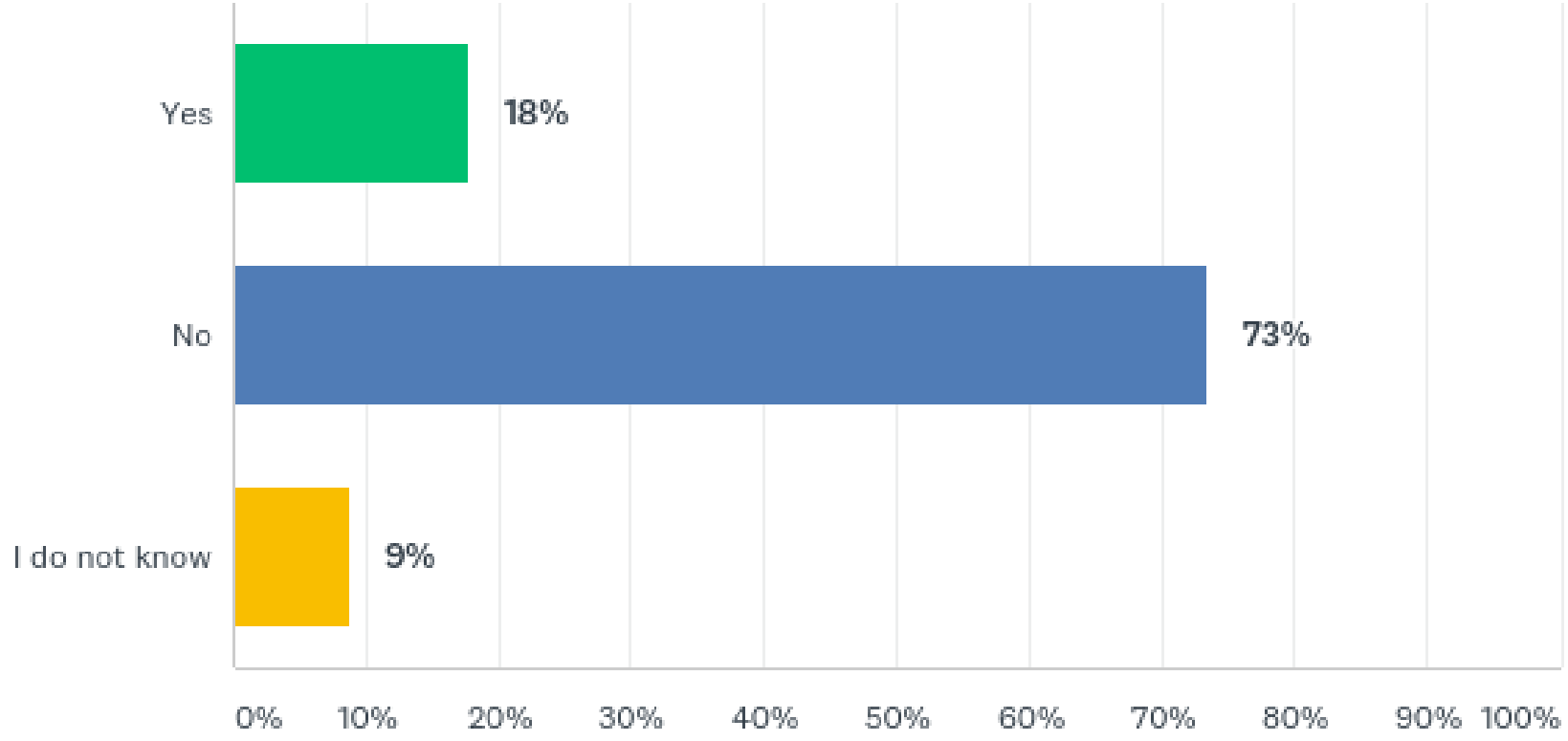
Do you currently have a regular family doctor?

Answered: 96 Skipped: 3



Does your regular family doctor travel to your community to provide care?

Answered: 90 Skipped: 9



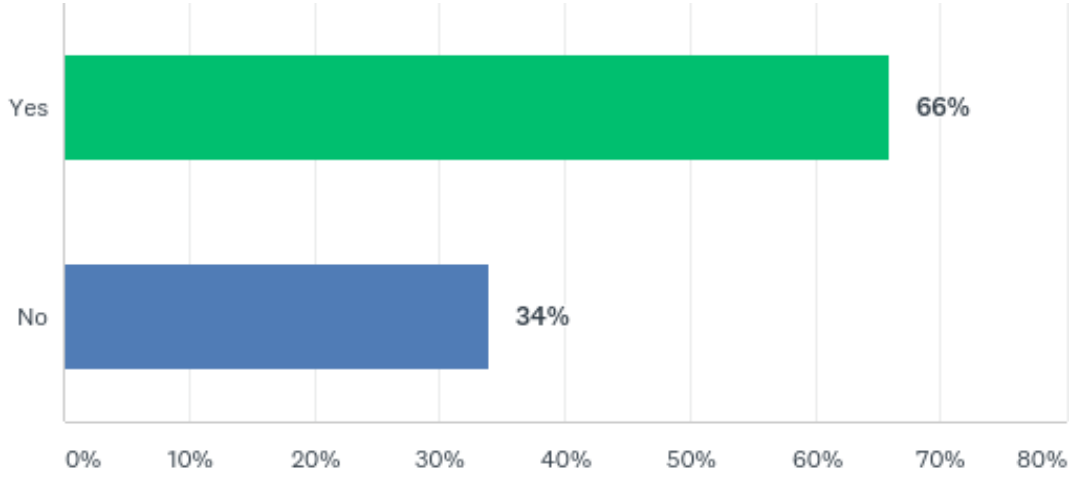
Focus Group Patient Quote:

“I’m having a hard time finding a family doctor, because my last doctor retired, and he knew everything about me. But right now, I’m having a hard time finding a doctor, a regular family doctor , which is what I really need. I have diabetes and I don’t have a doctor who knows me!”

ACCESS

- Close to half (47%) of patients said they rarely or never saw a Family Doctor in their own community
- A quarter of patients (25%) stated they often or always saw a Family Doctor in the Emergency department

Over the last year, were you unable to see a family doctor when you needed to?



ACCESS

Focus Group Quote:

“To get my son into testing for autism and ADHD was difficult…my son’s doctor only comes ever two weeks. There’s a long wait until next month…she’s booking next month.”

Over the last year, when you needed to see a doctor, on average how long do you have to wait (not including emergency room)?

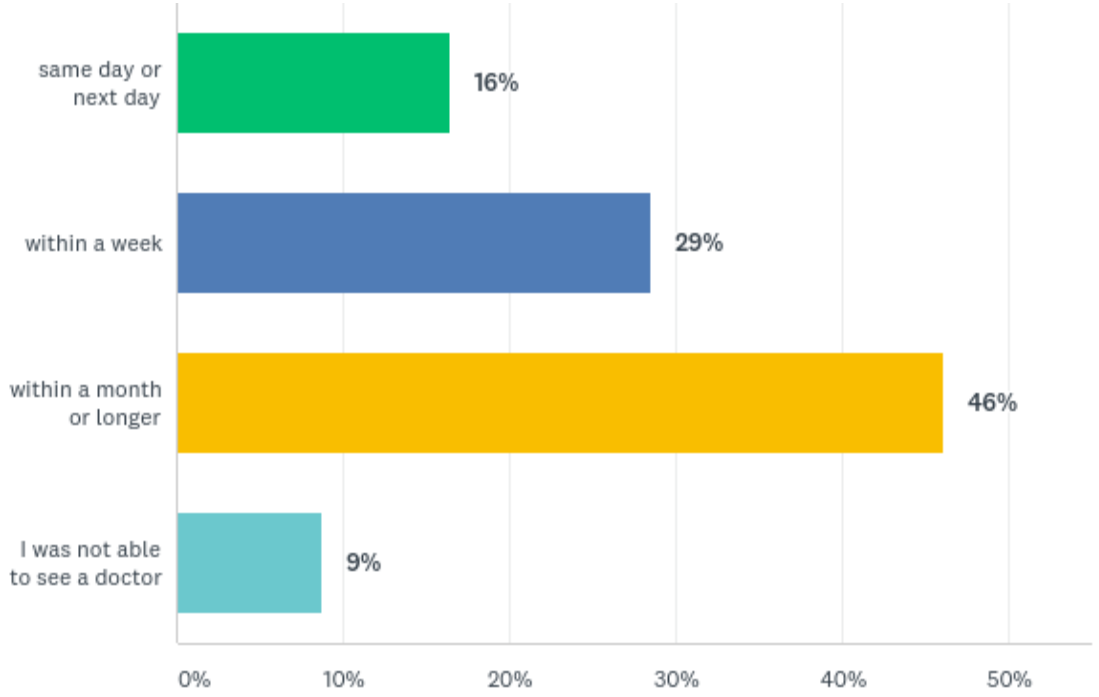
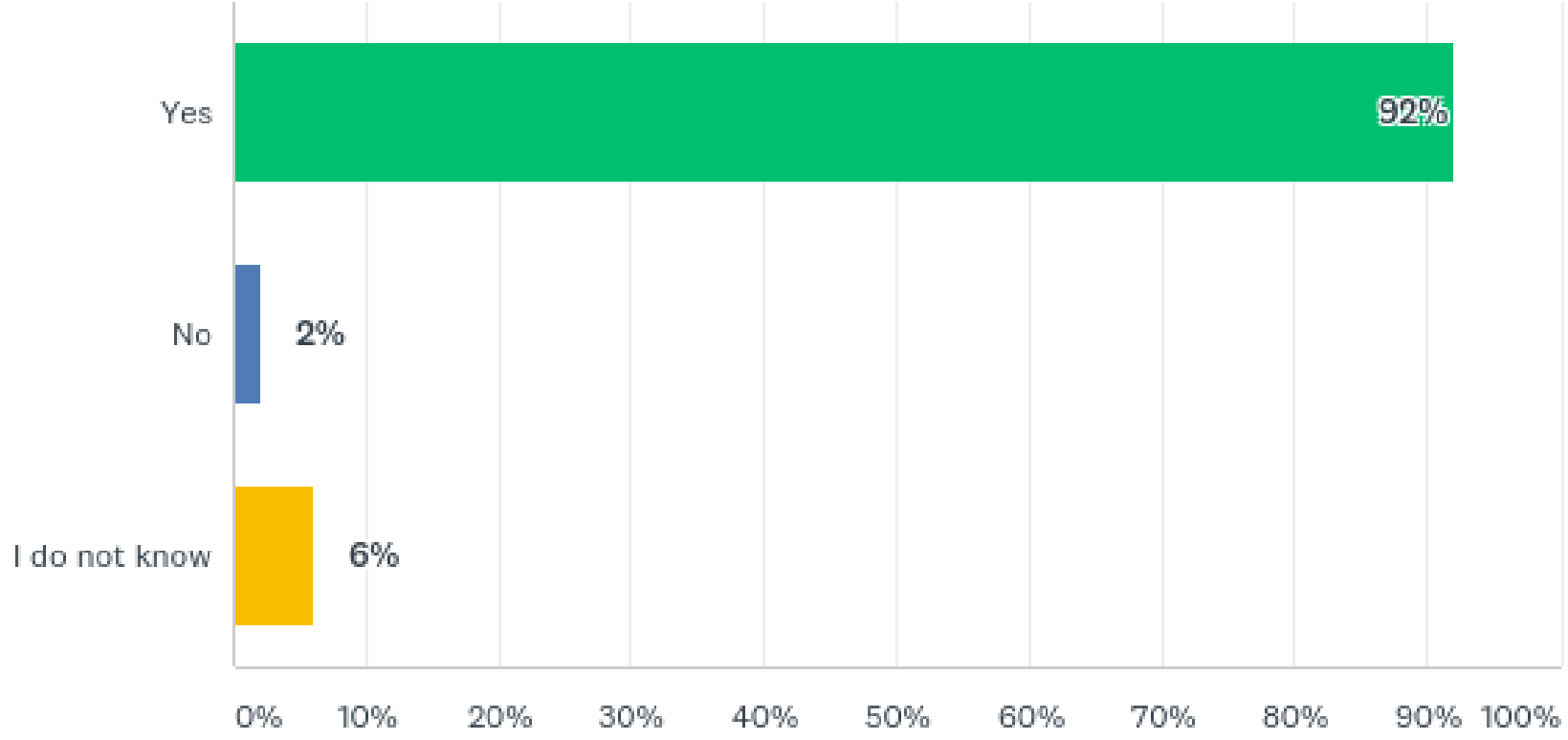


Table 1: Access to a Primary Care Provider by Community

COMMUNITY	NP VISITS	FAMILY DOCTOR VISITS
Washagamis Bay	Weekly	NO
Wabaseemong (White dog)	Weekly	2 doctors (weekly visits between 2 docs)
Asubpeeschoseewagong (Grassy Narrows)	Weekly	1 doctor (FHN doc every 2 wks)
NWA #33 DOGPAW NWA #33 ANGLE INLET	every 2 weeks monthly	NO NO
NWA #37 REGNINA BAY NWA #37 WINDIGO ISLAND	Weekly monthly	NO NO
SHOAL LAKE #40	weekly	NO
Niisaachewan Anishinaabe Nation (Dalles)	weekly	NO
Wauzhushk Onigum (Rat Portage)	Weekly	1 doctor (WNHAC doc weekly to every 2wks alternating with NP to ensure weekly coverage)
Naotkamegwanning (Whitefish Bay)	Weekly (now none?)	2 doctors (WNHAC doc weekly) (FHN doc every 2wks)

Do you think that a family doctor providing care in your community would or does benefit patients? (Key Informants)

Answered: 50 Skipped: 3



Focus Groups:
Need for Family Doctors:

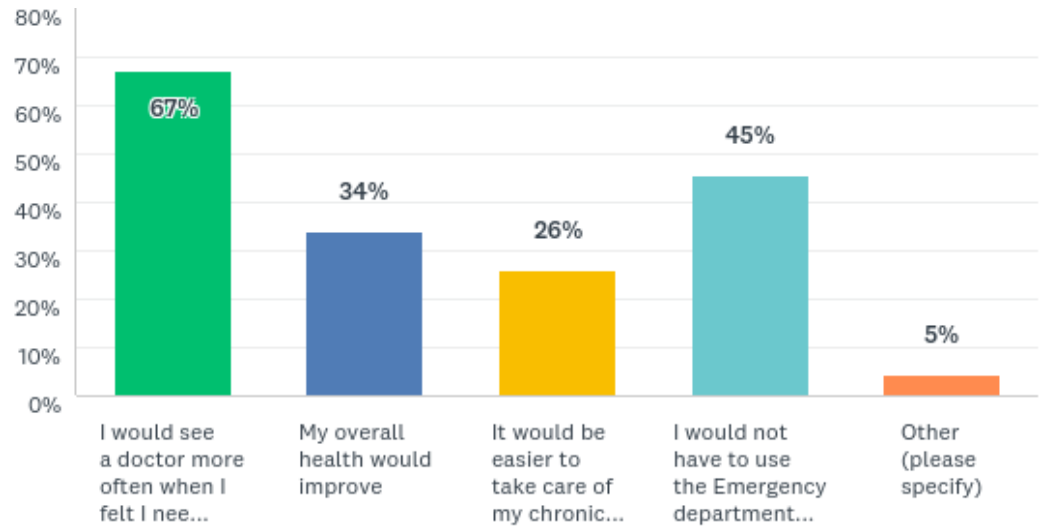
"I think it's a basic need to have a doctor in the community"

"It would be a lot easier [if we had a doctor in our community] because you could monitor your blood sugars easier and your blood pressure. Sometimes you need your insulin, but you can't get it. It needs to be prescribed and its important that you get that"

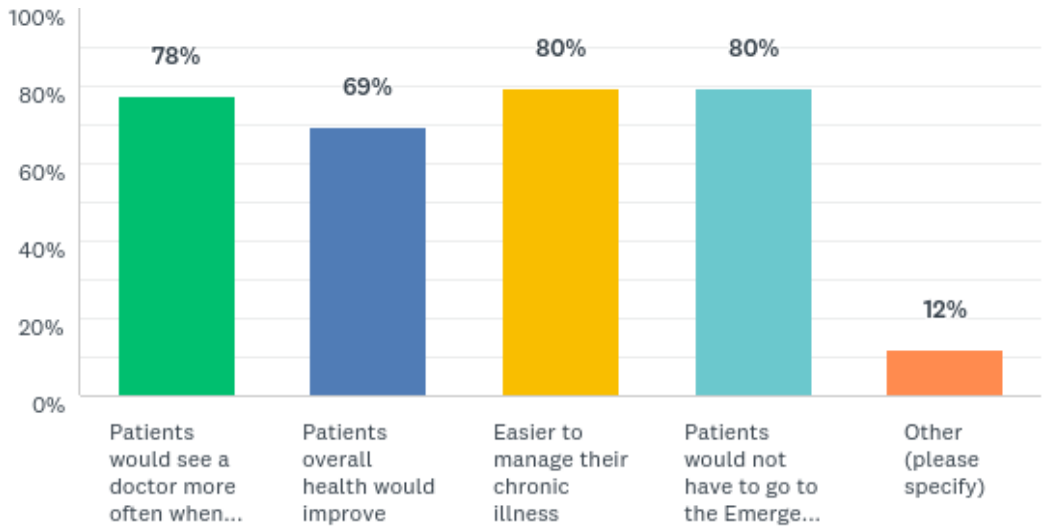
"A lot of people have more than one problem, you can have diabetes, you can have stroke, and you can have problems that are all mixed together, you know it's not just one thing, but a lot of chronic illnesses bunched together."

BENEFITS OF FAMILY DOCTOR PROVIDING CARE IN THE COMMUNITY

PATIENTS



KEY INFORMANTS



Focus Groups: Need for Family Doctors

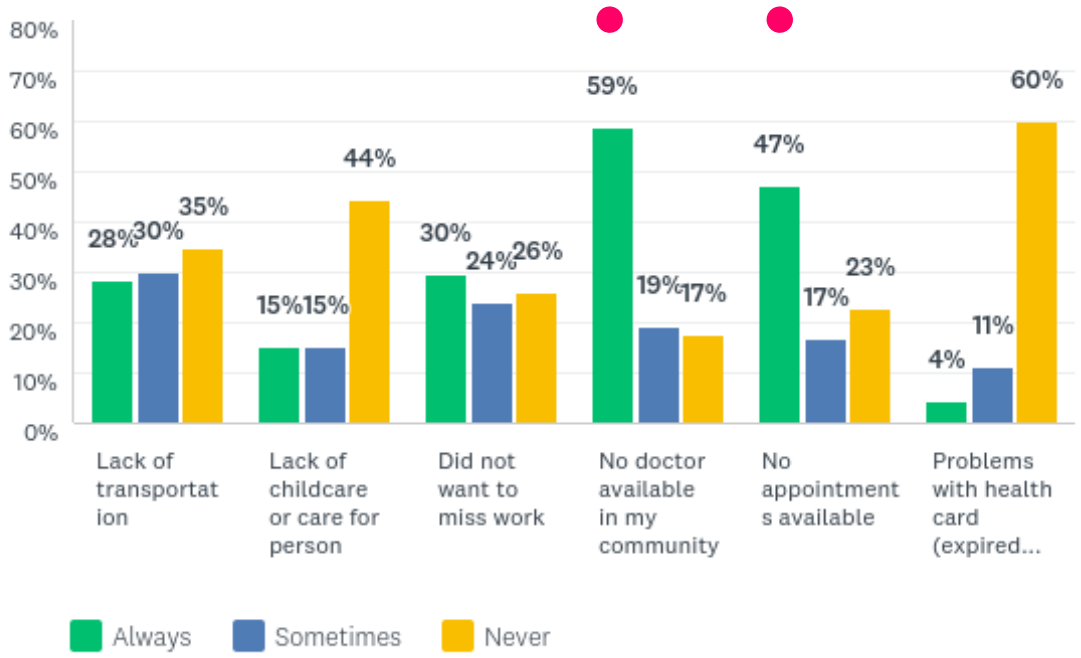
"I think to have a doctor here would really help the families, the community members, they would not need to travel. They could get their prescription here and then the medical van could go pick it up and bring it here. The working parents can't go to work, because their kids are home [sick] from daycare and they often need a doctor's note to go back".

"That's an issue with our elders, because some of them are handicapped and handicap [transportation] is not available Tuesdays and Thursdays due to dialysis. So, transportation is a big one. So, it would be easier if we had a doctor here twice a week especially for the elders.

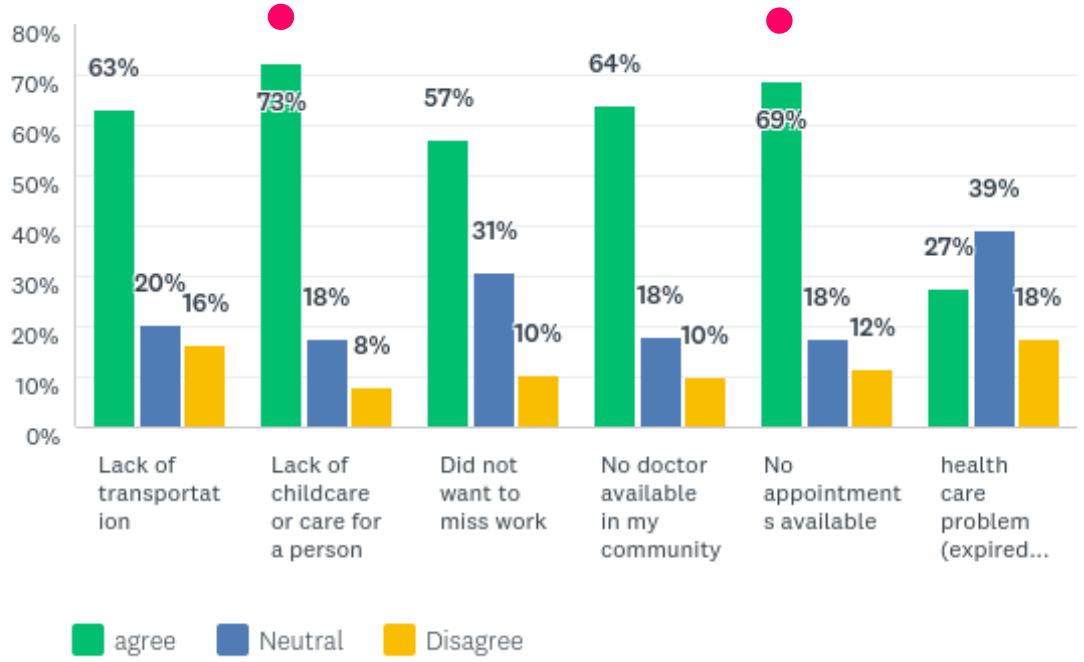
"I have a cousin and he went to the Emergency and the nurses would brush him off. They thought he was one of the street people, but he went in because he had stomach pains. I think if he was treated earlier, they would have found that tumor in his stomach. Now I don't know how he will be because it gotten bigger now, the tumor. So, I feel like if there is a doctor here all the time, it will help community members, they would order more tests for the people instead of later. Instead they get worse like that. Sometimes they just give up waiting and then they come home, and they get worse. You know…that cycle."

Barriers to Accessing Primary Care

PATIENTS



KEY INFORMANTS



Barrier: No Doctor Available in my Community

"They get sick, but they don't get the proper care. They end up coming back and just getting worse. It gets to the point where they must be pretty close to dying… like I have this one client, he was in and out of the hospital. By the time they figured out what was wrong with him, he was at a stage that all they could do was send him to Thunder Bay. And he kept getting sick and getting sick. That's kind of frustrating for us to see our people dying off like that, because they are not getting the proper health care."

Focus group particpant

Consequences:

- Delayed Diagnosis
- Delayed Treatment
- Increased Complications
- Advanced Disease States
- Higher Acuity Presentations
- More Transfers to Tertiary Centres
- More invasive procedures (surgeries)
- Higher Cost to System

Lack of Available Appointments

- Not enough appointments to meet needs
  - Caps on patient numbers/clinic
  - Short clinic hours
- High number of cancelled clinics
- New Policy whereby patients in community can not be seen if they have a regular family doctor in Kenora

"With the NP being here for 4 hours, they don't get to see everybody. Half of the time, it's full and then they are ready to go. They don't stay back and wait for the people to come in…I don't think that's fair if anybody who is sick has to wait again."

"They [the NP] told me to go see my regular doctor. Then I said well what are your services here for then? If you are not going to service our community members, then why are you here….sometimes for an appointment [with family doctor in town] you have to wait for a month and so I have to go to Emergency and then I have to wait 12 hours. It's too long to wait."

"The NP should be coming once every week; I think they come only every two weeks and sometimes they don't come at all. Sometimes they cancel all their appointments to come down to the community. It happens often."

Transportation Barriers

- Often only one medical driver
- Accessible transportation for disabled
- Many have to find and pay for own transportation
- Often results in missed or cancelled apts
- Patient have to find own way home sometimes
- Difficulties getting air ambulance

"To walk into the doctor office and you cancelled three times. They look at you and they judge you, but they don't ask why… they just judge you. Prior to my appointments now I would book and say 'pending on the weather' and they will ask 'so where do you live?' and you have to go through the routine of 'we have no access to roads, we sometimes have no access to boat because of the weather'. So, with that they go 'oh, ok'…so there's an understanding so when there is a cancellation due to weather with my dentist, she is very humble, she's like 'no problem', so it does change everything."

"It's not like when you live in the city and your appointment is at 1pm and you can get there in 15 minutes. Here you get your appointment, then you have to book your ride, then you go to the station, book it then you have to book out….it's a two and half hour trip, just for what?...a five minute appointment?"

"I mean the boat ride itself kills you, you know and if you have a bad back that's going to aggravate the whole situation. We have a band member now who is in a wheelchair, she can't move because she has injuries to her back right now, so she was being sent to therapy in Kenora but better for them to come here and go to her house. Its so wavy for her to cross that lake it could be more damaging. This time of year, that lake is really bad, my sister broke her back crossing the lake."

Indigenous Determinants of Health as Barriers

- Sheer isolation of geography
- Lack of road access
- Those with serious medical issues must often relocate for treatment away from social supports and family
- Lack of water treatment – skin infections, gastrointestinal
- Difficulties with system navigation
- Lack of education, low income

"The isolation of the reserve, no road access….freeze-up and then there is thaw. The lake, the windstorm came through, there is no access, unless you want to be a real dare devil and get snowshoes and a toboggan, it very humbling. We are at the mercy of the weather. Weather determines whether we go to town or stay home. May days we are stuck here you can't predict when you get sick."

And a lot [of health issues] its due to that water. The water we bath in comes from that lake. And that's why we need a water treatment plant. The younger and older people have been affected by that water. And now their health has changed due to that water. Our food, most of our food is from that water…I'm really surprised that this water treatment plant has happened yet.

"There's a lot of people who are older and want to come home but have health issues that prevent them from coming home, because they are afraid if they have an emergency, that a helicopter won't be around for 3-4hrs or that it will be too hard to get a boat out here. You got people stuck in cities where they don't' want to be, they just be home."

Cultural Sensitivity Barriers

- Language and Communication barriers
- Discrimination and Racism
- Lack of awareness of Anishinaabe culture

"They did the same thing to my brother. They even told me, and they told the family, you ever heard about that boy that cried wolf? That's what he is doing. He only lasted one month, he passed away, my brother. And so, they kicked him out of the hospital and said there was nothing wrong with him. That's the same way they treated my husband. That is why he doesn't want to see the doctor anymore. He totally refuses to go to the hospital when he is sick even though I know that he needs to go, but he doesn't want to go because he has no trust in the doctors anymore."

"I don't know if it has something to do with describing your symptoms. Maybe describing it in a way that is not clear to the doctor or NP. I know I have to interpret [for patients] in some cases, where they are having pain and they can only say it in Ojibway. "

"This lady with a sore back was in Emergency for 8 hours and she said I swear, they made me feel like I was faking it. Yes, they question us, they do they question us. Like we're just there for the pills. I put my back out too one time and I was literally keeled over and I sat at the emergency for six hours and I went in and he said so what happened? I said I was just bending down and he says "sure you probably fell while you were drunk, and I said I don't drink. He says ya right. He said get out of here, you are wasting my time and I said you are wasting my time. It makes me so mad!"

Consequences of Barriers to Primary Care

Emergency department is last resort

- Long wait times

- Poor quality of care as not designed for primary care and see multiple different doctors

- "I could be clean for ten years and I'll go into to Emergency…. They'll put in me in a room with a camera, not a room like everybody else. Then they will give me the worst treatment. I'm just sick of that! That's why when people ask me to go and they want me to go in, I don't go. An then they have to fly me in. I'd rather die before I go get help. Its sad to say, but that's how it is. So, I would much rather love for a doctor to come out here and someone who has a little more interest and care for you."

People get frustrated and lose hope

Stop seeking care altogether or

Take matters into their own hands

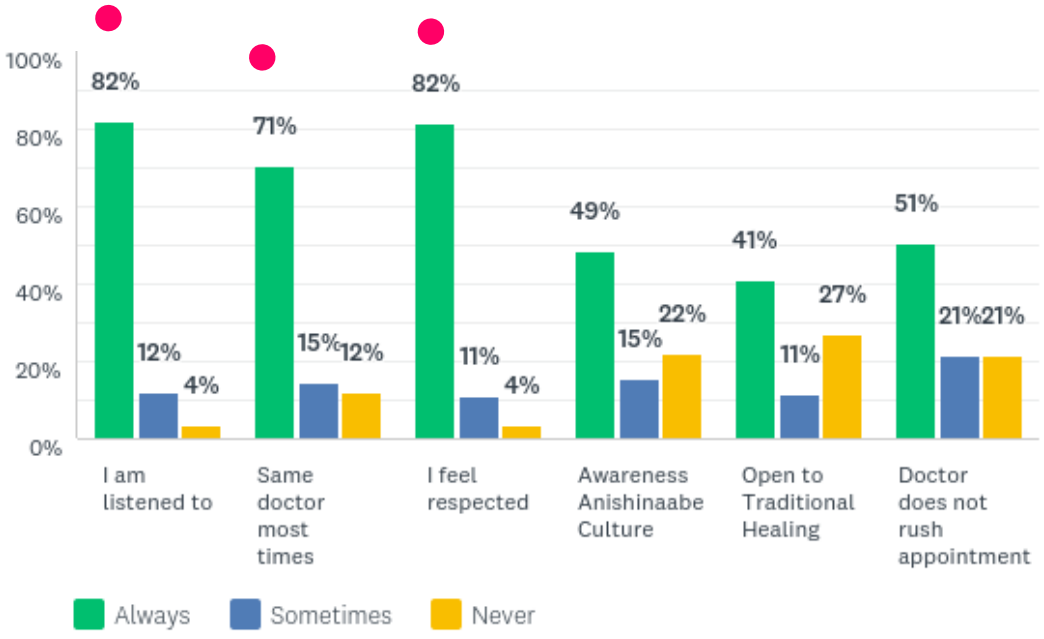
- "oh ya, I just wouldn't deal with it and then I would just buy something off the street or something. It would be easier to see a medical doctor, so you don't deal with it yourself instead off the street. That's sad to say right? It would be better to see a medical person in certain situations That's sad to say but that the truth most of the time. So sometimes you have to turn to your own devices or whatever you can do."

Consequences of Barriers to Primary Care

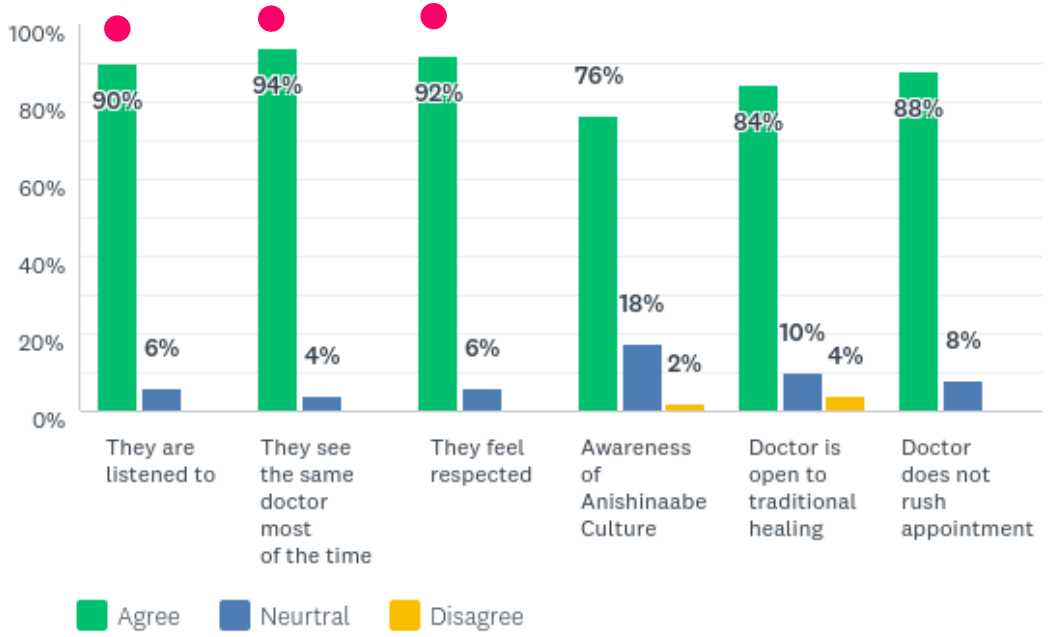
- Delayed Diagnosis
- Delayed Treatment
- Increased Complications
- Advanced Disease States
- Higher Acuity Presentations
- More Transfers to Tertiary Centres
- More invasive procedures (surgeries)
- Higher Cost to System

What Does Culturally Sensitive Patient-Centered Care Look Like?

PATIENTS



KEY INFORMANTS



What Does Culturally Sensitive Patient-Centered Care Look Like?

"they need to listen to us! They need to listen! We just want to get help. We want to be healthy like everyone else, we are just people, we don't want to be categorized. They just need to learn that we are people like everyone else."

"When you see a different person every time you are starting at step one each time you know it likely does more harm then good, basically if it's a new person I don't want to go talk to them."

"I know we had Dr. Pedersen and Dr. Harland and they were very respectful with our culture. They believed in our medicine and culture. They encouraged the people to go that way."

Focus Group Participants

Accessibility of Specific Primary Care Services

Most Difficult Services to Access

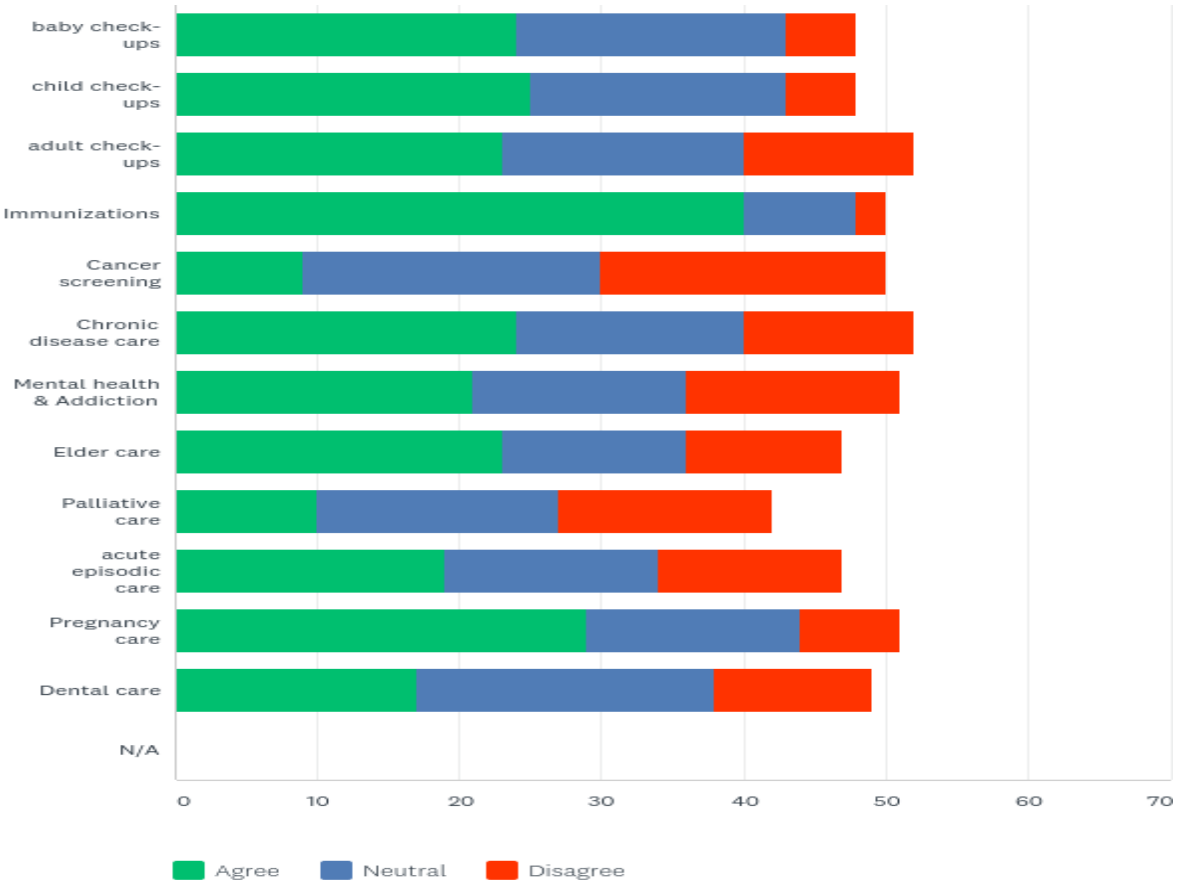
- Cancer Screening
- Mental Health and Addictions
- Palliative Care

Most Accessible Services to Access

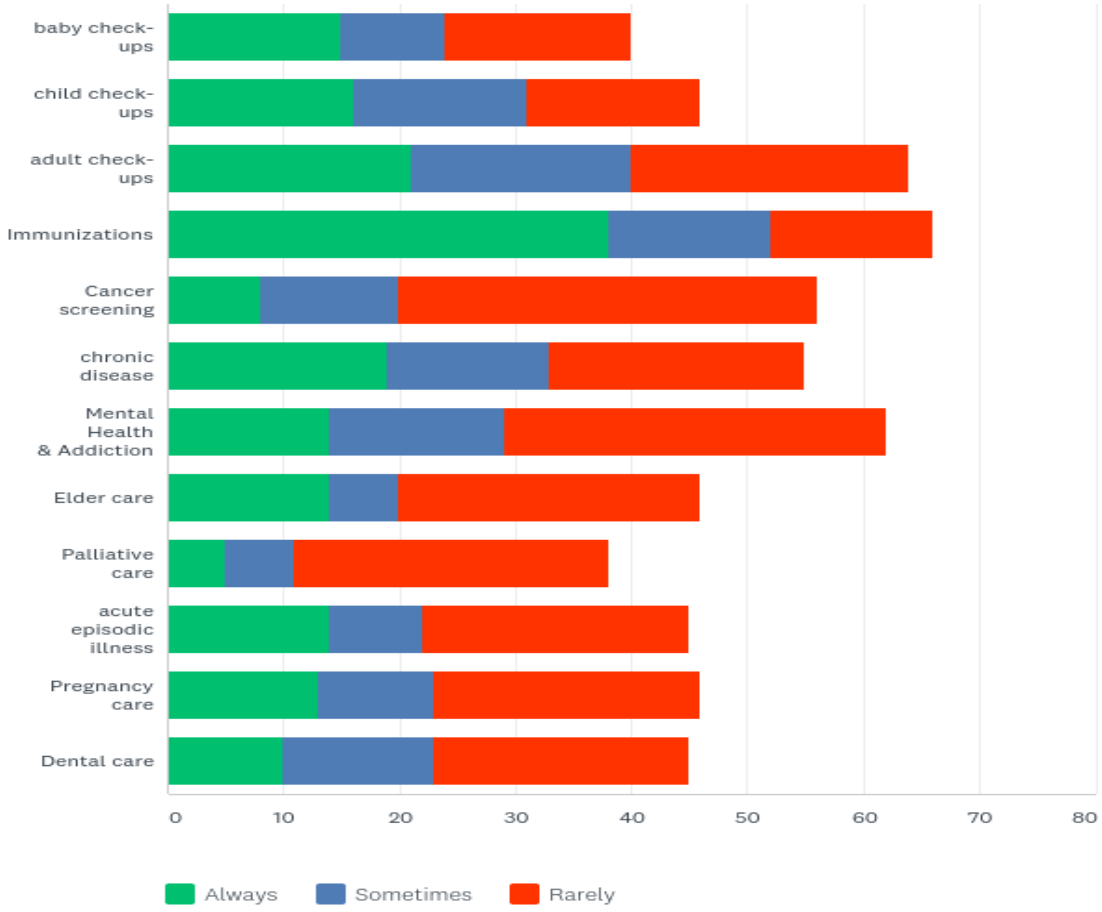
- Immunizations

Accessibility of Specific Primary Care Services

How easy is it for patients in your community to access the following services when needed?



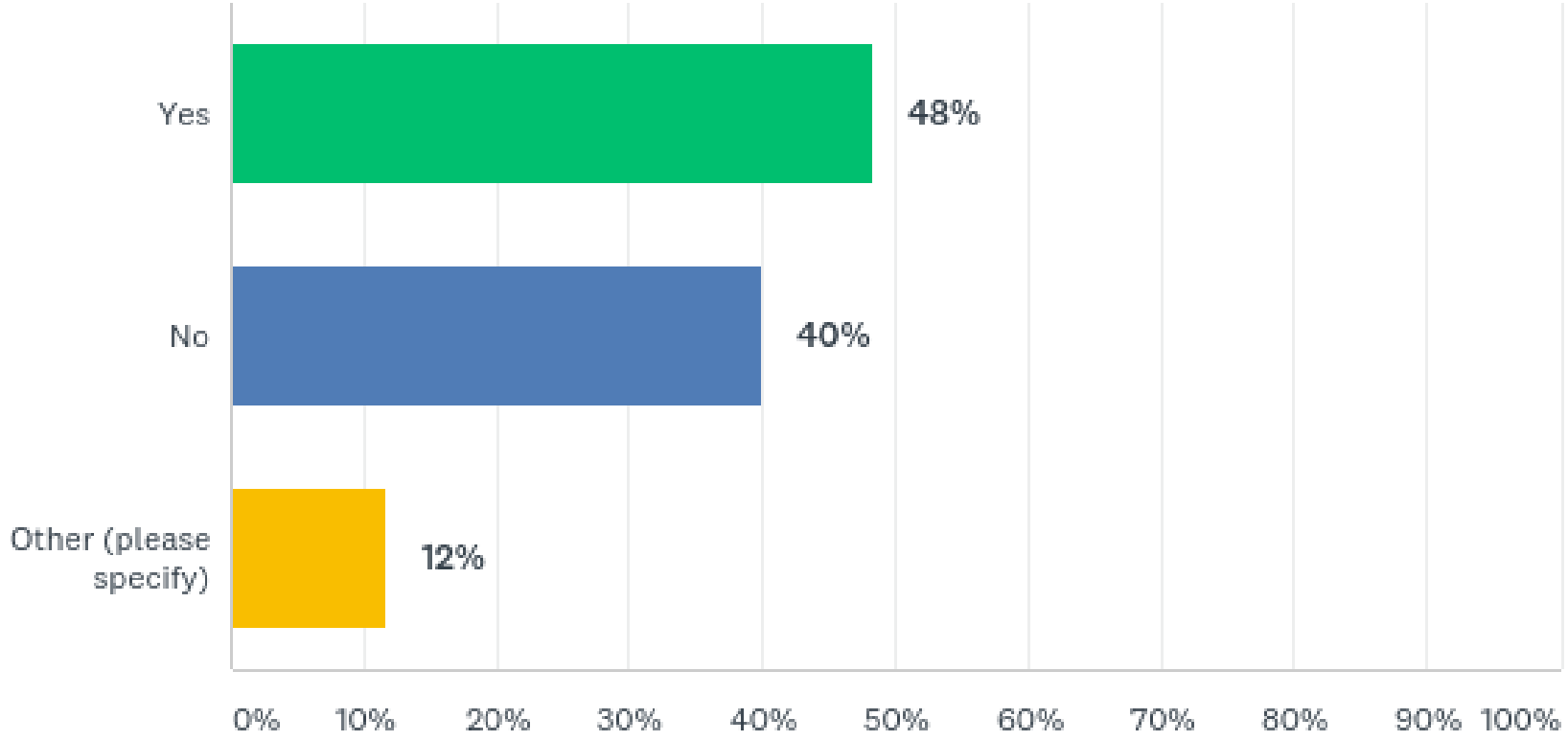
How often have you been able to access the following services when needed?



Are you currently satisfied with the primary care services provided in your community?

Answered: 85 Skipped: 14

PATIENTS



Gaps and Recommendations

Seven broad inter-related areas of action identified to close the gaps in primary care

1. **Increase equitable access to primary care providers**
2. **Increase equitable access to services**
3. **Increase cultural safety and decrease discrimination and Racism**
4. **Address indigenous determinants of health**
5. **Improve infrastructure, technology and transportation**
6. **Build relationships and partnerships**
7. **Address specific community needs**

An **eighth** area of action also identified but beyond the scope of this project

- need for First Responder Programs

But First….What is working well?

- Good work being done and strengths to build on!
- Doctors going out to community are respected and have built trusting relationships. Their skills are valued and they know the community
- NPs also valued for unique skills and taking time with patients
- Other service teams valued – i.e diabetes team, health nurse services, PSW and paramedics teams
- Communities want these services to continue but feel they need more visits and more coordination

1. Increase Equitable Access to Primary Care Providers (Family Doctors, NPs)

GAP

- Close to 40% of patients did not have a regular family physician and 9% did not know
- Nearly half of patients had to wait a month or more to see a doctor
- Only 16% of patients were able to get a same day or next day appointment

- In comparison to rest of the province:
  - Over 94% of people in Ontario have a family doctor and 84% of people in the Norwest region (HealthQualityOntario, 2018).
  - Only 5% of people in central Ontario have to wait longer than 8 days to see a doctor
  - 24% of people in Northwest and 44% of people in rest of province could access same day or next appointments
- Frequency of current physician and NP clinic days does not meet needs
- Lack of coordinated patient care between Doctor, NP, health nurse, and multidisciplinary team

1. Increase Equitable Access to Primary Care Providers (Family Doctors, NPs)

Recommendations:

A. Family Doctor services:

- Engage with physicians to determine enablers that would aid in their ability to provide service on reserve
- Examine existing contracts to identify current disincentives to providing care on reserve and replace with contracts that incentivise care on reserve
- Work with the ANHP health care recruiter to strategize and create recruitment plans for each community
- Aggressively recruit family doctors to provide services in communities that do not have regular family doctor visits
- Increase frequency of doctor visits in communities that have regular visiting family doctors (see Table 2 for breakdown by community)
- Create robust cross coverage systems for communities i.e. recruit at least 2-3 physicians to provide cross-coverage to each community to mitigate absences

1. Increase Equitable Access to Primary Care Providers (Family Doctors, NPs)

B. NP Services:

- Increase the frequency of NP visits aligned with stated needs for each community (see Table 2)
- Determine cause of high number of cancelled clinics and increase consistency of clinics
- Examine organizational policy preventing First Nations from accessing an NP in community if they have a family doctor in Kenora
  - At a minimum, allow every patient to see the NP for acute episodic care in community regardless of attachment to a family doctor in Kenora

1. Increase Equitable Access to Primary Care Providers (Family Doctors, NPs)

C. Coordination of Providers:

- Increase coordination of doctor, NP, and community health nurse clinics and with the Interdisciplinary team
- Doctor and NP work together to expand the number of clinic days per community
- Shared care of patients between Doctor and NP with strong built-in communication practises
- Maximize scope of practises - NP to target patients within their scope of practise and doctor to target more medically complex patients outside of NP scope
- Doctor and blood work services on the same day to prevent patients from falling through the cracks

Table 2: Doctor and NP Needs by Community

(need to validate with communities)

COMMUNITY	NP VISITS (Current)	NP VISITS (Future)	FAMILY DOCTOR VISITS (Current)	FAMILY DOCTOR VISITS (Future)
Washagamis Bay	Once weekly	1-3 d/wk	NO	1-3d/wk
Wabaseemong (White dog)	Once weekly	Weekly to 3-4d/wk	2 doctors (weekly visits btw 2 docs)	5d/wk coverage btw doctor and NP
Asubpeeschoseewagong (Grassy Narrows)	weekly	1-4d/wk	1 doctor (FHN doc every 2 wks)	1-5d/wk
NWA #33 DOGPAW	once every 2 wks	1-3d/wk	NO	Weely to every 2wks
NWA #33 ANGLE INLET	Once monthly	Every 2wks	NO	Every 2wks
NWA #37 REGNINA BAY	Once Weekly	Once weekly	NO	1-3d/wk (NP and doc cover 2d/wk total
NWA #37 WINDIGO ISLAND	Once monthly	1d/wk	NO	Once every wks to monthly
SHOAL LAKE #40	Once weekly	2-3d/wk	NO	Once every 2 wks
Niisaachewan Anishinaabe Nation (Dalles)	Once weekly	2-3 d/wk	NO	once weekly
Wauzhushk Onigum (Rat Portage)	Weekly to every 2wks	2-3d/wk	1 doctor (WNHAC doc weekly to every 2wks alternating with NP to ensure weekly coverage)	2-3d/wk (NP, doc, nurse work together collaboratively on these days, after hrs coverage)
Naotkamegwanning (Whitefish Bay)	?weekly (now none)	2-3d/wk	2 doctors (WNHAC doc weekly) (FHN doc every 2wks)	Once weekly OR 2-3d/wk (same day/next day access btw providers, after hrs coverage)

2. Increase Equitable Access to Services

GAP:

- Biggest service gap overall was cancer screening services – crucial for early diagnosis where cure or treatment is possible.
- Mental health and addictions services
    - especially counselling services and consistency of staff to prevent re-traumatizing patients and to build trust.
- End of life care (palliative care)
    - Crucial need for home visits for this patient population as well of for those with disabilities.
- Diabetes and complications of diabetes extremely common
    - more frequent foot care services, retinopathy and specialized chronic disease clinics for diabetes and blood pressure.
- Rehabilitation services such as physiotherapy and Occupational therapy to prevent patients with injuries from having to travel
- dental hygienist services
- Home care services.
- blood work services within the community.
- The Community Health Resource Workers (CHR) require more training to better assist the nurse practitioner and the position requires more built-in accountability.
- Outreach education on pertinent health issues within the school, as education helps prevention.

2. Increase Equitable Access to Services

Recommendations:

- Increase **cancer screening** services
  - i.e. specialized clinics for paps, colon cancer, breast cancer screening
  - Partner with Cancer Care Ontario and screening programs such as the Ontario Breast Cancer Screening Program/Bus to increase frequency of visits
- Increase **mental health and addiction** services with a focus on counselling services and consistency of staff for improved continuity of care, trust, and safety
- Increase **end of life** services and elder care services with focus on increasing home visits
- Increase **Diabetes** services: diabetes education and clinics, foot care, retinopathy screening
- Increase **Rehabilitation service** i.e. Physiotherapy/Occupational Tx
- Other needed services: home care services, dental hygienist, blood work services
- Increase training and build in accountability for Community Health Resource Workers

Table 3: Related Service Needs by Community

(Will need to be validated and prioritized with each community)

COMMUNITY	Other services
Washagamis Bay	Mental health, clinic/apt scheduling support, tech support, diabetes care, foot care, advocate/navigator, house calls
Wabaseemong (White dog)	First Responder program, specialized clinics, outreach education to schools, fiberoptic for OTN services
Asubpeeschoseewagong (Grassy Narrows)	Elder home, physio/OT, transport within community, home visits, foot care
NWA #33 DOGPAW	Foot care, diabetes care, support with health cards/system navigator
NWA #33 ANGLE INLET	Needle exchange and methadone dispensary, mental health, Diabetes care, CHR in office more – home visits Physio, basic first aid training, consistent mental health
NWA #37 REGNINA BAY	Cancer awareness, midwives, dental, more specialists
NWA #37 WINDIGO ISLAND	Mental health, CHR training, physio, home visits, diabetes care, palliative care, sexual health, blood work,
SHOAL LAKE #40	Home visits, physio/OT, end of life care, organized clinic schedule, interpreter
Niisaachewan Anishinaabe Nation (Dalles)	Cancer screening, retinopathy, mental health (child/adult)
Wauzhushk Onigum (Rat Portage)	Elder care programs, after hrs coverage call/weekends- walk in. Diabetes awareness, healthy eating, palliative care
Naotkamegwanning (Whitefish Bay)	Primary care nurse 40hrs/wk Cancer screening, mental health therapist/workshops, regular traditional healer, breastfeeding and prenatal classes, specialized chronic dz clinics once monthly (ie.diabetes, HTN)

3. Increase Cultural Safety and Decrease Discrimination and Racism

GAP

- Critical need to address the racism and discrimination that patients experience when accessing primary care.
- Especially prominent in the Emergency department, where patients must seek primary care if there is no other alternative.
- Result of racism - delivery of poor quality care or no care and patients refuse to return for needed care in the future.
- Results in delayed diagnosis and treatment of disease until patients return in much higher acuity or advanced disease states, requiring hospitalization, surgeries, and transfer to tertiary care centres away from supports.
- Need for Traditional healing services to operate in parallel to the primary care system. Some patients have difficulty knowing who and how to ask for the services.
- There is a cultural coordinator in communities but no centralized cultural coordinator.

3. Increase Cultural Safety and Decrease Discrimination and Racism

Recommendations:

- Introduce mandatory Cultural Safety Training and offer Educational Workshops for all Providers and Staff
- Recruit and Retain Indigenous Providers and Staff when Possible
- Offer Counselling services to providers especially in the ER
- Increase cultural navigator/liaison services/interpreter services both in communities and in hospital
- Facilitate access to traditional healers in primary care settings in a way that respects traditional protocols and culture
- Help patients become familiar with traditional protocols for accessing traditional healer. i.e. information sheet, directory of names of traditional healers and their healing gifts
-

4. Address Indigenous Determinants of Health

GAP:

- Critical need to address the gaps in indigenous determinants of health
- Addressing these gaps would have a profound and long-term positive impact on the heath of local First Nations
- Lack of education, lack of housing, unemployment, poverty, food insecurity, lack of clean drinking water, lack of road access, lack of transportation, lack of social supports and system navigation are all critical factors to address
- Racism is also a determinant of health

4. Address Indigenous Determinants of Health

Recommendations:

- Advocate for building of road access to communities without road access
    - Explore successful efforts that resulted in the building of Freedom Road and leverage these where possible
- Lobby for additional health and social services system navigators to assist with NIHB applications, ODSP, health card renewals, and general system navigation
- Install water treatment plants for communities with boil water advisories and untreated water
- Expand outreach Education to schools i.e. sexual education for girls especially with Fetal Alcohol Spectrum disorder or lower IQ at high risk
- Work with governments at all levels and existing health and social services agencies to address and work towards long-term solutions for a more upstream approach to health.

5. Improve Transportation, Infrastructure, and Technology to enhance Access

GAP:

- **Transportation:**
  - Only one medical driver in many communities
  - patients with more urgent situations are often left to find their own transportation into Kenora for services
  - Transportation not provided/covered for certain appointments including eye appointments, dental appointments, to renew health cards.
  - The disabled and elderly both require assistance with accessible transportation both on reserve and for appointments off reserve.
  - There is currently a lack viable transportation during freeze-up and thaw of lake for the two communities without road access limiting access to primary care. there are no living quarters for a nurse to stay overnight during these difficult periods
- **Infrastructure/Privacy:**
  - Patients felt a lack of confidentiality and privacy both due to health staff and infrastructure designs or limitations. This sometimes resulted in patients not wanting to seek care at the community clinic
  - Additional supplies and equipment such as basic analgesia like Advil and Tylenol, Ventolin puffers for asthma attacks etc. are needed as well as easier access to supplemental oxygen for emergencies and wheelchairs.

5. Improve Transportation, Infrastructure, and Technology to enhance Access

GAP:

- **Technology:**
  - Many communities did not have adequate bandwidth and fiberoptic cables into the communities to enable telemedicine and virtual care options, to improve access.
  - Training for staff in the use of OTN technology is required.
  - There were mixed feelings amongst focus group participants with respect to virtual care such as telemedicine, as a means to improve access. All communities felt that virtual care should not be the only method for accessing care, but it could be useful in certain situations
  - Lack of a shared electronic patient medical record for patients - patients have combinations of paper and electronic medial records used by providers from different organization. This limits access to a patients full medical record and can affect quality of care

5. Improve Transportation, Infrastructure, and Technology to enhance Access

Recommendations:

- Improve transportation services:
  - back-up medical driver in communities with only one driver
  - Ensure accessible transportation to medical appointments both on and off reserve for elderly, medically frail and the disabled
  - Advocate for funding to cover costs of transportation to renew health cards and for dental, eye and other health service appointments not currently covered
- Advocate for the building of a road to Angle Inlet #33 and explore if road access is desired/possible for Windigo Island as well.
- Hold staff accountable for maintaining patient confidentiality on reserve
- Infrastructure Upgrades
  - Increase number of clinical examination rooms on reserve to at least two and maybe more for larger communities
  - living quarters for nurse on island communities for freeze-up and thaw
  - building design to ensure patient privacy and confidentiality
- Improve bandwidth and fiberoptic cables to improve connectivity and capacity for virtual services and telemedicine to enhance assess
- A single shared electronic medical record for each patient that can be used by all providers
- Explore further with communities and providers how best to leverage telemedicine and virtual care – what types of visits and services are most appropriate to improve access and implement these
  - Examples included: follow-up appointments, to review test results, some counselling services, as a back-up when weather prevents provider from travelling to community, for immediate assistance in emergency situations

6. Build Relationships and Partnerships:

Gap:

- Need for more streamlined and coordinated planning and service delivery between indigenous organizations providing services to communities as well as between indigenous and non-indigenous organizations and with the communities.
- KCA, WNHAC, the Family Health Network (FHN) doctors, community health nurses generally provide good services, but the planning and delivery of these services are siloed. As a result, communities and staff could not take full advantage of workshops or meetings due to conflicting dates or conflicting locations.
- Communities requested more coordination of services and collaboration between these organizations.
- Relationship building of communities with providers and health care recruiter and vice versa is important to augment recruitment and retention of professionals and to build trust with patients and communities.
- There is great potential for communities in close proximity to partner and create formal agreements to recruit 2-3 regular physicians to provide primary care services to their collective communities, in collaboration with the NPs.
- Finally, it is crucial to continue building relationships with all levels of government, provincial and federal to mitigate jurisdictional ambiguities and to properly design and fund robust, sustainable models of primary care delivery to First Nations communities.
- Additional law and policy changes, such as Jordan's principle are required.

6. Build Relationships and Partnerships

Recommendations:

- Build relationships and partnerships between organizations providing health services on reserve in order to streamline and coordinate planning and service delivery for patients
    - WNHAC, KCA, FHN doctors and community health nurses should form partnership agreements and work to streamline and coordinate service delivery
- Build relationships and partnerships between communities, organizations and providers
    - Communities in close proximity could partner to recruit 2-3 regular physicians to cover 2-3 communities going forward
    - Communities should partner with the ANHP health care recruiter to develop provider recruitment plans and strategies.
    - Development of **Primary Care Task force with partnerships** to move recommendations forward
- Build relationships and engage with all levels of government (provincial and federal) to ensure more seamless delivery and funding of primary care services for indigenous peoples on reserve
- Advocate for additional law and policy changes, such as Jordan's principle to mitigate jurisdictional ambiguities

7. Address Specific Community Needs

Gaps:

- Each community has unique service and health needs that require community-specific primary care planning. Some examples:
  - Angle Inlet spoke about the unique need for a road to be built to deal with the transportation and weather struggles of living on an island.
  - Windigo Island advocated for the need for more mental health services specifically and the need for overnight quarters for a nurse during the freeze up and thaw.
  - Grassy argued for the need for an Elders' centre and the need to have doctors specifically trained in the health effects of mercury poisoning.
  - Whitedog spoke of the need for a more coordinated first response program given a recent tragedy that had resulted in the death of a community member.
  - Shoal lake 40 highlighted the need to address end of life care for their people and addiction issues, as well as repairs to the helipad so air ambulance could access patients.

7. Address Specific Community Needs

- **Recommendation:**
- Work with each community to address their own specific and unique health needs
  - Some examples listed on previous slide and in Table 4

Table 4: Community Specific Needs (work in progress)

COMMUNITY	NP VISITS (Current)	NP VISITS (Future)	FAMILY DOCTOR VISITS (Current)	FAMILY DOCTOR VISITS (Future)	Other services	Transportation, Infrastructure and Technolocy	Other specific community needs
Washagamis Bay	Once weekly	1-3 d/wk	NO	1-3d/wk	Mental health, bigger/private clinic space, clinic/apt scheduling support, tech support, diabetes care, foot care, advocate/navigator, house calls	Need or more private clinic area and design	
Wabaseemong (White dog)	Once weekly	Weekly to 3-4d/wk	2 doctors (weekly visits btw 2 docs)	5d/wk coverage btw doctor and NP	specialized clinics, outreach education to schools, more privacy in clinic, fiberoptic for OTN	Fiberoptic cables for OTN capacity, clinic design for privacy	First Responder Program
Asubpeeschoseewagong (Grassy Narrows)	weekly	1-4d/wk	1 doctor (FHN doc every 2 wks)	1-5d/wk	Elder home, physio/OT, home visits, foot care, doctor specialized in mercury	Transportation within community	Mercury specialist
NWA #33 DOGPAW	once every 2 wks	1-3d/wk	NO	Weely to every 2wks	Foot care, diabetes care, support with health cards/system navigator	Another exam room	
NWA #33 ANGLE INLET	Once monthly	Every 2wks	NO	Every 2wks	Needle exchange and methadone dispensary, mental health, Diabetes care, CHR in office more – home visits Physio, basic first aid training, mental health	Updated clinic space	Road Access Water treatment plant
NWA #37 REGNINA BAY	Once Weekly	Once weekly	NO	1-3d/wk (NP and doc cover 2d/wk total	Cancer awareness, midwives, dental, more specialists	Another exam room	
NWA #37 WINDIGO ISLAND	Once monthly	1d/wk	NO	Once every wks to monthly	Mental health, CHR training, physio, home visits, diabetes care, palliative care, sexual health, blood work	Overnight quarters for nurse during freeze-up and thaw	
SHOAL LAKE #40	Once weekly	2-3d/wk	NO	Once every 2 wks	Home visits, physio/OT, end of life care, organized clinic schedule, interpreter	Helipad repair	Water treatment
Niisaachewan Anishinaabe Nation (Dalles)	Once weekly	2-3 d/wk	NO	once weekly	Cancer screening, retinopathy, mental health (child/adult)		
Wauzhushk Onigum (Rat Portage)	Weekly to every 2wks	2-3d/wk	1 doctor (WNHAC doc weekly to every 2wks alternating with NP to ensure weekly coverage)	2-3d/wk (NP, doc, nurse work together collaboratively on these days, after hrs coverage)	Elder care programs, after hrs coverage call/weekends- walk in. Diabetes awareness, healthy eating, palliative care	New clinic – more privacy	
Naotkamegwanning (Whitefish Bay)	?weekly (now none)	2-3d/wk	2 doctors (WNHAC doc weekly) (FHN doc every 2wks)	Once weekly OR 2-3d/wk (same day/next day access btw providers, after hrs coverage)	Primary care nurse 40hrs/wk Cancer screening, mental health therapist/workshops, regular traditional healer, breastfeeding and prenatal classes, specialized chronic dz clinics once monthly (ie.diabetes, HTN)	Transportation of elders to apts	Traditional healers

Conclusions

Study demonstrates urgent need to address inequities in access to primary care

Roughly 40% of people do not have regular family doctor – likely more

Close to 50% waiting up to a month or longer for an appointment

Only 15% could get an appointment same day or next day

Striking when compared to rest of Ontario:

- 84% in Northwest and 94% in rest of Province have a family doctor,
- only 5% of people had to wait longer than 8 days
- 24% of people in Norwest and 44% of people in central Ontario can get same day or next day appointment

These inequities have devastating consequences:

- Delayed Diagnosis
- Delayed Treatment
- Increased Complications
- Advanced Disease States
- Higher Acuity Presentations
- More Transfers to Tertiary Centres
- More invasive procedures (surgeries)
- Higher Cost to System

Next Steps… Keep the Momentum Going!

- **Validate findings with each Community**
- **Engage with physicians and providers**
  - Examine outdated contracts that disincentivizes care on reserve
  - Determine what enablers and new models could facilitate recruitment on reserve
- **Research strengths of other existing indigenous primary care models** for ideas:
  - Nuka (Alaska), B.C. First Nations Health Authority, Sioux Loukout, Moose Factory
- **Further explore technologies-** telemedicine and virtual care options
  - enhance access without replacing face-to face care
  - Ensure one shared electronic medical record (quick win…already happening!)
- **Consider a design event** that brings everyone together – health directors, kca, wnhac, physicians, NPs, community health nurses to determine what a new collaborative model might look like
- Creation of a **Primary Care Task Force** with **key partnership representation** and **smaller core working group** to do the work
- **Within context of the All Nations Health System building and OHT initiatives**


KEZAGIDAWIGAMAG
Ojibwe First Nation
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FOURSTROKE


Zhaawanaabinesiik
Health Centre
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WELCOME TO SHOAL LAKE
NO 40
HOME OF THE FLYERS


ASIBIKAANSCHE SEEWAGONG
ANISHINABEK