SIX NATIONS OF THE GRAND RIVER LONG TERM CARE/HOME AND COMMUNITY CARE

DESCRIPTION OF WORKPLAN

The overall purpose for this work plan was the development of an Aboriginal Community Based Palliative Care Shared Care Outreach Team under the Mentorship of the Stedman Community Hospice/ St. Joseph's Healthcare Foundation.

Once the funding was awarded from the Local Health Integrated Network, it was necessary to determine the process for the flow of funding from the transfer payment agency (TPA) assigned, in order to roll out the funding as quickly and easily as possible before the end of the year. To this end a meeting was held with the Manager of the Home and Community Care Program, the Executive director of the Hospice and LHIN Palliative Advisory Committee.

Following the roll out of the funding, the two agencies needed to determine who would manage the administration of the funds within the partnership. A meeting was set up with the senior management officials and finance of each agency and a Memo of Understanding for the partnership was finalized. This MOU would outline the responsibility of both parties in the partnership and would determine the budget for the year.

A key component to the functioning of a Shared Care team is the role of the palliative physician and specifically for this team was that it be an Aboriginal physician. A meeting was set up with the Family Health Team physicians to determine a commitment to being mentored by the Stedman Hospice Outreach Team physicians. Once received a meeting was set up with the two groups to work out a compensation package for mentorship and on call. The interested physicians would attend Learning Essentials in Palliative Care Training in the next scheduled session and begin their palliative training.

The critical component was to hire the positions of the clinical nurse specialist and the psychosocial spiritual bereavement clinician. This recruitment and orientation would be carried out as per Council hiring policy, with preference given to candidates of Aboriginal descent. The position descriptions would be tailored from the common HNHB LHIN Palliative Advisory resources and encompass the Haudenosaunee philosophy. The commencement of the mentorship with the Hospice would be immediate on the hiring of these two positions.

In order for the mentorship to proceed as soon as possible, it became more convenient for the Shared Care team to be stationed at the Hospice for the first year at least and then a satellite office could be planned to determine needed equipment, program supplies and office expenses.

Task groups were established by the palliative leadership committee to develop palliative program guidelines and a process or care pathway for the provision of services.

Three months following the roll out of the funds referrals were accepted from the Hospice Outreach Team for Six Nations clients and a Six Nations Family Health Team physician began providing palliative care services under the mentorship of the Stedman Hospice physicians. Marketing of the services began to the community and stakeholders via email blasts, local papers, family physicians and pamphlets distributed.