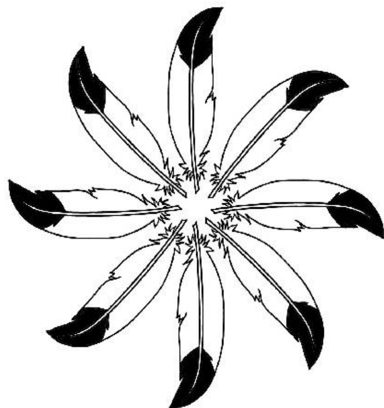
Improving End-of-Life Care in First Nations Communities:



Engaging stakeholders in journey mapping: Identifying the current and desired care pathway for palliative clients in Naotkamegwanning First Nation

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Conflict of Interest Declaration: Nothing to Disclose

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Title of Presentation: Engaging stakeholders in journey mapping: Identifying the current and desired care pathway for palliative clients in Naotkamegwanning First Nation

We have no financial or personal relationships to disclose

Acknowledgements

Fort William First Nation

Peguis First Nation

Objectives:

- Describe the process of completing *journey mapping* in Naotkamegwanning First Nation
- Demonstrate important linkages and partnerships between internal and external health care and service providers
- Recommend how this community engagement activity could be done in other First Nations Communities

Naotkamegwanning First Nation

- Naotkamegwanning is located in North Western Ontario in the heart of the Treaty #3 Territory
- The nearest urban center Kenora (approx. 15,000 people) is 96 km north of NFN
- The community has year-round road access and also has an ice road in winter
- There are 712 community members living in the community

Cultural Identity

- NFN is one of the very few communities that have been able to keep their Anishinaabe cultural practices and beliefs strong and vibrant
- 48% of the population are able to speak Ojibway
- Many of the people of NFN continue a connection with the land and maintain a lifestyle that includes fishing, hunting & harvesting of wild rice
- The importance of passing on teachings, language and cultural practices are evident in their delivery of programs and services within the community
- Death and dying and community cultural context implications

Community Support

- Baibombeh Anishinaabe School (Kindergarten to Grade 12)
- Mino' Giizhigad Elders Centre (Independent Living Apartments)
- Netaawgonebiik Health Centre (Clinic /Traditional Care)
- Naotkamegwanning Emergency Medical Service (Ambulatory services/paramedics)
- Naotkamegwanning Head Start Program
- Naotkamegwanning Women's Shelter
- Naotkamegwanning Administration Office
- Naotkamegwanning Social Services Administration Office
- Black River Camp (Youth & Elder Cultural Camp)
- Traditional Roundhouse and pow wow grounds

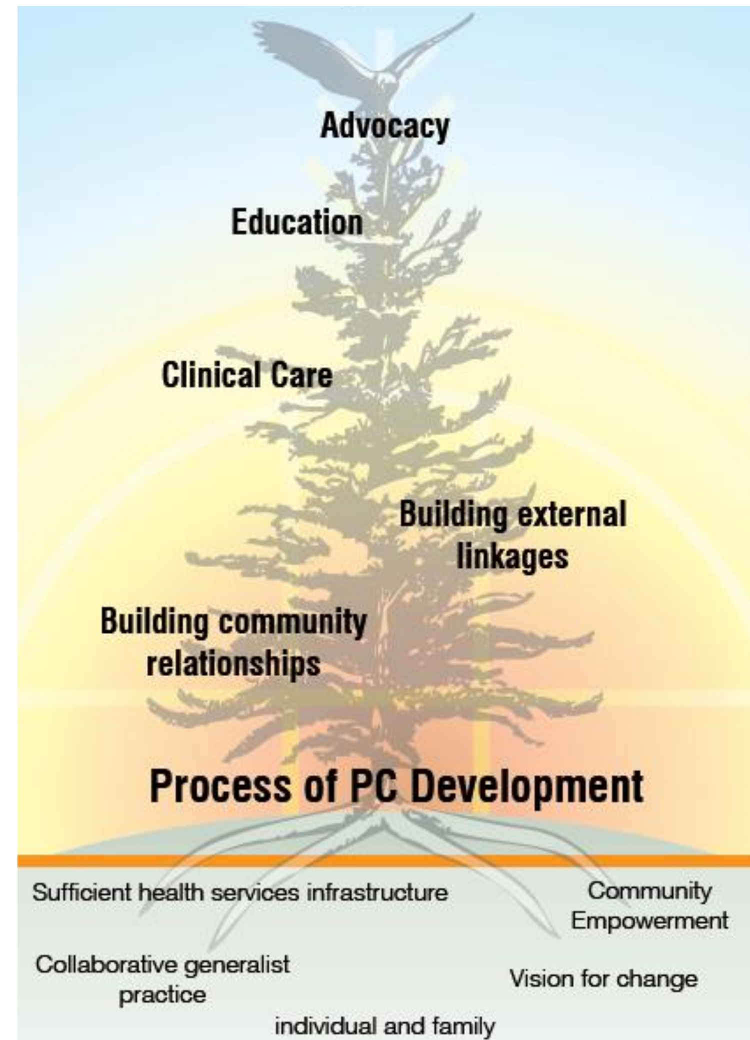
An important shared characteristic amongst all the programs and services offered with Naotkamegwanning is the cultural component which is mandatory for all service providers.

Health System Barriers at EOL

- Communication and language barriers
- Lack of cultural safety and competency (hospital culture)
- Inadequate hospital discharge planning
- Health system lacks understanding of FNIHB & NIHB policies and procedures
- Lack of timely access to medication and equipment in FN community
- Lack of support for client choice to die at home
- Lack of palliative home care services in FN communities

Wiisokotaatiwin Program:

Care Pathway for a Naotkamegwanning Community Member



Journey Mapping Exercise

- Engaged in a “journey mapping” exercise to create a new integrated path of care for clients to receive palliative care at home
- Included 23 internal and external health care and service providers who participated in 4 workshops
- The purpose was to create a care pathway by exploring how community members transition through the health care system as they approach end of life; identifying potential obstacles, improving communication and service integration amongst health care and service providers

External Health Services Partners

- Community Health Care Professionals
- Lake of the Woods District Hospital
- Northwest Community Care Access Centre
- Palliative Care Telemedicine, St. Joseph's Care Group
- First Nations Inuit Health Branch
- Waasegiizhig Nanaandawe'iyewigamig Health Access Centre (WNHAC)
- Thunder Bay Regional Health Sciences Centre
- Palliative Care Volunteer Program

August 2013

- Presented PC Needs Assessment results to community members and internal and external health care providers
- High level discussion about gaps and barriers
- Began mapping the current and future state
- Engaged the participants, created linkages and got commitment to move forward collaboratively

February 2014

- Attempted a “Value Stream Mapping” workshop
- Transitioned to a journey mapping format
- Discussed breakdowns in the care pathway process and generated strategies to solve them
- Developed a nine step process for the care pathway

Client is identified
Client is referred
Comprehensive assessment
Case conference and development of care plan
Coordinated health services delivery
Planning for client
Client has passed on
Follow-up and bereavement support
Case closure
WIISOKOTAATIWIN
NAOTKAMEGWANNING
FIRST NATION
CARE PATHWAY

Steps 1-5 with external care partners

Steps 1-5	What is already in place	Key process and consent	What needs to be accomplished/ implemented	Decisions to be made	Stakeholders
CLIENT IS IDENTIFIED (15 min)	Points of entry Program criteria	Information sharing (what and to whom)			
CLIENT IS REFERRED (20)	Community referral process	Information sharing (what and to whom)			
COMPREHENSIVE ASSESSMENT (20 min)		Information sharing (what and to whom)			
CASE CONFERENCE AND CREATION OF CARE PLAN (15 min)		Information sharing (who is in the Circle of Care)			
COORDINATED HEALTH CARE DELIVERY (25 min)		Information sharing (what and to whom)			

October 2014 Steps 6-9

Steps 6-9	What is already in place	Key process and consent	What needs to be accomplished/ implemented	Decisions to be made	Stakeholders
PLANNING FOR CLIENT (passing)					
CLIENT HAS PASSED					
FOLLOW_UP AND BEREAVEMENT SUPPORT					
CASE CLOSURE					

Next Steps

- Continue developing and implementing action plan for Leadership Team and external health care partners
- Implement the H-SIP proposal November 1, 2014
- Evaluate pilot through March 31, 2015
- Continue to work with the Wiisokotaatiwin program to document lessons learned to share with other First Nations communities

Key Processes in the 9 Steps

- Creating the local resource team and program
- Client identification (hospital, community, HCP office)
- Client Assessment—tools and processes
- Care conferences
- Education and support for family and HCP
- Communication and coordination
- Respite care and Volunteer programs

Lessons Learned

- The importance of developing strong partnerships with external care providers—developing the care path requires a real commitment of time and resources from these providers
- The importance of making certain that communication lines between all parties are open
- The importance of ensuring that the community feels that they maintain ownership of the process
- The importance of ensuring that the care path is culturally appropriate and inclusive of traditional practices and beliefs

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