



Canadian Health Services Research **Foundation**
Fondation canadienne de la recherche sur les services de santé

Facilitating the Continuity of Care for First Nation Clients within a Regional Context

September 30, 2001

Bruce Minore, PhD
Margaret Boone, BScN, MSc
Mae Katt, BScN, MEd
Peggy Kinch, BScN
Stephen Birch, BA, MSc, DPhil

Decision-maker partners:

Mae Katt

Funding provided by:

Canadian Health Services Research Foundation
Ontario Ministry of Health and Long-Term Care
Medical Services Branch

Principle Investigator:

Bruce Minore
Research Director
Centre for Rural and Northern Health Research
Lakehead University
955 Oliver Road
Thunder Bay, Ontario P7B 5E1

Telephone: (807) 343-2136

Fax: (807) 343-2104

E-mail: bruce.minore@lakeheadu.ca

This document is available on the Canadian Health Services Research Foundation web site (www.chrsf.ca).

For more information on the Canadian Health Services Research Foundation, contact the foundation at:

1565 Carling Avenue, Suite 700

Ottawa, Ontario

K1Z 8R1

E-mail: communications@chrsf.ca

Telephone: (613) 728-2238

Fax: (613) 728-3527

Ce document est disponible sur le site web de la Fondation canadienne de la recherche sur les services de santé (www.fcrrs.ca).

Pour obtenir de plus amples renseignements sur la Fondation canadienne de la recherche sur les services de santé, communiquez avec la Fondation :

1565, avenue Carling, bureau 700

Ottawa (Ontario)

K1Z 8R1

Courriel : communications@fcrrs.ca

Téléphone : (613) 728-2238

Télécopieur : (613) 728-3527

Facilitating the Continuity of Care for First Nation Clients within a Regional Context

Bruce Minore, PhD ¹
Margaret Boone, BScN, MSc ²
Mae Katt, BScN, MEd ³
Peggy Kinch, BScN ⁴
Stephen Birch, BA, MSc, DPhil ⁵

¹Centre for Rural & Northern Health Research, Lakehead University

² Associate Professor, School of Nursing, Lakehead University

³ Regional Director, Medical Services Branch (Ontario)

⁴ Senior Policy Analyst, Medical Services Branch (Ontario)

⁵ Centre for Health Economics and Policy Analysis, McMaster University

Acknowledgement

We would like to thank the Director and staff of the Shibogama Health Authority for their assistance in conducting this study.

Key Implications for Decision Makers

- The management of oncology patients shows that good continuity of care is achievable for clients who live in northern First Nation communities, although there are serious disruptions in areas like mental health. Continuity depends on having adequate, appropriate and well-prepared staff at the local level and effective communication between primary and tertiary care centres.
- The ideal is to recruit and retain staff who are knowledgeable about the unique requirements of highly independent northern practice. Even those hired to provide short-term coverage must use holistic approaches to care.
- The interdisciplinary team of care providers is small. Achieving continuity depends upon local paraprofessionals being accepted, recognized and supported by the professionals, both inside and outside the community.
- The First Nation and Inuit Health Branch (Ontario Region), working in collaboration with local health authorities, must find ways to provide stable funding for health promotion, early screening and detection efforts in oncology, diabetes and mental health.
- A national mental health strategy for Aboriginal peoples should be developed to shift from the current emphasis on crisis intervention to providing a full continuum of mental health care.
- Access to client information is hindered by time, distance and providers' lack of knowledge about the work environment in other care settings. At the local level, client charts need to be organized so information is easy to find and understand. Further, the importance of timely and complete client information needs to be reinforced for all those who deal with northern First Nation communities.

Executive Summary

A physician providing stand-in services in three remote Ontario First Nation communities raised serious questions about the continuity of health care clients received after reviewing their charts. Dr. Dignan's report prompted the Shibogama First Nations Council and the First Nations and Inuit Health Branch (Ontario Region), Health Canada, to initiate a study with researchers from Lakehead and McMaster Universities to explore whether northern residents receive health services in an appropriate sequence and interval of time and the costs to patients and the system that result when disruptions occur. The study was based on a systematic review of 135 diabetes, oncology and mental health client charts, in-depth interviews of 30 care providers/health administrators, and an analysis of data on program delivery costs. Five questions were asked.

1) What, if any, disruptions occur in providing care, and why? There was evidence of many disruptions as a result of situational, systemic and personal issues. The small size and remote location of the communities result in reliance on a “fly in-fly out” model of care where access may be dictated by weather. Isolation also makes it difficult to recruit health professionals who are willing to serve the communities for reasonable periods of time. The resulting staffing instability tends to limit services to providing treatment, rather than prevention, detection or client education. Delays occur in the flow of information as clients move between community-based primary care and tertiary care in larger regional centres. And sometimes client information gets overlooked in the multi-chart system used in the local nursing stations. Communication also depends on having people who understand and can convey clinical information in the local dialect (*Oji-Cree*).

(2) What effect does lack of continuity have on client outcomes? Perhaps the lack of continuity that has the largest effect on client health is the turnover in health human resources. Newly arrived physicians and nurses tend to deal with immediate symptoms, often unaware of long-term conditions. And clients get tired of dealing with constantly

changing practitioners, having to repeat their symptoms and submit to re-examinations. Frustrated, they frequently give up on a course of treatment, allowing their condition to deteriorate. Mental health clients may deteriorate because they are not monitored or followed-up systematically. Indeed, they are sometimes released back to the community with no treatment information. The lack of communication between tertiary care centres and nursing stations results in serious disruptions of care.

(3) What is the impact of these problems on patients, their families and communities?

The systemic focus on acute care comes at the expense of chronic and public health care. Although there is increased emphasis on both of the latter types of service in the case of diabetes clients, and to some extent for oncology patients, little is done to promote good mental health. As well, successful prevention programs like well-women's clinics are put on hold during periods of staffing shortages. For families, the effects are greatest when supportive care is inadequate or their family member has disengaged from care.

(4) What are the costs (both monetary and in terms of human resources) to the health system due to lack of continuity? Inefficiencies are a by-product of staff turnover. The expenses associated with constant recruitment are compounded by the costs of continually orienting new staff. Then there are the monetary and more important human resource costs generated by people who are unfamiliar with the system. One example is the need to place a special rush order for medications to replace supplies depleted by a relief nurse who was dispensing medications as prescribed, but did not know how to place a routine re-stocking order. Failure to maintain timely communications from tertiary to primary care settings can prove costly. If they do not receive information needed to manage a client's care, the nursing station staff have to get it from the physician's office, necessitating the extra work of initiating a formal request for release of medical information.

(5) How can the system support communities and care providers in order to achieve

better continuity of care? Given the problems associated with attracting health professionals, appropriate use must be made of health caregivers from the communities. The communities differed in the availability and use of paraprofessionals, although evidence suggests they can play a significant role in providing certain types of interventions. As well as making appropriate use of these workers, it is vital to support them in their job. Too often they tire and quit due to excessive demands.

While the study confirmed what Dr. Dignan found, it also showed that comparatively good continuity of care is achievable. For example, the majority of oncology cases reviewed were those of women diagnosed through routine screening at well-women's clinics. Some clients, especially older males, ignore symptoms until their disease reaches more advanced stages. However, once known, every suspected or confirmed oncology case is referred out to specialists in a timely fashion and provided with relatively consistent follow-up care. Similarly, although prevention and early detection are a problem, diabetics have access to education about self-care through the Diabetes Program in Sioux Lookout, the region's service centre, which also periodically sends a nurse specialist and dietician to the communities. There were calls for more community-based programming, but those interviewed affirmed what the clients charts show; on-balance, diabetes care was comparatively good.

In stark contrast, the treatment of those suffering changes in their mental health was generally poor. The incidence of suicidal behaviour among youth is so high that the mental health care system functions in crisis mode only. Emergency interventions occur, but there is little capacity for prevention or follow-up. Long-term treatment of psychoses resulting from solvent abuse and situational grief reactions are, at best, inconsistent.

In sum, in one way or another, good continuity of care in northern First Nations comes down to one thing — having consistent, knowledgeable and appropriate care providers.