



Aboriginal Health Improvement Committees

MAPPING SUMMARY REPORT



northern health
the northern way of caring

TABLE OF CONTENTS

- Acknowledgments 2
- Executive Summary 3
 - Why patient journey and process mapping? 3
 - Shared themes 3
 - Conclusion 4
- Introduction 5
- Purpose of this document 5
- Background 5
- Why patient journey and process mapping? 6
- Aboriginal Health Improvement Committee Mapping Reports 7
- Shared themes 8
 - 1. Culture and Care 8
 - 2. Meeting the information and communication needs of patients 9
 - 3. Strengthening information sharing in the health system 10
 - 4. Traveling for care 12
 - 5. Access to care 13
 - 6. Roles and training 14
- Conclusion 15

ACKNOWLEDGMENTS

This document represents the generous and engaged work of the Aboriginal Health Improvement Committees (AHICs) across northern BC. We wish to thank the members of each AHIC, as well as the many individuals who joined AHIC members to complete the mapping projects. Thank you to the many people who worked to bring the AHIC maps and reports to completion.

We would also like to acknowledge the support of the First Nations Health Authority (FNHA) and the Aboriginal Health team within Northern Health.

The individual acknowledgments for each of the AHIC mapping reports are too lengthy to include here. Please see each individual mapping reports for full acknowledgment for each AHIC’s mapping process. A list of mapping reports can be found on page 7.

EXECUTIVE SUMMARY

This document is a summary of 13 reports and 21 associated patient journey and process maps completed by Aboriginal Health Improvement Committees (AHICs) across northern BC between July 2014 and July 2015. The report’s purpose is to provide an overview of what the reports and maps have in common by discussing the key themes that emerge from the reports and maps as a group. For a complete list of each AHIC’s individual report(s) and associated patient journey and process maps, please see the table on page 7.

Why patient journey and process mapping?

Patient journey mapping and process mapping involve collaboratively producing a visual representation of the steps and processes a patient moves through during a care journey. Mapping patient journeys allows participants to represent the current realities of patient experience and identify strengths and opportunities for health system improvements – from the patient’s point of view.

Shared themes

AHICs’ patient journey and process maps each looked at particular situations and topics, but shared several common themes. Each AHIC report emphasized the energy and commitment of the mapping groups, and identified key strengths and opportunities for future work. Not each AHIC or each map spoke to every theme, and each AHIC and each map contained important observations and analysis specific to individual communities and contexts. However, there were substantial commonalities across the AHICs.

1. Culture and care

The importance of the rich diversity of First Nations, Métis, and Inuit cultures across northern BC underpinned much of the work of mapping participants. Strong cultures and strong connections to culture – including to Indigenous knowledge systems, languages, and cultural practices – are crucial to health and well-being.¹ Mapping participants focused on the importance of the health care system more effectively understanding the diverse Aboriginal cultures and geographies across northern BC. Participants also discussed opportunities to Indigenize care and resources across the health system.

2. Meeting the information and communication needs of patients

AHIC mapping participants noted the importance of multi-directional and effective communication (including culturally safe communication) and agreed that Aboriginal Patient Liaisons (APLs) are an important strength in supporting

¹ National Aboriginal Health Organization (NAHO), The importance of culture and health, <http://www.naho.ca/blog/2011/06/20/celebrating-national-aboriginal-day-the-importance-of-culture-and-health/>

patient information and communication needs. At every step in the patient journey, but especially at discharge from hospital, patients and their families and circles of support need clear and complete information – communicated in plain language. Language differences between the health care team and the patient can be a barrier to receiving the best care, particularly for Elders.

3. Strengthening information sharing in the health system

Mapping participants felt that strengthened information sharing among health professionals and between institutions (e.g. Northern Health, First Nations Health Authority (FNHA), and community health centres) would be beneficial. Overall, they observed opportunities to improve the quality, clarity, and completeness of information sharing at key points in care journeys – at admission and transfer, but especially at discharge. Mapping participants also identified a need for clear processes to gather up-to-date patient histories and other pertinent information so that it can be shared to support continuity of care.

4. Traveling for care

Depending on where they live, patients and those who accompany them might travel for emergency hospital visits, complex procedures, to see a specialist physician, for wound care, or other reasons. Participants observed that strong relationships and good communication between individuals and institutions involved in patient care and travel are important to success, and saw several opportunities to strengthen understanding of patient and family travel needs across the health system. Participants also discussed wayfinding for patients and families, Northern Health Connections bus services, funding for travel, the role of the patient escort, and the relationship between access to services (especially in small communities) and the need to travel.

5. Access to care

Overall, participants observed variability in the type of services available across communities, and that remote communities have different access challenges as well as different opportunities for development of in-community resources and services. In some cases, access influenced how far and how often a patient must travel or how complex the patient's journey would be to navigate generally. Participants observed access issues ranging from limited primary care in small communities to the availability of advocacy and language services throughout northern BC. The availability of preventative care programs and services also emerged as a topic of discussion for participants, who identified diabetes prevention, holistic healing, traditional medicine, addictions, mental health, and nutrition as important areas for future attention.

6. Roles and training

Across AHICs, mapping participants observed a number of opportunities for further training across the health system and shared a focus on examining how the APL and patient escort roles fit into patient journeys. Mapping participants saw opportunities to strengthen the APL and patient escort roles, and to provide various types of training across the health system (e.g., culturally safe care, trauma-informed care, mental health and addictions).

Conclusion

Patient journey and process maps are a way for communities to bring their voice into the health care system and identify opportunities for change in health services – as well as to identify local solutions and concrete actions that can be taken at the local level. This report articulates where these next steps might lead. There are numerous avenues to pursue that can contribute in meaningful ways to the transition of health services to better serve First Nations, Métis, and Inuit people within their contexts, communities, and realities.

INTRODUCTION

Each of the three Northern Health service delivery areas (Northeast, Northern Interior, and Northwest) is home to permanent Aboriginal Health Improvement Committees (AHICs). AHIC members include health representatives from First Nations and Aboriginal communities and organizations, First Nations Health Authority, and local Northern Health leadership.

AHICs meet to share information and work in partnership on identified health care issues facing Aboriginal people in the area. They review issues and concerns and work together towards practical solutions. AHICs can provide helpful local and regional health system information including information about the health of their local population and the health of their communities. Committees can engage in meaningful dialogue with local service providers and managers to provide Northern Health with direction on a wide range of issues.

There are eight AHICs in three Health Service Delivery Areas:

Northeast

- Northeast AHIC

Northern Interior

- Lakes District AHIC
- Omineca AHIC
- Prince George and Area AHIC
- Quesnel and Area AHIC

Northwest

- North Coast AHIC
- Northwest East (Smithers and Area) AHIC
- Terrace/Kitimat AHIC

PURPOSE OF THIS DOCUMENT

This document is a summary of the reports and associated patient journey and process maps completed by AHICs across northern BC. This report's purpose is to summarize what the reports and maps have in common by discussing the key themes that emerge from the reports and maps as a group.

For details associated with each AHIC and its member communities, please see the individual reports developed by each AHIC. (A complete list of reports and patient journey and process maps can be found on page 7).

BACKGROUND

At the AHIC Gathering held in June 2014, Margo Greenwood (Vice President of Aboriginal Health, Northern Health) announced funding to support a new initiative to understand the challenges facing Aboriginal patients, families, and communities in accessing Northern Health services for health and wellness. This initiative included funding for patient journey and process mapping as well as for developing cultural resources. AHICs across northern BC convened patient journey and process mapping events over the fall and winter of 2014-2015. Mapping event participants varied depending on the topic of the mapping, and included regular AHIC members, health representatives from AHIC member communities, Northern Health leaders and staff, patients, physicians, Aboriginal organizations, and other organizations involved in the health care journey (e.g., Coast Guard, RCMP). Meetings were uniformly positive and engaging, characterized by collective energy, enthusiasm, collaboration, and creative problem solving.



A total of 21 maps (in 13 separate reports) have been produced. AHICs across the northern BC began their patient journey and process mapping projects in autumn 2014, and completed their maps and mapping reports in the spring and summer of 2015. Mapping events were undertaken by the Prince George and Area AHIC and the Omineca AHIC but the reports were in process of being completed when this summary was written.

Mapping participants generally created a fictional patient for whom they would map a care journey, often naming their patient and filling in background details about their collective creation. In developing their fictional patients, mapping participants across northern BC shared a common priority: Elders with complex health status were by far the most common fictional patients. Other fictional patients included women receiving maternity care (including for a complex pregnancy), a trauma care patient, and mental health and addictions patients. In the individual reports, maps using fictional patients are referred to as “process maps.” A small number of maps were created based upon the care journey of one patient. In some cases, these individual patient experiences were shared one-on-one by the patient with a member of the AHIC mapping group. These individualized maps are referred to as “patient journey maps”.

For a complete list of each AHIC’s report(s) and associated patient journey and process maps, please see the table on page 7.

WHY PATIENT JOURNEY AND PROCESS MAPPING?

Patient journey mapping and process mapping involve collaboratively producing a visual representation – a chart, picture, or model – of the steps and processes a patient moves through during a care journey. A small number of the maps completed were based upon individual patient experiences (in some cases, the journey was shared one-on-one by the patient with a member of the AHIC mapping group). Mapping patient journeys and processes is important because it allows participants to represent the current realities of patient experience as opposed to showing how an ideal patient journey ‘should’ progress. This type of mapping helps to identify strengths and opportunities for improvement in the health system – from the patient’s point of view.²

Mapping of this kind is an avenue for the direct voice of the community to share what they see, while also bringing their knowledge together in a systematic way. Patient journey and process mapping accommodates perspectives from different sectors and different disciplines, and supports positive change by looking at patient’s care journeys from multiple perspectives. The mapping process also allows stakeholders to collaboratively address opportunities for improvement.

² National Health Service Institute for Innovation and Improvement, “Process mapping – an overview,” http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/process_mapping_-_an_overview.html

ABORIGINAL HEALTH IMPROVEMENT COMMITTEE (AHIC) MAPPING REPORTS

HSDA	AHIC	Report	Map(s)
Northeast	Northeast AHIC	Fort Nelson First Nations and Prophet River	<ul style="list-style-type: none"> Elder going for surgery and returning home Shared stories of travel from home to hospital and home again
		Halfway River	<ul style="list-style-type: none"> Modified process map of Elder care in Halfway River
		Saulteau First Nation	<ul style="list-style-type: none"> Elder discharged to community post-op
		Doig River First Nation and Blueberry River First Nation	<ul style="list-style-type: none"> Elder health, home to hospital and home again
		Dawson Creek Urban Aboriginal Focus	<ul style="list-style-type: none"> Elder receiving cataract surgery - urban focus Complex teen pregnancy - urban focus
Northern Interior	Lakes District AHIC	Lakes District	<ul style="list-style-type: none"> Patient flow process map – Elder traveling from community to UHNBC Prince George for bone scan Patient journey map – Seeking care for long-term complex health issues and diagnoses Patient journey map – Seeking care for trauma injury requiring specialist services
	Omineca AHIC	unavailable at writing of summary report	
	Prince George and Area AHIC	unavailable at writing of summary report	
	Quesnel and Area AHIC	Quesnel and Area	<ul style="list-style-type: none"> Complex Elder patient discharge planning with multiple transfers Mental health journey from admission to discharge for a rural community
Northwest	North Coast AHIC	Lax Kw’alaams	<ul style="list-style-type: none"> Patient flow from Lax Kw’alaams to Prince Rupert Regional Hospital and home
	Northwest East (Smithers and Area) AHIC	Dease Lake	<ul style="list-style-type: none"> Patient flow from community to care and back
		Gitanyow	<ul style="list-style-type: none"> Elder discharged from Mills Memorial to Gitanyow
	Terrace / Kitimat AHIC	Mental Health and Addictions	<ul style="list-style-type: none"> Process map of patient journey with acute mental health and addictions crisis from home community to services in Terrace and back home
		Terrace / Kitimat	<ul style="list-style-type: none"> Pregnancy to six months post delivery Elder discharged from Mills Memorial or Kitimat General to outlying community <ul style="list-style-type: none"> Elder’s return to Gitinmaax, Gitsegukla, Iskut, Gitanyow, Hagliwilgyet, Telegraph Creek, Kispoix, Glen Vowell Elder’s return to Kitsumkalum, Kitselas, Haisla
		Emergency Department	<ul style="list-style-type: none"> Mills Memorial Hospital Emergency back to home



SHARED THEMES

AHIC mapping participants across northern BC shared a number of common themes in their patient journey and process mapping reports. Each AHIC report emphasized the energy and commitment of the mapping groups, and identified these as strengths in moving their work ahead in the future. AHIC reports also emphasized that both communities and the health system have important strengths and structures that can be built upon. For example, mapping participants saw Aboriginal Patient Liaisons (APLs) as invaluable in ensuring continuity of care for patients. First Nations, Métis, and Inuit cultures were seen as key points of strength by mapping participants. For example, participants discussed the importance of Indigenous knowledge systems, the wisdom community members can provide to support culturally safe care, and the strength and commitment of health care providers in communities and across the health care system. Mapping participants commonly indicated that families and circles of support – and community members as a whole – represented an important strength as well. In each of the themes discussed below, mapping participants identified both strengths to be built upon and opportunities for action.

AHICs' patient journey and process maps each looked at particular situations and topics, but shared many common themes. It is important to note that in the summary of themes that follows, not each AHIC or each map spoke to each and every theme. Each AHIC and each map contained important observations and analysis specific to communities and their contexts across northern BC. Nonetheless, across communities there were substantial commonalities. See the individual reports developed by each AHIC for details. Each of the following themes is discussed in this section.

- Culture and care
- Meeting the information and communication needs of patients
- Strengthening information sharing in the health system
- Traveling for care
- Access to care
- Human resources

1. Culture and care

Culture was an important topic for many of the AHIC mapping groups. Participants used a range of different terms when they spoke about the role of culture in health programs, services, and resources, including Indigenization, cultural relevance, cultural competence, cultural safety, and holistic health. The importance of the rich and diverse cultures of First Nations, Métis, and Inuit cultures across northern BC underpinned much of the

work of mapping participants. Strong cultures and strong connections to culture – including to Indigenous knowledge systems, languages, and cultural practices – are crucial to health and well-being.³

1.1 Diverse Aboriginal cultures and geographies in northern BC

AHIC mapping participants underlined the diversity both within and between Indigenous cultures in northern BC. Aboriginal people in northern BC live in diverse settings, both on and off reserves, and in isolated, rural and urban communities. Each type of community is important for the health system to take into consideration. Mapping participants suggested that people living in urban communities are sometimes seen as a challenging population to reach (for a range of reasons, from jurisdictional issues to migration), and that intentional efforts are needed to ensure these urban voices and perspectives are heard as part of the larger conversation about Aboriginal health in northern BC.

But although differing geographies are important, Aboriginal diversity is much more complex than this, and includes differences between individuals and within and between communities. Furthermore, First Nations, Métis, and Inuit people in northern BC live in contexts that are informed by multiple histories (including colonial histories) and present realities.

1.2 Indigenizing care and resources

Indigenizing health care and health resources – the process of “infusing Aboriginal knowledge and perspective into the structural layers of an institution”⁴ – was an important theme in the AHIC maps and was seen as important to patient care in the present, but also to ensuring more avenues for Aboriginal people to contribute their opinions and experiences toward the improvement of health programs and services. In mapping patient health care journeys, participants said that applying an “Aboriginal lens” to care in general and to patient resources (those in development and those already completed) would be beneficial.

Participants also suggested that work remains to be done to ensure cultural competency of Northern Health staff through training (such as the online Indigenous Cultural Competency program) as well through learning about local cultures, traditions, and protocols. (See section 6.3 for further details on mapping participants' views on training.) This would also include cultural competency being built into any processes where patients are asked to self-identify as First Nations, Métis, and Inuit. Participants mentioned the importance of holistic approaches to health as well as

³ National Aboriginal Health Organization (NAHO), The importance of culture and health, <http://www.naho.ca/blog/2011/06/20/celebrating-national-aboriginal-day-the-importance-of-culture-and-health/>

⁴ Camosun College, Learning about Indigenization, <http://web.camosun.ca/cell/curriculum-design/learning-about-indigenization>

culturally safe care, with a focus on patient experience (as opposed to diagnosis and disease), personhood, individual needs, and mutual respect.

Mapping participants saw opportunities for Indigenization in a number of more specific areas:

- existing health resources (for example, the *BC Ministry of Health My Voice: Advance Care Planning Guide*);
- communication tools, including those currently in development;
- supportive resources for Elders seeking care;
- wellness plans;
- prevention programs;
- ‘wraparound’ care strategies;
- mental health assessments;
- emergency department staff training in hospitals; and
- communities' mental health and addictions implementation plans (including community reflection on what each is able to implement, collaborating with FNHA, and implementing such programs and services like in-community detox, health passports, and tele-health modules for patients).

2. Meeting the information and communication needs of patients

One of the strongest themes to emerge in the AHIC patient journey and process maps was the importance of meeting the information and communication needs of patients – and their families and circles of support. Overall, mapping participants observed that many opportunities exist for strengthening the communication strategies used across the health system with patients.

2.1 Multidirectional and effective communication is needed

AHIC mapping participants made many observations about the importance of multidirectional and effective communication – including culturally relevant, culturally safe communication – between the health care team and the patient and his/her family and circle of support. Some participants focused on approaches to communication (for example, the need for more ‘sensitive’ communication by health professionals). Others observed that communication needs to be open, clear, reciprocal (engaging patient as a partner in decision making), and support effective self-management by patients.

2.2 Aboriginal Patient Liaisons (APLs) effectively support the information and communication needs of patients and families

AHIC mapping participants agreed that Aboriginal Patient Liaisons (APLs) are an important strength of the health care system. APLs work to ensure First Nations, Métis, and Inuit patients, clients, residents and their families have access to high quality, culturally appropriate care. They help to bridge the gaps between western and traditional medicine ensuring a holistic health approach.

2.3 Supporting patients with clear and complete information on their care journey

At every step in the patient journey, patients and their families and circles of support need clear and complete information – communicated in plain language. Participants observed that patients would benefit from more and better information on their care and condition generally, as well as from more information on some specific items like wait times (e.g., for referrals, in the Emergency Department) and timing of hospital discharge.





Discharge planning was a particularly common area of focus for mapping participants – development of an “information package” or template to be used at discharge that would cover patient care information, medications, and next steps to wellness. Participants also noted that those living in urban settings have different information needs – without a Community Health Team supporting them, they may need system navigation support, additional information on resources available to them in the community, and linkage with the First Nations Health Authority.

Ensuring patients have access to clear and complete information was seen by mapping participants as key to patients being able to advocate for themselves. Timeliness of information was also seen as important, because late communication of information about medications or equipment (e.g., dialysis equipment) can burden patients and their circles of support with frustrations and additional travel.

Mapping participants also suggested the need to revisit clarity and completeness of communication of information with patients on a range of topics, including:

- pre-operative procedures and processes;
- interpretation of lab results;
- prescribed medications;
- mental health and addictions services available;
- patient education topics, such as diabetes self-management topics;
- navigation of prescription coverage through Non-insured Health Benefits (FNHA), Northern Health, and/or BC Medical Services Plan;
- transfer from one facility to another (e.g., to receive maternity care);

- community resources, including maternity resources, Aboriginal organizations and agencies, and health authorities;
- how to reschedule missed appointments (e.g., missed because of travel difficulties or other reasons);
- when to go to the Emergency Department and what can be cared for at home or in home communities; and
- triage and wait times in the Emergency Department.

2.4 Language differences can be a barrier to receiving the best care, particularly for Elders

Mapping participants felt that language was an issue that required continuing attention. For example, Elders may consent to a care strategy without being fully aware of what they have agreed to, or may return home from a hospital stay without a full understanding of their discharge care plan – including how best to care for themselves or what follow-up care they may need. The current FNHA escort role does not include support with language interpretation. Participants also noted that current levels of access to interpretation services are not adequate, as well as suggesting that health professionals receive training and/or resources in Indigenous languages (e.g., development of a *Practical Carrier Phrasebook*).

3. Strengthening information sharing in the health system

Mapping participants felt that strengthened information sharing among health professionals and between institutions (e.g. Northern Health, FNHA, and community health centres) would be beneficial to First Nations, Métis, and Inuit patients in northern BC. Participants mentioned hospital, clinic staff, family physician, community health team/community health centre, home care, public health and community health nurses, specialist physicians, community agencies (especially urban Aboriginal

organizations), dietitians, pharmacists, and BC Patient Transfer Network (interfacility transfer services through BC Emergency Health Services).

Participants specifically noted that APLs are effective in coordinating information sharing. However, where there is no APL, information sharing across institutions and professions is not as effective in ensuring continuity of care. As part of conversations about information sharing, mapping participants also observed that patient confidentiality requirements can be seen as a barrier to information sharing, including when information is to be shared across jurisdictions.

When a number of institutions and practitioners are working with patients during their care journey, information sharing is very important. In some situations, information sharing roles and responsibilities for different institutions and health professionals may not be as clear as they could be. Participants noted that there are opportunities to strengthen information sharing in a number of specific contexts in order to support improved patient safety and wraparound care. Overall, they observed that it would be beneficial to enhance quality, clarity, and completeness of information sharing at key points in a care journey – at admission, transfer, and discharge. Other opportunities identified included:

- improving communication from community health centre to hospital (for example, patient charts from community health teams do not always arrive at hospital);
- strengthening communication from Northern Health (in areas like acute care, Emergency Department, outpatient care, public health, etc.) to community health centres (for example, discharge plans are not necessarily sent to the community health team);

- strengthening communication between acute care and family/specialist physicians;
- raising awareness among Northern Health staff of services available in patients’ home communities (for example, by developing service directories to support continuity of care planning);
- strengthening information sharing related to prescription medications;
- writing discharge information and instructions in plain language for home care support staff;
- developing protocols, policies, and consent forms to support information sharing for continuity of care;
- enhancing communication for patients with more complex care needs (for example, Elders, women receiving maternity care away from home, palliative care patients, especially those with advanced directives or ‘No Cardiopulmonary Resuscitation’ order, and mental health and addictions patients, especially suicidal patients); and
- sharing patient travel information. (See section 6 for further discussion).

3.1 Strengthening discharge planning

Collaborative discharge planning (e.g., following inpatient admissions and Emergency Department visits) received a great deal of attention from the AHIC mapping participants. In addition to the discussion of sharing discharge plan information with patients and families (discussed in 2.2, above), mapping participants also indicated that discharge planning processes could also be strengthened by engaging multiple care providers and/or institutions. For example, coordination of follow-up appointments may not occur, or home care may not be set-up in time for the person’s arrival at home.

Participants observed that planning is most important for Elders, complex patients, and new mothers – with each patient (and patient population) having its own post-discharge needs. Strengthening relationships and improving structures and processes were both identified as important for building more collaborative and effective discharge planning in northern BC. Involving APLs in discharge planning was seen as one effective way to support patients' continuity of care.

Discharge planning can be influenced by a range of factors, including day of the week (Monday to Thursday discharges have the best planning behind them), and whether or not the patient is admitted to a ward. If, for example, a person receives care in the Emergency department and is discharged directly from there, then staff who could otherwise support effective discharge planning for the individual may not even be aware the person has made a hospital visit.

3.2 Gathering up-to-date patient information

Mapping participants identified a need for clear processes to gather up-to-date patient histories and other pertinent information. Doing so would allow for the right information to be shared with the right health care professionals or institutions to support effective wraparound care. One mapping group noted the efficacy of the Dawson Creek prenatal registry, while another suggested the possibility of using provincial forms and processes to support this work. One important site for gathering information is at hospital admission. Here, mapping participants suggested that a clearer and more standardized process is needed to support Aboriginal self-identification at the time of admission.

4. Traveling for care

Leaving home for care is a common experience across northern BC. Patients travel short and long distances for many reasons. Depending on where they live, patients and those who accompany them might travel for emergency hospital visits, urgent care, complex procedures, to see a specialist physician, or even for wound care or bloodwork. Some travel alone, while others travel with escorts, family, or other individuals in their circle of support.

4.1 Strong relationships and good communication are important to successful travel

AHIC mapping participants said that when patient travel goes well, strong relationships and good communication have been behind those successes. APLs are very effective in doing this important work. At times where an APL is not involved, relationships and communication are still important. For example, physician signatures for use of the NH Connections bus service works smoothly when the Community Health Team and physicians have a strong relationship.

4.2 Strengthening understanding of travel needs across the health system

Overall, mapping participants agreed that strengthening understanding of patient travel needs across the health system would ensure smoother journeys for patients and their families and circles of support. One method suggested by mapping participants was to create a 'Travel Checklist' document that could help health care professionals and facilities to better understand how they can take into account each patient's travel needs.

AHIC patient journey and process maps helped to explain how important travel can be. For example a patient discharged from hospital might be able to make a short local trip home by car, but that same patient may not be well enough to make a longer, multi-step journey – one that could include first filling prescriptions for medications not available at home, followed by traveling by bus and then again by car.

Mapping participants made several other suggestions about how important it is to strengthen understanding of patient travel needs.

- When appointments are booked, consider the time needed to arrange for travel.
- Travel is sometimes required for patients to attend prenatal classes.
- More effective communication and information sharing between organizations (e.g., between BC Ambulance and community health centre) would improve travel, including timeliness of travel, especially for emergency travel to hospital.
- Timing is important for patients arriving at or being discharged or transferred from the hospital on the weekend. For example, accommodations for patient family or escorts can be difficult to navigate for a weekend arrival at the hospital.
- Weather, especially in winter, plays an important role in patient travel. Bad weather or poor road conditions can determine how a patient travels (for example by car, bus, or air) and how long it takes for the patient to arrive at their destination.
- It can be challenging to use the patient escort system. In some cases, health care professionals do not recognize that a patient needs an escort, funding for escorts may be limited, and there may be difficulty identifying an appropriate escort. (For further details on escort availability and role, see section 6.2 below).
- Families and other members of a patient's circle of support often travel to be with their loved one. But these journeys are not always easy for them to organize, and there is sometimes confusion about funding for travel.

- Some patients travel to Alberta or the Yukon to receive care and this can create additional challenges because of the different jurisdictions.
- Some patients must travel to update their Status Cards as part of their health care journey.
- Patients who have arrived by ambulance may not have a means to return home, and may not have adequate clothing or funds for the return journey.

4.3 Wayfinding for patients, families, and circles of support

An illness is stressful and challenging at the best of times, but being away from home can be even more difficult. Traveling patients, their families, and the other members of their circles of support could benefit from additional 'wayfinding' information to build their knowledge of 'what to expect' during the patient journey. Some mapping participants felt that Community Health Teams could share information with patients and families in advance of travel, while others suggested development of a written wayfinding tool containing maps, contact information, timelines, and information about what to do at arrival, while waiting, during appointments, and when departing for home.

4.4 Northern Health Connections bus services

The NH Connections bus services received attention in many mapping sessions. Several opportunities were identified to strengthen these services.

- Ensure patients, circles of support, and health care professionals have clear information about bus schedule and physician signature process. Where Community Health Representatives and physicians have strong relationships, signatures for travel can work quite smoothly.
- Collaborative work between Northern Health and other parts of the health system – including community health centres – is needed. Bus service and appointment scheduling can be difficult for patients to navigate, and access to bus services continues to be an issue for some communities.

4.5 Funding for travel

Mapping participants made several suggestions about the funding processes for medical travel in northern BC.

- Support patients, families, and circles of support to better understand travel voucher process. Confusion over this process can be difficult, and lead to missing documentation needed for later financial reconciliations.
- Help staff and patients alike to better understand the role of FNHA in travel funding.
- Investigate potential gaps in travel funding. Participants suggested that funds for use of own automobile do not adequately cover fuel costs and that some travel

situations (e.g., travel for fasting bloodwork) could provide funds for meals. Funding for an escort after birth and delivery is limited.

- Developing policies on securing funding could be beneficial to patient care journeys. (Some communities have or are working on these policies.)

4.6 Traveling and access to health services

Some mapping participants suggested that access to care in smaller communities could alleviate travel burden for some. For example, participants felt that having patients travel for routine wound care, lab blood draws, and physical or occupational therapy strained the community travel budget and could also be difficult for patients and their circles of support.

5. Access to care

Mapping participants identified a number of areas where access to care was important to their patient journey and process maps. Overall, participants observed variability in the type of services available across communities, and that remote communities have different access challenges as well as different opportunities for development of in-community resources and services. In some cases, access influenced how far and how often a patient must travel or how complex the patient's journey would be to navigate generally. In other cases – for example, where there is delayed access to the services of a tradesperson who can install a wheelchair ramp – a patient's discharge from hospital might be delayed.

Participants observed that enhancing access in the following areas would be beneficial:

- advocacy services, especially for Elders with no family or circle of support available;
- language interpretation services, both in hospitals and while receiving care in other settings away from home;
- family physician and specialist physician services in general (i.e., physician workforce issues having an influence on access to care);
- availability of 24/7 primary care services;
- in-community access to care of physicians, nurses, dietitians, physiotherapists, mental health professionals, etc.;
- in-community access to lab services;
- mental health assessments;
- mental health and addictions services (acute and long-term) in home community, including challenges with funding of services by population rather than need;
- pharmacy services, including better in-community access and access when a traveling patient is discharged after regular pharmacy hours;
- discharge planning services;



- appropriate housing, including physical accessibility supplies for homes (e.g., wheelchairs, ramps, bathroom accessibility equipment) as well as tradespeople able to install necessary equipment;
- timely transportation to receive emergency care, including ambulance services;
- timely access to Emergency Department care, specialist physician referrals, and follow-up care;
- more effective access to accommodation and related needs when travelling for care;
- telehealth;
- preventative care services (e.g., health education, self-management practices); and
- holistic care (i.e., care that endeavours to include considerations of the 'whole person').

5.1 Prevention

Access to preventative care programs and services emerged as a theme in the mapping discussions. Participants noted several areas where enhanced access to preventative programming and services would be beneficial, including diabetes prevention, nutrition, addictions, mental health, holistic healing, and traditional medicine.

5.2 The physician workforce and access to care

Mapping participants discussed the influence of the family physician and specialist physician workforce on access to care, noting that shortages of both types of physicians can mean longer waits for care and needing to travel in order to receive care from a physician. For example, if a family physician visits a community twice each week, then some patients will need to travel – sometimes to the nearest Emergency Department – in order to receive timely care.

6. Roles and training

Across AHICs, mapping participants indicated that health professionals in communities represented a key strength in the health system, from physicians who might visit a community twice each month to community health centre staff and home care providers. Participants also shared a focus on examining how the Aboriginal Patient Liaison and patient escort roles fit into patient journeys. Participants also observed a number of opportunities for further training across the health system.

6.1 Aboriginal Patient Liaisons (APLs) are providing valuable services

As discussed in 2.2 above, AHIC mapping participants agreed that APLs represent a great strength in the Northern Health system. Mapping participants saw opportunities to strengthen the APL role.

- Create an information sharing strategy to further support the work of APLs by developing a strategy for sharing patient information:
 - with APLs at the time of hospital admission;
 - between APLs when someone moves from one hospital to another; and
 - from APLs to Community Health Teams when people with complex care needs are returning home and will require family and/or community supports.
- Inform potential patients and others in the health system know about the geographic reach of APLs (for example, the APL in Fort St. John can provide services to Fort Nelson).
- Increase available time and access to APLs overall (for example, providing support with primary care appointments).

6.2 Availability and role of patient escort

Across the AHICs, mapping participants agreed that patient escorts are invaluable to supporting patients across their health care journeys. In some cases, escorts are not available when needed. In other cases, funding guidelines do not support an escort or there may not be room in available transportation for an escort to accompany a patient. Participants also observed that the escort role is sometimes not well-defined – for example, health professionals who do not fully understand the escort role may not identify that a patient could benefit from travelling with an escort. The patient escort role could perhaps be revisited to see if the scope of the escort role might include providing language support and/or patient advocacy. It was also suggested that it would be beneficial to create a process for identifying advocates who could work with teen patients – for example, young women receiving maternity care away from their home community. It was also suggested that training for escorts on how best to support a patient (e.g., in communication with health professionals, with coordination of care) would be beneficial.

6.3 Opportunities for training across the health system

Mapping participants identified a number of opportunities for further training across the health system. Suggested training topics included:

- culturally relevant and culturally safe care;
- community resources available for Aboriginal populations, including urban Aboriginal populations;
- resources that are available in communities, and scope of practice for community nursing;
- trauma-informed practice (to inform providers how best to support the needs of people who have experienced trauma);

- end of life support in community settings, including advanced directives and “do not resuscitate” (DNR);
- mental health and addictions for community-based professionals, including first responders, justice workers, nurses, families and others (to better understand mental health and addictions, how best to support the patient, and how to reduce stigma); and
- mental health and addictions for Emergency department staff and mental health and addictions professionals (to help them better understand the realities Aboriginal mental health and addictions patients face, what resources are available in each community, and information on accessing funds for care when a patient is outside of reserve).

CONCLUSION

The AHIC mapping projects completed across northern BC between July 2014 and July 2015 represent the voices of community and of the members who make up the eight AHICs in the Northeast, Northern Interior, and Northwest. Patient journey and process maps are an opportunity for communities to bring their voice into the health care system and identify opportunities for change in health services – as well as to identify local solutions and concrete actions that can be taken at the local level. Each mapping report, and the reports summarized together, include observations and analysis pointing to many concrete actions.

This report articulates where these next steps might lead. There are numerous avenues to pursue that can contribute in meaningful ways to health services that better serve First Nations, Métis, and Inuit people within their contexts, communities, and realities.



Aboriginal Health
600 - 299 Victoria Street
Prince George, BC V2L 5B8
T 250-649-7226 | F 250-565-2640
aboriginal.health@northernhealth.ca
www.northernhealth.ca



© 2015 Northern Health. This publication may be reproduced for non-commercial use, in full or in part, without permission provided the source is fully acknowledged.

Recommended citation: Aboriginal Health. (2015). *Aboriginal Health Improvement Committees: Mapping Summary Report*. Prince George, BC: Northern Health.

This document is available online at www.northernhealth.ca/yourhealth/aboriginalhealth.aspx

Photo credits:

Cover "Glow On The Falls" (near Atlin, BC) by Lyndsay Esson is licensed under CC BY-SA 2.0: www.flickr.com/photos/98198789@N02/11019842284
P.3 "Falling for Colour" (near Atlin, BC) by Lyndsay Esson is licensed under CC BY-SA 2.0: www.flickr.com/photos/98198789@N02/11019705815
P.4-5 "Dragonfly in Flight" (near Atlin, BC) by Lyndsay Esson is licensed under CC BY-SA 2.0: www.flickr.com/photos/98198789@N02/11019714565
P.6 "Water drops lined up" (near Terrace, BC) by miguelb is licensed under CC BY 2.0: www.flickr.com/photos/mig/173660926
P.8 "Weathered and mossy cedar at the entrance to Gitanmaax School of Northwest Coast Indian Art at 'Ksan Historical Village, Gitanmaax, Hazelton BC" by Brodie Guy is licensed under CC BY-NC-ND 2.0: www.flickr.com/photos/brodieguy/7103871961
P.10-11 "The Afternoon Glow" (near Atlin, BC) by Lyndsay Esson is licensed under CC BY-SA 2.0: www.flickr.com/photos/98198789@N02/11828406195
P.14-15 "Basketwork Piece, Northwest Coast" by A.Davey is licensed under CC BY 2.0: www.flickr.com/photos/adavey/2609806414

10-307-6026 (IND09/15)