

KITIKMEOT
HEALTH AND SOCIAL SERVICES BOARD

STRATEGIC BUSINESS PLAN

Draft

Draft

Rob Johnson

1998 01 30

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1.0 INTRODUCTION

1.1 Introduction

The Kitikmeot Regional Health Board was established as one of eight Regional Health Boards in 1988 when all Federal insured health care services and administration of Federal non-insured health care services were transferred to the Government of the Northwest Territories. The Territorial Government assumed its full constitutional responsibility for health care and is now on an equal footing with the provinces. Under the Territorial Government, The Kitikmeot Regional Health Board assumed responsibility for providing the following services in the Kitikmeot region:

- A full range of community and public health services
- Health promotion programs
- Environmental health services
- Emergency preparedness program
- Visiting medical specialists program
- Non-insured services
 - Vision
 - Hearing aids
 - Pharmacare benefits
- Long term care placements
- Dental Services
- Psychiatric placements
- Medical transportation program
- Health Centers (6) (Nursing Stations)
- A patient boarding home in Yellowknife

In 1996 Health Care Service and Social Service departments were amalgamated into one entity in the Northwest Territories. The Kitikmeot Regional Health and Social Services Board was appointed to provide combined services in the Kitikmeot Region. On appointment, the immediate challenges to the Board were to continue to provide quality health and social services while integrating internal departments and developing a new operating structure for the Community Health Centers.

During the first year, the Board concentrated much of their efforts on staffing, organization and creating an operational business plan that integrated numerous programs, systems and resources. The organization structure and staffing for the structure has been achieved, and a business plan to guide the first year of operations implemented. Co-location of resources and a new service model has been developed and put in place in Kugluktuk. The challenge now heading into the second year is to implement the strategies in the Departmental Health and Social Services Business Plan and the further integration of more focused services and achievement of greater efficiencies to meet the needs of our clients.

The Northwest Territories Department of Health and Social Services has completed a 1998/99 - 2000/01 Business Plan. Now each Regional Health and Social Services Board must also develop a strategic and tactical business plan within the framework of the Departmental plan. The Boards must be in alignment with the philosophies, principles, directions and fiscal goals described in the Departmental plan.

The pace of change in health care and social services has been rapid and the pace of this change has created uncertainty and apprehension for some. The Board acknowledges that future change must be

made in a logical, timely and effective manner. This Business Plan outlines a three year, staged plan to provide effective programs while meeting fiscal objectives and address various strategies related to developing partnerships with the community and other health related agencies and groups in affecting future program and service change. The approaches and solutions put forward in this plan of the Kitikmeot Regional Health and Social Services Board also address the fundamental issues and challenges in the Departmental plan.

1.2 Governance Structure

The Kitikmeot Regional Health and Social Services Board is comprised of eight Trustees, one of whom is Chair. The Chair is named at the Pleasure of the Minister, while Members are appointed by the Minister. The initial Board Trustees were appointed in July of 1996 and were mandated to restructure the governance and organizational structures in the Region consistent with Territorial wide restructuring of the Health Care and Social Services system. Members of the Board are a diverse group of individuals who reside throughout the Region, have a demonstrated understanding on health and social issues, a commitment the health and social restructuring and a history of volunteering their time and knowledge to community initiatives. The existing Board has the following members:

• Sharon Ehaloak	Chair	Cambridge Bay
• Robert Kuptana	Member	Holman
• Raymond Kayasark	Member	Pelly Bay
• Peter Kamingoak	Member	K.I.A.
• Attima Hadlari	Member	Cambridge Bay
• Ralph Porter	Member	Gjoa Haven
• Mary Harvey	Member (Awaiting Appointment)	Kugliktuk
• Mona Igutsaq	Member (Awaiting Appointment)	Taloyoak

1.3 Management Structure

Kitikmeot Regional Health and Social Services Board is comprised administratively of six Community Health Centers and a Regional Headquarters. The Board has appointed in accordance with Policies, an Executive Director who is responsible for the total organization. Reporting directly to the Executive Director are an Executive Assistant, a Manager of Personnel, a Manager of Finance and Administration, a Manager of Health Programs and a Manager of Social Programs. Reporting to this senior management group in Headquarters are a Staff Recruitment Officer, a Health Promotion Officer, a Purchasing Officer, a Regional Corrections Officer, an Environmental Health Officer, a Staffing Officer, a Finance Officer, a Personnel and Administration Assistant, a Payroll and Benefits Clerk and Administration clerks. Reporting to the Managers of Health Programs and Social Programs from Community Health Centers in the Region are Supervisors of Nurses and Supervisors of Social Workers.

1.4 Community Health Centers Organization

Each of the six Community Health Centers has a Supervisor of Nurses and a Supervisor of Social Workers. Depending on the size of the community the Community Health Representative and varying numbers of Nurses, Social Workers, Receptionists, Clerks and Janitorial staff report to the respective Supervisors. In the future, Homecare workers will be co-located in and supervised through staff at the Community Health Centers.

1.5 Critical Issues And Strategies Impacting On This Plan

1.5.1 Rapid Population Growth

Rapid population growth and environmental damage fuels a growing demand for health programs and social services. Over thirty percent of the population is under the age of fifteen and the birth rate is twice the national average. Issues such as extensive unemployment, serious shelter problems and crime rates are symptoms of pressures that are created by the growth of our population. Throughout their developing years, our children need to be safe, to remain healthy and be cared for if they are to become productive members of tomorrow's society.

1.5.2 Life Styles and Values

The demand for programs and services is not simply a result of population growth. Too many babies are damaged by their mother's use of alcohol and tobacco. Too many infants and children are injured or die through accidents. Too many adolescents begin life-long addictions to tobacco and put themselves at risk for sexually transmitted diseases. Too many adults compromise health and well-being with alcohol abuse and family violence. These, and similar health and social issues, suggest that people need to learn new, or return to old, ways to care for their personal and family health and well-being. There is a need for everyone – service providers, planners, administrators, and the public at large – to examine their beliefs and review their priorities.

1.5.3 Appropriate Investment In Our Future (Together)

The Department of Health and Social Services has directed funds toward providing some of the best health care services available, yet the overall wellness of residents does not reflect the magnitude of this investment. There may once have been a common view that good health could be achieved through the purchase of more services and better technology, and that social wellness could be found by providing financial supports. However, it is becoming increasingly clear that solutions to the many health and social challenges faced by individuals, families and society must also emerge from within communities themselves. With finite resources, the pursuit of prevention through multiple levels of partnership is not only desirable, but essential.

1.5.4 Prevention vs Treatment Issues

It is estimated that the Department of Health and Social Services, and its Boards, spend twenty percent of its budget on health promotion, prevention and early intervention activities, and eighty percent on treatment and other forms of diagnosis, care and rehabilitation. If a system could be developed in which these proportions were reversed, the well-being of our population would be vastly improved. However, this is not a simple shift as population health affects our spending more than our spending affects population health. Shifting the expenditure pattern will require a focussed, deliberate and sustained effort by residents as stakeholders in their future. Tough decisions based on a balanced approach of sound analysis in concert with compassion are needed to determine where best to allocate funds.

1.5.5 Reforms Within The Health And Social Service Sectors

In the 1997/98 business plan, the Department outlined a number of initiatives directed toward reforming selected programs within the health and social sectors. Included were reforms to addiction programs to support the needs of people with addictions in the community and revisions to chronic care programs to foster greater home support services and decrease the need for institutional care. Implementation of these initiatives is ongoing.

The Department is committed to a more preventive, population-based approach to health and social services and is positioned to move forward with the development of expected outcomes across broad programs and services within its mandate, and with partner. The Department has also committed to further enhance the quality of programs and services. Toward this end, specific attention will be directed towards development of program and service standards, with direct linkages to outcomes.

1.5.6 Community Development Through Integration And Partnership

The Government has set a vision for the future to establish political and economic viability of the territories and to ensure financial security with healthier, better-educated and more self-reliant residents who have access to more jobs. While good progress can be made toward this, full realization of this vision will require a sustained, strategic, strategic approach.

Coordinated action, with a dedicated and co-operative effort across the entire socio-economic spectrum is necessary to achieve this vision. Creation of new strategic alliances, linking fiscal, social and economic initiatives will involve forging new (and renewed) partnerships between and among government, non-government and private sector organizations. As a partner in the social envelop, the Department of Health and Social Services will continue to support and foster the community empowerment initiative, helping communities to become more self-directed. Jointly with the Department of Education, Culture and Employment, and others, the Department of Health and Social Services will assist communities in their actions to implement the Healthy Children initiative.

The Department will also continue to help regional and community boards to assume greater responsibility for health programs and social services, through the development of a Memorandum of Understanding and by providing an equitable and secure funding base through a Funding Allocation Formula.

2.0 Visions Missions Principles Values

2.1 Visions

2.1.1 The Government of Northwest Territories Vision

A healthier, better educated and more self-reliant citizenry, able to enjoy a good quality of life.

2.1.2 The Department of Health and Social Services Vision

That our children will be born healthy, and raised in a safe family and community environment which supports them in leading long, productive and happy lives.

2.1.3 The Kitikmeot Health and Social Services Board Vision

That our children will be born healthy, raised in a safe environment which supports them in leading long mentally and physically productive, happy lives.

2.2 Missions

2.2.1 The Department of Health and Social Services Mission

To promote, maintain and enhance the health and well being of individuals and families.

2.2.2 The Kitikmeot Health and Social Services Board Mission

Healthy communities that respect peoples values

We will promote and enhance the quality of life for the people of the Kitikmeot by providing excellent health care and social programs.

2.3 Principles

2.3.1 Department Health and Social Services Principles

- The development of health lifestyles is a shared responsibility of individuals, communities, government and non-government health and social service organizations and others;
- Programs and services should be integrated and coordinated to allow for the most efficient and effective utilization of resources at the community, regional and territorial levels;
- Programs and services should respect people's rights to dignity, privacy and confidentiality;
- Residents of Northwest Territories must be eligible for benefits under the Northwest Territories health care system anywhere in Canada, and outside Canada under certain conditions;
- Health programs and services must exhibit the Canada Health Act principles of comprehensiveness, universality, portability and accessibility.

2.3.2 The Kitikmeot Health and Social Services Board Principles

*Have in place Results Policies that answer the questions:
What good ? For what People ? At what cost ?*

2.4 The Kitikmeot Health and Social Services Board Values

<i>The Board will provide direction</i>	Honestly, with integrity, in a professional manner
<i>The Board will be accountable</i>	Proactive and responsive to Kitikmeot Region needs
<i>Cultural sensitivity</i>	To be aware of the cultural diversity within the community and honor the differences.
<i>Quality of service</i>	The responsible investment and management of people and resources to provide health care and social services to meet and where possible exceed the wellness needs of the people of Kitikmeot.
<i>Respect</i>	To acknowledge the values of others and honor the differences.
<i>Knowledge & growth</i> for	To have acknowledgment of one's ability to live and provide family and community
<i>Fostering independence</i>	To use one's own independent skill of self-reliance rather than on the programmed dependence of others for existence.
<i>Wellness</i>	To recognize and accept one's own health as a responsibility to themselves and as a gift to others.

3.0 Client Services Programs

3.1 Overview

3.1.1 Background

The Kitikmeot Health and Social Services Board is capable of meeting the majority of the population's health and social needs within the Region. To accommodate needs which are not provided in the Region and to ensure a full range of health services, the Kitikmeot Health and Social Services Board has agreements with Stanton in Yellowknife and numerous agencies and facilities in Alberta and other provinces.

The Kitikmeot Health and Social Services Board is committed to maintaining and enhancing current programs where appropriate, and to develop new or alternative programs as justified by population and need. The challenge is to achieve this commitment while meeting the aggressive fiscal plans and strategic directions of the Department of Health and Social Services.

During the past year, the Kitikmeot Health and Social Services Board has completed the first phase of amalgamation of Health and Social Services into an integrated, service unit. Many of the change initiatives were relative to changes in the governance, staff responsibilities, administration, shared systems and co-location. As well, a model for co-location and expanded clients service was developed in Kugluktuk. Phase II will focus primarily on delivery and implementation programs and services.

3.1.2 Treatment vs Prevention

A great deal of emphasis in the future will appropriately be focused on prevention . In describing our programs, we have attempted to define what portion of each program is treatment and what portion is prevention. In order to implement change initiatives to more clearly focus on prevention, we understand that there are three levels of prevention and that each level will require its own strategy. Those levels are:

- Health promotion
- Disease prevention
- Preventative, restorative, rehabilitative and supportive care

In addition, we will endeavor to work with other public and private agencies to look at the greater picture and how life styles, values, a vision for the future and greater levels of personal accountability for health and wellness are critical in achieving significant improvements in prevention.

3.2 Our Clients

The Kitikmeot Health and Social Services Board serves a multitude of individual, family, organizations, agencies and municipal clients in the Kitikmeot Region. They include:

3.2.1 Families

- Single Parents
- Adoptive Families
- Foster Parents
- Families In Crisis
- Kids In Need
- Teenagers In Crisis
- Children In Need Of Protection
- Women

3.2.2 Individuals

- People With Addictions
- People Needing Counseling (Mental Health Issues)
- Jobless
- People With Losses (Grief)
- Dead People
- Homeless
- People In Crisis
- Residents, Tourists
- Victims Of Violence
- Sick People
- Abused People

3.2.3 Community

- Hamlet and Hamlet Employees
- Elders and Elders Groups
- Community Residents
- Church
- Awareness Center
- Women's Groups
- Youth Groups

3.2.4 Other Agencies

- Laboratories
- Hospital Staff
- Stanton Regional Hospital
- Visiting Physicians
- Media

3.2.5 Schools

- Students
- School Counselors
- Teachers
- Elementary Schools
- High Schools
- Nunavut Arctic College

3.2.6 Justice

- Non-Convicted Criminals
- Criminals (Convicted)
- Inmates
- Court Party
- The Court System

3.2.7 Government Organizations

- Government of Northwest Territories
- Royal Canadian Mounted Police
- Public Servants
- Coroner

3.3 Promotion of Health and Prevention of Illness and Injury

Fundamental to a re-orientation of our system towards health and well being are enhanced health promotion and prevention of illness and injury programs. Health promotion and injury/illness prevention largely focus on enabling people to increase controls over and improve their health and well being. This is achieved through a combination of strategies involving health and social education, protection measures, risk factor detection, health and well being enhancement and maintenance. These strategies will be developed with input from Regional and external health and social services providers (physicians, nurses, dentists, RCMP, Justice, etc.) who maintain a key role in health promotion and injury/illness prevention.

3.3.1 Birth and Parenting Services

Nurses from each community provide a continuum of service to support families pre and post baby delivery. This includes physical assessment of mother and baby, suture and cord clamp removal as well as counseling on breasts feeding, infant development and coping skills. While nurses provide pre-natal and post-partum services, Community Health Representatives do Denver testing to detect unusual and atypical development and do at least one postnatal visit as a follow up.

Treatment: 20%

Prevention: 80%

Barriers:

- Postnatal visits are not happening
- Denver testing is given low priority and done outside of preferred testing period
- Poor parenting skills in high risk, or marginalized or young mother families

Strategies:

- Bring in elders and other interested people to assist with delivering programs and answering questions
- Involve community wellness centers in developing a strategy to address FAS and FAE and to better utilize and coordinate existing services in the community
- Increased involvement of home care people to promote healthy and safe parenting including effective nutrition, infant stimulation and home management practices

3.3.2 Family Health

This program assists in strengthening individual and family support systems through a partnership with the health care system works to promote optimal health and wellness. Client needs are assessed and they are linked with appropriate resources. Identification of gaps in available support is important to the development of this service. Staff at Community Health and Social Services Centres focus on:

- Prenatal Education
- Risk Family Follow-Up
- Hospital Liaison
- Telephone Counseling Service
- Post-partum Support
- Well Child Clinics
- Immunization

Treatment: 0%

Prevention: 100%

Barriers:

- Everything is done at the center instead of conducting parts of program at other facilities.
- Time and resources to do the program/s
- Non-compliance issues
- Services mostly outside the home

Strategies:

- Support the Nobody's Perfect program
- Involve community wellness centers in developing a strategy to address health and to better utilize and coordinate existing services in the community
- Take a more holistic view of family and related medical and social needs to address the larger picture of lifestyles and awareness

3.3.3 Oral Health

The Dental Health Program emphasizes dental disease prevention and optimum oral health. Dental hygienists located in the schools provide a Regional service including oral assessments, screening, dental health education, dental health promotion and the fluoride program. The public health dental program aims to develop the knowledge, skills, and attitudes for good oral health for a lifetime.

Treatment: 40 %

Prevention: 60%

Barriers:

- They are always in the school and not visible in the Community Health Centers. Don't participate much in other programs
- Limited or no pre-school or well baby program
- Minimum contact with parents who buy pop, candy, chips, etc.

Strategies:

- Develop job definitions for position
- Encourage participation in pre-school or well baby program
- Involve dental therapists in a planning session to formalize their programs, expand their effectiveness
- Become involved in community activities to promote programs and services and increase public awareness
- Use visible (hands on) models vs pictures to demonstrate appropriate methods and procedures

3.3.4 School Health

Community Health Nurses assist children and youth (5-19), their families, teachers and communities by providing a program for immunization, TB testing and communicable disease control. Consultation and health education programs meet the needs of students, parents, and school staff by focusing on illness and injury prevention and health promotion.

Treatment: 0%

Prevention: 100%

Barriers:

- Time issues to free up nurse ½ day a week
- No dialogue between school and nurses

Strategies:

- Build school health program as deliverable into Community Health Representative job and Schedule as a regular event
- Involve Center staff in school year planning including planning for suicide prevention (positive reinforcement and hope vs despair)

3.3.5 Pre School Health Program

The program provides education, counseling and diagnostic services related to birth defects, hereditary diseases, physical and learning disabilities. The goal of this program is to provide early warning and provide support, counseling, and follow-up to families with children with physical development delays and physical or learning needs.

Treatment: 50%

Prevention: 50%

Barriers:

- There are many pre-school children with diagnosed disabilities
- Lack of specialized personnel in Region
- Not sharing information with school system

Strategies:

- Develop a plan to share pre-school program information with other agencies and educational institutions for all ages between 1 and 5 years
- Conduct case conferences with health and social services center staff and visiting specialists to coordinate treatment, planning and application

3.3.6 Emotional Crisis Intervention

Center staff provides a 24-hour on call service. As well, there is a 1 800 number to Yellowknife for counseling. A pilot crisis response team project is up and running in Gjoa Haven. This team can mobilize in 45 minutes to provide comprehensive support for 48 hours. This model will be replicated in other communities.

Treatment: 50%

Prevention: 50%

Barriers:

- Few are trained to handle crisis intervention for the many people that are in crisis
- Not all communities have a crisis intervention plan or process or group in place
- Clients and staff not aware or sensitive to the emotional and physical strain on center personnel who are involved in crisis intervention
- Confidentiality or trust is an issue when volunteers are involved
- A reactive response

Strategies

- Develop a good communication plan to inform public when/how to access/utilize on-call services
- Develop the Gjoa Haven crisis intervention model; then standardize and implement in other communities
- Review strategies on mental health for preventative measures

3.3.7 Nutritional Health

The Public Health Nutrition Program aids the development of knowledge, skills and attitudes necessary to make healthy food choices. Community Health Representatives and a Regional Nutritionist provide leadership, education and direction for community nutrition programs in the Region.

Treatment: 20%

Prevention: 80%

Barriers:

- Lack of community education about healthy food choices
- Additional training required for some staff and community members
- Regional nutritionists visits are infrequent and do not cover entire Region

Strategies:

- Regional nutritionist or other qualified professional to provide nutrition training to staff
- Review visiting schedule timing, location, numbers to be met and set up according to needs

3.3.8 Sexual and Reproductive Health

The program aims to ensure individuals at all life stages have an understanding of sexual growth and development, skills for healthy decision making, and positive relationships. This is accomplished through education, consultation and clinical counseling services. This program will be put in place within this three-year business plan.

Treatment: 0%

Prevention: 100%

Barriers:

- Lack of training for social workers, community health representatives and nurses
- Information given to caregivers and community not adequate
- Access to condoms and other means of birth control and prophylaxis is not universally user friendly
- Substance abuse results in poor decisions and unhealthiness regarding partners, prevention and disease
- Difficulty in changing attitudes and life styles
- Reluctance to discuss publicly

Strategies:

- Develop a strategy for better access to and usage of condoms
- Develop a training plan, then resource and implement
- Promote more proactively in public meetings, Nunavut Arctic College and schools the standard prevention program

3.3.9 Prevention of Chronic Disease

The Chronic Disease program is presently treatment oriented. In the future, prevention will become a greater focus aimed at improving knowledge of heart health and other chronic issues and by addressing risk factors in adults through identifying behavior and lifestyle factors.

Treatment: 70%

Prevention: 30%

Barriers:

- Addictions to tobacco, alcohol and drugs are difficult to deal with and contribute to chronic disease

- Difficulty in changing attitudes and lifestyles

Strategies:

- Work with community groups and wellness centers to increase profile of addictions and poor life styles chronic disease as they it relate to chronic disease
- Develop early prevention programs and work more closely with Nunavut Arctic College and schools

3.3.10 Wellness Program - Injury Prevention/Alcohol & Addiction

This program aims to strengthen public understanding about what makes us healthy and the need for public participation in health action. It also aims to enable communities to take responsibility for their health and create supportive environments by encouraging positive changes in health behaviors. Of particular focus is alcohol and addiction.

Treatment: 50%

Prevention: 50%

Barriers:

- Addictions are usually symptomatic of other trauma
- Long standing practice is to cope with stressful issues by using alcohol and drugs
- Community members do not take responsibility for themselves or others e.g. reporting drunk drivers

Strategies:

- Increase frequency of healing workshops in Region
- Provide an education program for coping skills and publicize through Health & Social Services staff and clinics
- Encourage individuals to make responsible decisions regarding themselves and others
- Campaign with other agencies – RCMP, Schools, GNWT

3.3.11 Well Woman Program

The Kitikmeot Health and Social Services Board collaborates with other community agencies to provide a variety of educational programs to the public focusing on women's health. Each year every woman over the age of 16, or those under 16 years that are sexually active, in the community receives a physical examination. The examination includes breast screening, blood work, weight and counseling.

Treatment: 20%

Prevention: 80%

Barriers:

- Not reaching some clients in need (younger teens)
- Presume provisions of Act dealing with Sexual issues is known by staff
- Individuals who do not take responsibility for their own health care
- Difficulties in reaching younger women

Strategies:

- Set up clinics in the schools
- Implement an awareness program targeted at younger women
- Promote self-health care in the community

3.3.12 Well Man Program

There is no formal Well Man Program to date. Men are encouraged to come in to be examined. Future plans call for more focus in this area to formalize a program for men.

Treatment: 20%

Prevention: 80%

Barriers:

- Men have not been conditioned to seek health care or social services
- Men's macho image and egos prevent them from coming in until they are really suffering

Strategies:

- Develop a program oriented to encourage men e.g. off-site clinics
- Develop a promotional program that explains benefits of health and mental care and make them appealing to men

3.3.13 Family Support

Through special project initiatives, funding is provided to communities who decide what they will focus on for family support. Center staff works collaboratively with community partners to foster the development and provision of family support. A portion of these funds is dedicated to critical incident stress debriefing.

Treatment: 10%

Prevention: 90%

Barriers:

- Baseline data for analysis and planning is insufficient
- Staff don't have time to run a lot of programs or projects
- Reporting procedures complex in some grants
- Unemployment is a major cause of family dysfunction
- Funding sources are not flexible
- Communities reluctant to take on leadership and ownership of programs and projects

Strategies:

- Development of community profile in each community (Review and update regularly)
- Include adequate staffing support and training requirements in funding proposals to better meet the needs of the community
- Make Grant Reports simple and user friendly
- Transfer, gradually as appropriate, ownership and leadership of projects and programs over to the community

3.4 Control of Communicable Disease

The aim of communicable disease control activities is to prevent and control the spread of communicable diseases, including AIDS/HIV and tuberculosis. This is achieved through reporting, surveillance, treatment and follow-up systems; public and professional education; consultation to physicians and other health care workers. Health and Social Services Center staff in each community carries out communicable disease control activities. Activities and efforts are also coordinated through the Regional Environmental Health Officer.

3.4.1 Notification

An essential component of Communicable Disease Control is notification community health staff by physicians, labs, etc., of certain diseases. This triggers follow-up activities including contact tracing and provision of education, chemoprophylaxis and/or immunization of contacts of those diseases. Notifiable Disease Reports forwarded to the Regional Environmental Health Officer and contribute to territorial surveillance activities.

Treatment: 20%

Prevention: 80%

Barriers:

- CDC must notify H&SS Center staff quickly
- Response plan must be known by all appropriate staff and public officials
- Effective lines of communication must be in place
- No contingency plans in place

Strategies:

- More staff required to respond to issues
- Develop an Emergency Procedures Manual for the Region
- Ensure staff know roles and responsibilities and are aware of communications plans
- Develop a contingency plan for Community Health Center for emergency situations

3.4.2 Immunization and Screening

Public programs centre on childhood immunization against Diphtheria, Pertussis, Tetanus, Polio, Haemophilus, influenza type B, Measles, Mumps, Pneumonia, Rubella and Hepatitis B. Monitoring and reporting on vaccine-preventable disease activity, immunization coverage rates, adverse reactions, and vaccine utilization is undertaken. Adult immunization programs are strongly encouraged, including annual Influenza vaccination for elders and high risk clients. Immunization and counseling on health risks for travelers and overseas workers is carried out on a cost-recovery basis and clients may be referred to private physicians for travel-related health problems.

Screening and diagnostic testing for tuberculosis, contact tracing, chemoprophylactic or chemotherapeutic treatment of cases or contacts is carried out through Community Health staff. Prenatal screening for Hepatitis B is monitored and follow-up of contacts with immunization and blood work is done to identify disease and/or confirm immunity.

Treatment: 25%

Prevention: 75%

Barriers:

- Mobility of clients may interrupt immunization and contact tracing
- Some clients are concerned about confidentiality when reporting contacts
- Time and resources for contact tracing
- Public awareness

Strategies:

- Ensure staff is aware of client mobility
- Put Welcom system in place to standardize patient needs and history
- Increase public awareness of screening and immunization issues

3.4.3 Treatment

Chernoprophylaxis of contacts of communicable diseases such as TB or meningococcal infection is common; treatment for TB is provided free of charge. The Kitikmeot Health and Social Services Board currently provides treatment for sexually transmitted disease. Community Health Centers will be encouraged to set up Teen Clinics to better serve their specific needs; especially with sexually transmitted diseases.

Treatment: 50%

Prevention: 50%

Barriers:

- Some patients will not comply with taking medication or with follow up
- Lack of awareness of these diseases
- Time and resources required for contact tracing

Strategies

- Conduct one on one teaching by Community Health Center staff to increase public awareness of sexually transmitted diseases, meningococcal infection and tuberculosis
- Use local radio and other available media to provide awareness messages to community

3.4.4 Selective Testing

When necessary to confirm a diagnosis (e.g. measles or hepatitis A) testing of some suspected cases can be carried out by Community Health staff. Community health nurses or public health inspectors may carry out specific outbreak investigations.

Treatment: 0%

Prevention: 100%

Barriers:

- Diagnosis may be delayed due to lack of awareness of Health personnel and community

Strategies

- Use various methods to increase awareness of Health staff and community

3.4.5 Consultation and Public Education

Consultation and education through signs posted in the community and radio announcements contribute to the control of communicable disease. Public relations are important by providing information and advice to the general public through the media. Center staff in each community regularly attends community meetings and participates on inter-agency committees to provide information and education.

Treatment: 0%

Prevention: 100%

Barriers:

- Media accessibility
- Continued participation in inter-agency initiatives
- Written information not as effective in Inuit culture
- Targeting wrong age groups
- Cultural beliefs and behaviors may block healthy attitudes and behaviors
- Not enough hands on education

Strategies:

- Explore new ways for message delivery e.g. Internet
- Use and knowledge of free media opportunities
- Meetings – regular, specific agenda items, discussion related to measurable outcomes
- Community groups – schools, guest speakers, home made videos, traditional story telling
- Keep aware of trends and epidemiology in order to target appropriate age groups regarding prevention issues
- Health care providers must be able to change attitudes and behaviors and be sensitive to past cultural beliefs and behaviors
- Education must be visually demonstrated as well as written

Draft

3.5 Environmental Health Hazards Protection

Environmental Health Services strive to protect human health through prevention, correction or control of physical, chemical and biological environmental conditions. Program activities are mandated by the Health Act. Public Health Inspectors are organized in a Regional program and work closely with the Medical Officer of Health.

3.5.1 Monitoring and Inspection

Monitoring of food preparation and distribution at public facilities, recreational facilities, personal service facilities and institutions, as well as the development and operation of solid waste management facilities comprise the bulk of the current workload. Inspection services utilize screening and assessment processes and focus on public facilities, the review of waste management and project development. A priority ranking system ensures that complaints with greatest impact are dealt with first.

Treatment: 10%

Prevention: 90%

Barriers:

- Lack of community understanding and/or compliance with Public Health Act including safe food preparation, etc.
- Lack of cooperation or reluctance if costs are involved
- Traditional practices vs contemporary practices

Strategies

- Enhance and promote public education programs regarding safe and unsafe practices
- Encourage compliance through education and enforce penalties if required

3.5.2 Hazard Analysis and Assessment

Investigations often include determination of the source and health effects environmental conditions and enteric communicable diseases before the institution of control measures. Priority is given to those situations where there are agents with significant health effects and public concern. Many investigations require input or coordination with other agencies.

Treatment: 50%

Prevention: 50%

Barriers:

- Not keeping abreast of trends and data analyses
- Non-compliance of enforcing agencies e.g. Hamlets responsible for rabies vaccination

Strategies

- Develop consistent data collection and monitoring program and ensure compliance
- Enhance linkage between communities and Environmental Health Officer
- Report suspected cases immediately

3.5.3 Consultation and Public Education

The Environmental Health Officer provides consultation on environmental health matters to individuals and groups. Information on public health concerns is available on request and specifically targeted

information may be disseminated (e.g. seasonal messages on food handling). Education, counseling and advice to the public on a variety of environmental issues such as indoor air quality, proper food handling practices, water supplies, institutional environments and waste material represent a significant proportion of services delivered.

Treatment: 0%

Prevention: 100%

Barriers:

- Traditional practices vs healthy, approved methods
- Lack of proper handling and storage of traditional foods
- Public Health Act and Environmental Health Act are in conflict regarding burning of land fill waste
- Industry and environmental people are not consulting with people who know about traditional land use

Strategies

- Develop a video in all languages regarding the proper storage and handling of traditional food
- Consult Environmental Health Office regarding the design of homes and public buildings
- Address environmental issues in a more cooperative spirit
- Encourage land users to participate in the planning process regarding environmental health issues

3.5.4 Data Collection

Data on types of contacts is routinely gathered and reported to allow review of the activities undertaken over the course of the year. Information is maintained on permitted and inspected facilities. The Public Health Act provides for the gathering of relevant environmental health information through a hearing process in some instances.

Treatment: 0%

Prevention: 100%

Barriers:

- Expense of traveling in the Region
- Follow up on inspections are limited
- Only one Environmental Health Officer
- Communities not familiar with Public Health Act

Strategies

- Allocate more funds for this program
- Charge backs to users of the data
- Train local people to educate and perform some inspections
- Explain Public Health Act to key community people

3.5.5 Enforcement

When necessary, under the authority of the Public Health Act, The Environmental Health Officer or Board staff may issue orders to assist in the correction of problem situations. Every effort is used to ensure that such legal measures are taken only as a last resort

Treatment: 50%

Prevention: 50%

Barriers:

- Due to the size of the Region, the Environmental Health Officer cannot do adequate inspection or follow up to ensure compliance
- Enforcement may become political, putting enforcement officer in the middle
- Rarely enforced because no official continuously on site to enforce
- Enforcement can become a race issue with aboriginal ventures
- Education vs enforcement an issue

Strategies

- Have officials spend more time in communities
- Consistent application of the Public Health Act
- Processes or mechanisms put in place to ensure follow through
- More involvement with the schools and community groups to discuss issues involving the Public Health Act

Draft

3.6 Home Care and Support

The Kitikmeot Home Care Program has been developed with focus on both treatment and prevention to provide an array of professional health care, social care, personal care, home support and respite care services to assist clients to live in the community. Services are provided in five areas of direct community support:

- Personal Care
- Socialization
- Early Childhood Development
- Home Management
- Basic Counseling

Since 1995, community support workers have been trained in each of the six primary Kitikmeot communities. These community members are graduates of a special Nunavut Arctic College CSW 6-8 month program. They encourage client independence, contribute to client welfare and participate in a team approach with the Community Health Center to help improve and promote community wellness. This is done while maintaining standards of personal conduct such as caring, respect, reliability, honesty and confidentiality.

The positive integration of home care services with health care and social services is achieved through linkage with all Community Health Center staff, particularly the Community Health Representative. The CHR may in some cases supervise the community support workers and the program. Referrals can be made by family members, through the Community Health Center or through external agencies such as Wellness and Elders Centers, Schools, and the RCMP.

3.6.1 Case Coordination

Home Care and Support is the process whereby a Community Health Center staff professional, in partnership with the client, identifies, mobilizes and coordinates those supports which are available and appropriate to promote the client's independence, health and well being. The client's ability to function independently in the community by drawing on information related to the client's physical, psychological, emotional, social and spiritual strengths and needs is assessed. The client's existing informal resources are an integral component of the assessment. Then the Case Coordinator, in partnership with the client, develops a plan for the provision of coordinated health and support services. The plan reflects the coordination of activities of all service providers whether they are family, friends, Home Care, physicians and other health and social services professionals, community agencies or self-help groups.

For rehabilitation needs, Stanton Regional Hospital presently does assessments. In the future a complete rehabilitation, physical and occupational therapy program will be implemented that enables and supports clients with rehabilitation needs to enhance their quality of life at home through daily living activities. The program is designed to improve access for ambulatory clients living in the community who have a high need for rehabilitation through physical therapy, speech, language pathology, occupational therapy, respiratory therapy and/or audiology. Treatment priority is based on assessed degree of need. Service delivery may be direct treatment, consultation, education and health promotion and is accessed through the Centres.

Treatment: 50%

Prevention: 50%

Barriers:

- Community Health Center assessor must have knowledge of generic program and responsibilities
- Case coordination not being done
- Physical location of services not uniform throughout Region

Strategies

- Establish integrated health, social service and home care service by co-locating all three functions in each community
- Establish the Community Health Representative as responsible for program delivery and supervision
- Establish a formal case coordination process
- Ensure that those coordinating cases have all of the necessary training

3.6.2 Personal Care

Care providers with basic training, under the direction of a Center staff professional, provide client assistance with activities of daily living including hygiene, grooming, skin and nail care, toileting, feeding, mobility, uncomplicated wound care.

Treatment: 90%

Prevention: 10%

3.6.3 Home Support

Clients who are unable to do their own homemaking as a result of a health problem or disability are offered assistance with light housekeeping tasks, grocery shopping and light meal preparation. These services are not offered if the client has family, friends or neighbors who assist or if the client can afford to purchase private services.

Treatment: 90%

Prevention: 10%

3.6.4 Respite Care

Respite Care is temporary care provided to a client, when the usual caregiver (family member or friend) requires relief from the duties of caring for the client. The amount of service can vary from a few hours on a regular interval to continuous care for a 1 - 2 week period. The care may be provided in the home or in a host family setting.

Treatment: 50%

Prevention: 50%

Barriers:

- No licensed facilities in the Region
- Shortage of appropriate caregivers to provide respite care

Strategies

- Increase public awareness of the need for respite caregivers
- Provide sufficient training and compensation for respite caregivers

3.6.5 Palliative Care Services

Center staff provide terminally ill clients the necessary support and care they require should they choose to die at home. Working closely with the client, family and physician, the Case Coordinator arranges the provision of services including personal care, home support, respite care and professional services as needed. The focus is on pain management and comfort measures and on using the family. Also the focus is on assisting family members with coping and to assess if those grieving need counseling or additional assistance.

Treatment: 80%

Prevention: 20%

Barriers:

- Lack of trained personnel
- Cultural sensitivity to beliefs and values regarding death
- Lack of understanding about the human dynamics of dealing with death – this includes the extended family and the community

Strategies

- Develop a program to address cultural sensitivity and awareness
- Train Community Health Center personnel to counsel, educate and train community members on the stages of dying and death

3.6.6 Home Parenteral Therapy

This program between hospitals and Health and Social Services provides short and long term intravenous medication therapy to clients in the community. Home Parenteral Therapy enhances the client's quality of life by enabling them to live in an independent environment.

Treatment: 100%

Prevention: 0%

Barriers:

- No qualified personnel in communities working in Home Care to administer this program
- All medications are administered at Community Health Centers

Strategies

- Work with Community Health Centers, communities and physicians to conduct a feasibility study into providing this program

3.6.7 Mobility and Communication Aids

Persons with physical disabilities may be assisted to be more mobile and communicate better through the provision of specialized aids including wheelchairs, seating devices, bathroom and toileting aids, walking aids, lifters or positioning aids, hearing aids and telecommunications devices as authorized by an Occupational Therapist. Community Health Centers consult with Stanton Hospital to determine best appliance and then apprise Home Care caregivers. This includes people with speech impairment as a result of throat surgery who may have potential to improve their communication through the use of an electro larynx, acquired through referral to a Speech Language Pathologist. Clients with hearing impairment may be referred by the Case Coordinator to an audiologist for a hearing aid.

Treatment: 50%

Prevention: 50%

Barriers:

- Lack of availability of assessors and aids
- Specialized assessments must be done at Stanton Regional Hospital
- Expensive to send patients out

Strategies

- Improve communications between specialists at Stanton Regional Hospital and Community Health Center staff for better assessments and easier access to aids
- Invite specialists to participate in conference calls
- Use Polaroid pictures to assist with assessments
- Use tele-communications video conferencing to assist with assessments
- Use tele-medicine
- Use Welcom program

3.6.8 Supplies and Equipment

An array of supplies, fixtures and equipment is available to clients. These include medical/surgical supplies like catheters, compression garments, dressings, incontinence, injection, ostomy, oxygen and oxygen supplies and hospital beds. Also provided are fixtures and appliances for physically debilitated people including shower and bath tub fixtures and access appliances for mobility in the home

3.5.9 Short Stay Rehabilitation Program Pilot Project

Clients may have short stop-over in the hospital planned for Cambridge Bay before going back to their community. Focus is on clients recovering from strokes, orthopedic or multi-trauma with rehabilitation needs. A second focus is on clients who need to be watched for further complications and might need the expanded services available at the hospital.

3.7 Primary Level Acute Care Services

Primary level services are those provided by nurses, social workers and the Regional physicians at the Health Centers in each community. Services include diagnosis, treatment and prevention of disease and/or rehabilitation and are provided on an outpatient basis. Specialized services are provided by physicians at the Stanton Regional Hospital and through annual or bi-annual visits to the community. When they travel, they bring specialized equipment such as ultrasound and audiometry.

The Region is served by six Community Health Centers. Each facility provides basic and limited services in obstetrics, pediatrics, medicine, minor outpatient surgery, palliative care, social and justice services, and home care services. Each health center provides public health in the form of well baby, pre-natal, post natal, chronic disease, and well women clinics. The Community Health Representatives are important members of the team and help with the teaching. Nurses and social workers provide a 24 hour emergency service on an on-call basis.

Treatment: 50%

Prevention: 50%

Barriers:

- Nurses and social workers provide most of the Primary Care within the Region
- Most referrals must be done by long distance telephone
- Computer and more advanced tele-communication services are not available
- Many specialized services are only provided by Stanton Regional Hospital
- Times when system opposes traditional values or belief system

Strategies

- Hire multi-disciplinary personnel with experience in specialized areas such as Registered Psychiatric Nursing, Family Violence, Midwifery, etc.
- Install Welcom and Tele-Medicine system in Region to improve communications and diagnoses
- In concert with other strategies, develop trust and respect between Community Health Center and people in the community to work together to provide optimum holistic health care

3.7.1 Obstetrics

Each center in the Region provides prenatal, post partum and newborn care for families. Labor and delivery are available on an emergency basis. Stanton Regional Hospital in Yellowknife provides obstetrical procedures such as fetal monitoring, cesarean sections and vaginal birth. An obstetrician/gynecologist makes annual or bi-annual visits to the communities. Mobile ultrasound equipment is provided to communities three or four times a year.

Treatment: 50%

Prevention: 50%

Barriers:

- High pregnancy and birth rates in Region
- All prenatals must travel to Yellowknife for delivery in the 36 – 38 week period of gestation
- Prenatals with premature labor are sent by medi-vac to Yellowknife
- Mothers must leave families for an extended period of time
- Fathers lack parenting skills to take care of family when mothers are out having another baby

Strategies:

- Family planning issues must be discussed at all ages and for all members of the community

- Counseling of families to prepare them for when mother is away having a baby

3.7.2 Mental Health/Psychiatry

Regional physicians provide basic psychiatric services at a General Practitioner level. Patients are referred to Stanton Regional Hospital if assessment is required by a psychiatrist. Nurses, physicians, social workers and Mental Health specialists provide basic counseling. Medication therapy is administered under the direction of a physician or psychiatrist.

Treatment: 75%

Prevention: 25%

Barriers:

- Biggest cost driver we have
- Impossible to get quality psychiatric and psychological assessments
- Rarely have psychiatric and psychology professionals in Region
- Health care providers may lack skills in counseling specific issues and illnesses
- Communication between referring center and treatment center is not always complete or timely hindering assessment and/or follow up
- Clients and families often feel embarrassed to openly discuss or admit to their symptoms or condition
- Lack of understanding about mental health issues
- Treatment methods are foreign and often rejected
- Traditional beliefs vs modern day practice can hinder communications, diagnosis and treatment

Strategies:

- Inventory who provides mental health services
- Conduct follow ups immediately after admission to or discharge from treatment center
- Educate to improve awareness and understanding in the Region about mental health issues and psychiatric illness

3.7.3 Surgical

Most surgery needs are met at Stanton Regional Hospital in Yellowknife. Only minor surgical procedures such as suturing lacerations and some biopsies are performed at the Community Health Centers by nurses and visiting physicians. When the new facility is in operation in Cambridge Bay, there will be some increase in the surgery procedures available in the Region.

Treatment: 100%

Prevention: 0%

Barriers:

- Clients must be sent to Yellowknife for surgery
- Travel is expensive
- Clients are away from families for long periods of time disrupting family life
- Travel back to community can be painful and stressful

Strategies

- Continue with existing arrangements

3.7.4 Pharmaceutical Services

Every Community Health and Social Services Center has a pharmacy stocked with a limited amount of medication approved by the Kitikmeot Health and Social Services Board. Nurses and a lay person dispense short-term medication to clients in the community. Clinic specific and long term medications are assessed by and prescribed by a physician then ordered through a pharmacy in Yellowknife. The client specific prescriptions are kept at and dispensed through Center pharmacy.

Treatment: 100%

Prevention: 0%

Barriers:

- Each Health Center has a limited budget for medications. There is no way to predict what illness will occur in the community and what medications will be required. With some medications being very expensive, the Center is limited in what it can cover.
- Clients will come to Center for non-prescription drugs to avoid cost/or because they didn't get to local store

Strategies

- Supervisors must track budgets closely
- Encourage clients to purchase non-prescription drugs at local store

Draft

3.8 Secondary Level Acute Care Services

The Stanton Hospital and other facilities in Alberta provide an extensive list of secondary level acute care services to referrals from this Region. Secondary level services include first level specialty care (eg. pediatrics, internal medicine, surgery, psychiatry and obstetrics). Future plans for the facility to be built in Cambridge include providing some secondary level services like monitoring.

3.8.1 Intensive Care

Units at Stanton Regional Hospital in Yellowknife and Royal Alexander in Edmonton provide intensive care services to adult and pediatric patients. Patients admitted are generally coronary, respiratory, trauma, post surgical and multi-system failure. The units also provide continuous cardiac monitoring for patients with complex medical and surgical problems who cannot be handled safely on a medical or surgical unit. Examples of patients referred to a tertiary care facility are patients with severe head trauma and patients requiring open heart surgery, hemodialysis, angiogram, angioplasty and electrophysiology studies.

Treatment: 100%

Prevention: 0%

Barriers:

- Patients cannot communicate properly because translators are not available
- Treatments costs are high and could be avoided with preventative measures
- Patient care management is sometimes not appropriate
- Patients will sometimes dictate
- Question of sufficient specialist resources in the Region

Strategies

- Co-ordinate scheduled surgery in order to take advantage of airline excursion rates
- Provide monthly financial reports on treatment costs to the Board and the communities
- Better co-ordination between hospital and community regarding patient release and patient care in the community

3.8.2 Laboratory

Other than basic blood work, a laboratory work is sent to Stanton because of more accessible air routes between communities and Yellowknife. The new facility in Cambridge Bay will not provide expanded laboratory services.

3.8.3 Diagnostic Imaging

Basic diagnostic imaging is available at each center. X-rays can be done for chest, limbs and teeth. The new facility in Cambridge Bay will have ultrasound on-site and a mobile ultrasound unit. Extensive diagnostic imaging is offered at Stanton through a variety of mechanisms providing general x-ray, ultrasound, mammography, nuclear medicine, angiography, computerized tomography (CT scan) and fluoroscopy to support diagnostic requirements of physicians.

3.8.4 Nutrition and Food Services

There is a Regional nutritionist in Yellowknife who works on projects such as CPNP and the Kitikmeot Contaminant Working Group. On an outpatient basis, nutrition education is provided for clients with special diets and nutrition care for the Home Care client.

Treatment: 50%

Prevention: 50%

Barriers:

- Use of traditional food vs food bought in stores
- Unsanitary handling of food
- Health issues related to diet
- High cost of food
- Pre-cooked food is popular
- Knowledge has not resulted in behavior change

Strategies

- Educate on proper food handling in schools, through the media, through community support workers and the Environmental Health Officer
- Encourage through subsidization stores to advertise and carry healthy foods and parents to buy healthy food
- Teach people how to prepare simple, healthy meals
- Graph on a time line sickness and disease related to changing diets
- Influence change in attitudes and behaviors regarding food high in sugar, fat and salt by implementing public policy regarding nutrition in NWT

3.8.5 Residential Long Term Care Services

The goal is to deliver services within the community setting whenever possible, with the acknowledgement that facility placement as a last resort is sometimes the best choice for delivering the most appropriate level of care to meet the individual's needs. Long-term support is provided out of the Region in Yellowknife or alternative facilities in Alberta.

Treatment: 75%

Prevention: 25%

Barriers:

- Lack of appropriate facilities in the Region
- Client loneliness and isolation from community
- High costs associated with long-term care

Strategies

- Train home care workers to provide higher levels of home and personal care

3.8.6 Tertiary Level Services

Stuff like RCMP, Territorial Treatment Center for kids, Ft Smith Trail Cross for kids, AVEN for seniors, Woodlands, **Write Up**

3.7.7 Pastoral Care

Pastoral services are a key component of services in the communities. Strategies to increase these services and integrate them with other programs like crisis intervention will be developed.

Treatment: 50%

Prevention: 50%

Barriers:

- There may not be a minister or priest available in the community
- Ministers and priests are not made to feel like part of the team
- Staff bias and thinking at times can interfere with the care of the patient

Strategies:

- Patients, upon admission, should be asked if they wish to meet with clergy
- Clergy should be contacted when there are serious situations
- Meet with clergy to develop a better plan for their involvement

Draft

3.8 Social Services

The Social Service program is integrated with Health Services and Home Care as equal partners. The Board now offers a complimentary, integrated and comprehensive health and social service model that meets the complete health, care and well being needs of our clients. The social services component of the model provides a broad range of support for individuals, families, children and the community. Programs include judicial and correctional services, social/personal counseling, conflict resolution, child welfare, critical incident or significant event support, and mental health services, drug, alcohol and inhalants addiction and career counseling. With integration, client needs are more readily reviewed and proactively addressed.

3.8.1 Family Violence

To offer programming, family and individual counseling in the areas of parent/teen conflict, spousal assault, sexual assault, child sexual abuse, marital and mediation to those in distress or families which are showing those signs of family breakdown. Provide immediate physical needs of victim/s.

Treatment: 50%

Prevention: 50%

Barriers:

- Inadequate or qualified personnel to address the issues
- No service centers to address family violence in the Region
- Victims may have no safe place to go, and often return to the threatening environment and feel trapped
- Lack of parental skills by students who attended residential schools
- Overcrowding in homes
- Family issues get low priority in times of high work load

Strategies:

- Secure or build a facility for treatment, safety and trauma victims
- Training on family violence for staff
- Encourage community members to take ownership by making their homes available to victims of violence
- Provide parental skill training
- Raise family issues on agendas of inter-agencies meetings

3.8.2 Mental Health

We offer home supports and counseling to those members of the community suffering from mental illnesses or disabilities (psychotic or neurotic). Arrange those appointments with visiting mental health professionals and medical personnel.

Treatment: 70%

Prevention: 30%

Barriers:

- No services available for children or adults within the community
- Visiting specialists don't assess clients; therefore doesn't get done and are not usually useful due to lack of availability, lack of consistency and inadequate follow-up
- No follow up treatment available in the community if a client is assessed at Stanton

- Increased rate of suicide ideation and completion
- Embarrassment and attitude of family and community

Strategies:

- Each Health Center should have at least one nurse and/or social worker with psychiatric training or experience

3.8.3 Court/Justice

Administer under the direction of the Dept. of Justice Canada a full community corrections program. Program consists of:

- Youth corrections
- Protection services (parole and probation)
- Probation services (youth and adult)
- Parole supervision
- Court reports (predisposition, pre-sentence and file updates as directed)
- Community service orders
- Fine option programs
- Support for individuals in court (defendant and plaintiff)
- Represent in the community the decisions of the court as directed
- Other duties include informing the courts of any medical/mental illnesses, which may be the cause of client conflict with the law.

Treatment: 100%

Prevention: 0%

Barriers:

- In smaller communities there is only one person and they must do the court work, documentation and serving, registering and filing with the courts
- Social workers are also responsible for the full range of Community Corrections Program
- Little time left for community and people
- 85% of people in jail are there for assault/sexual assault – often because of overcrowding
- Not enough Justices of the Peace

Strategies:

- Provide adequate housing
- Community based programs ie parenting, traditional skills
- Demonstrate actual costs to offender and community
- Train more aboriginal Justices of the Peace
- Encourage aboriginals to seek careers within Justice system

3.8.4 Children in Need

This program provides services to those children who are not in the care of the Board in regards to individual counseling and advocating on their behalf for services/educational programs which are not offered in the community. And, provides protection services for children at risk according to the provisions of the Child Welfare Act.

Treatment: 100%

Prevention: 0%

Barriers:

- Lack of trained staff
- Lack of community and parent involvement and follow through with children who leave system

Strategies:

- Maintain telephone help line for children at risk to assess and delegate to a local authority
- Programs for adolescents who are moving to independence and adulthood
- A system that is functional and aggressive in helping children achieve individual self-determination, independence and a sense of future and becoming a contributing member in the community
- Identify visible role models in the communities for children to relate to and emulate

3.8.5 Foster Care

Deliver an inclusive program of foster care, long and short term possibly specialized residential, treatment oriented for those children, in care, under the authority of the Child Welfare Act.

Treatment: 100%

Prevention: 0%

Barriers:

- Lack of trained foster parents for special needs kids
- Lack of training and support from social workers
- Shortage of potential homes and foster parents
- Traditional ways vs the system
- In today's society both parents work

Strategies:

- Public campaign to recruit more foster parents and then train them
- Social worker dedicated to recruitment, training and issues related to foster parents and foster homes
- Criteria for foster parents that qualifies people in circumstances other than being a nuclear family, having significant income or no criminal record

3.8.6 Adoption Services (Legal)

This program provides in areas of home studies and suitability according to the provisions of the Adoption Act assistance for those persons who are legally adopting. The Board assists in the securing and preparation of those legal documents required by the courts.

Treatment: 100%

Prevention: 0%

Barriers:

- Traditional practice vs legal adoption
- Perception process is too complex, too long, too expensive, too intensive
- Home studies not completed or not done thoroughly

Strategies:

- Traditional practices should be understood and taken into account before placement is made
- Ensure process is completed thoroughly as per mandate, and that social worker involvement is one of diminishing degree after placement
- Utilize CSSW1's to conduct home studies under supervision of supervising social worker

3.8.7 Unemployment Programming

To work with individuals, as well as families in the securing of job training or career planning both at the skilled and entry level positions. We assist with securing of job training and courses offered in the communities. To ascertain whether or not there are medical/physical reasons for their situation.

Treatment: 100%

Prevention: 0%

Barriers:

- No jobs for trained people
- Employment available is often in other communities e.g. Yellowknife, Inuvik, Hay River
- People take training to just satisfy the system
- People take training as a source of immediate income, but are not really motivated
- Life skills rarely part of courses

Strategies:

- More realistic by providing training that is aligned with job opportunities
- Look at Pathways model
- How to establish accountability in client group
- Develop realistic and flexible criteria that allow for making the right choice/decision
- Develop inter-agency strategies towards employment and training
- Provide programming and emotional support for families whose partner is working out of the community

3.8.8 Assistance for the Homeless

Center professionals counsel and assist those persons (primarily single males) who do not have homes of their own or a usual place of residence and ensure, where possible, that their health care needs are also met.

Treatment: 100 %

Prevention: 0%

Barriers:

- Lack of adequate housing (crisis proportion)
- Single males have low priority status for housing
- No place for males to go as a result of domestic breakdown/violence like the females have
- Numbers of homeless are increasing dramatically

Strategies:

- Assist hamlets in the planning and prioritizing of block funding to re-direct funds for building of crisis accommodations for males
- Support/ advocate on behalf of communities for additional housing funding targeted for singles

3.8.9 Guardian/Trusteeship

This program has been established to assist families and those persons who are unable to care for and make sound decisions on behalf of their loved ones or themselves. A guardian or trustee is secured on their behalf to act in their best interest as provided for in the Guardian and Trusteeship Act.

Treatment: 100%

Prevention: 0%

Barriers:

- Difficult to ensure that the rights of dependent adults are protected
- Social workers find it difficult to take a stand on selection of guardians/trustees when politics or internal family rivalries prevent consensus or agreement
- Necessary medical attention or home care is a low priority and it is difficult to secure the permission of family members

Strategies:

- Program or counseling to have families become more aware and assume responsibility for dependent family members

3.8.10 Suicide and Critical Incident Stress Process

Deliver a full range of services from intervention and prevention to critical incident stress debriefing to any and all members of the community who are at risk or whose families who are at risk as a result of an attempted or completed suicide. To offer an opportunity to front line personnel who deal with the results of the attempted or completed suicide. To deal with the emotional and psychological stresses which may be caused.

Treatment: 50%

Prevention: 50%

Barriers:

- No sense of future for individuals or communities
 - No jobs or industry
 - Depression
 - Drug and alcohol use and abuse
 - Anger, frustration
 - Domestic violence
 - Child abuse

Strategies:

- Consider a program that promotes having a couple of community members leave, get good jobs elsewhere and return as role models to explain that this will always be home, but a quality life can be found elsewhere
- Implement Significant Event Response Model developed in Gjoa Haven in other communities
- Continue with critical incident stress de-briefing workshops for staff and key members of the community

3.8.11 Treatment - Addictions/Mental Health

This program offers individual counseling and the securing of treatment programs for youth and adults with addiction or mental health problems in need of tertiary services.

Treatment: 100%

Prevention: 0%

Barriers:

- Lack of treatment facilities (especially mental health)
- No qualified people in the Region
- Medical model will work if you can get qualified people in Region

Strategies:

- Secure Health personnel with a RPN/RN designation

3.8.12 Health Care for Children

This program is in place to assist in the securing of services for those children who, are as a result of disability, allergies or handicap in need of services which will improve their quality of life and reduce the stresses and demands on the family members or care givers. Social workers work in conjunction with medical personnel to ensure the health of the children.

Treatment: 0%

Prevention: 100%

Barriers:

- Present system doesn't allow for appropriate and timely intervention
- It take far too long to access TTD or TYY equipment for deaf and/or mute kids
- Rules around equipment like wheel chairs that are provided by more than one agency with different conditions and regulations

Strategies:

- Ensure that services to children have no means test (basic home, clothes, food) as criteria for not intervening
- Non-Insured Health Benefits monies should be transferred to local government to expedite the purchase of equipment and services

4.0 Goals Strategies Outcomes Measures

4.1 Goals

4.1.1 Client Satisfaction Goal

We are providing high quality health care and social programs that reflect the needs of the people of the Kitikmeot.

4.1.2 People Goal

We have created an environment that promotes a core of dedicated professionals, reflecting the population of Nunavut, that are committed to serving the people living in the Kitikmeot.

4.1.3 Process Management Goal

We provide a quality service which is characterized by efficiency and effectiveness in an environment where staff work together to best meet the needs of our clients.

4.1.4 Financial Management Goal

Without compromising the quality of care and services, we conduct ourselves in a business like manner, through good planning and sound investment strategies.

4.2 Client Satisfaction - Strategies Outcomes Measures

Goal We are providing high quality health care and social programs that reflect the needs of the people of the Kitikmeot.

Strategies	Outcomes	Measures
Co-locate all health, social and home care programs	<p>Clients have a single point of access</p> <p>Clients receive better integrated services</p> <p>Better mix of care providers</p>	<p>By 1999 all health, social and home care programs are co-located</p> <p>Client surveys indicate increased client satisfaction</p>
Put in place a Feasibility Assessment to have a cottage hospital in the Region by 1999	<p>Feasibility study indicates what programs and services will be provided</p> <p>Facility, HR, equipment, management and administrative needs are clear</p>	<p>Feasibility assessment is accepted and plans for construction are underway</p> <p>Decrease in out of Region institutionalization</p>
Incorporate traditional knowledge, healing and values into program service delivery	Health and social programs reflect the unique needs and culture of the communities	<p>Increased utilization of community based prevention programs and services</p> <p>Increased participation in preventable screening</p>
Make residents of the Kitikmeot aware of our health, social and home care programs and the increased emphasis on prevention through focused promotion programs	<p>Increased public awareness and ownership of health and social programs and issues</p> <p>Communities are proactively involved in addressing health and social issues</p>	<p>By end of 1997, all of the people of Kitikmeot clearly understand our services</p> <p>Communities are involved in addressing health and social issues</p> <p>Shift in expenditures to community based preventative services</p>
Unsure frequency and duration of specialist visits are meeting the needs of the communities	<p>Specialists are meeting specialized needs of clients in all communities</p> <p>Individual assessments, programs and treatments are timely, effective and meeting needs</p>	<p>Increase in proportion of clients who report their health to be good or excellent</p> <p>Shorter cycle time for clients who access services of specialists</p>
Focus on staff retention to more positively impact on client satisfaction	<p>Clients feel more comfortable to discuss their care issues</p> <p>Staff turnover is reduced with permanent staff retained and fewer agency personnel</p>	<p>Client surveys indicate increased client satisfaction with H&SS staff</p> <p>Staff turnover is reduced and fewer agency are called upon</p>
Advocate and contribute to development of ways to address and respond to the social and moral issues that face our clients around health care and social programs	<p>Adoption by communities of public health and social programs and increased public awareness and ownership of health and social issues</p> <p>H&SS staff are actively involved in inter-agency and community groups</p> <p>Frank, productive discussion is achieved to address lifestyles, values and a clear vision of the future in the Kitikmeot</p> <p>Families are stronger and more able to care for own needs</p>	<p>Greater level of involvement with agencies and community groups and number of public programs and initiatives</p> <p>Kitikmeot residents are aware of lifestyle and values necessary for healthy living</p> <p>Reduced infant mortality rates</p> <p>Increase in disability-free life expectancy</p>

		Decrease in PYLL, family violence and alcohol related crime
Promote optimal health with communities in the region through nutrition resources, education, information and consultative services	<p>Increased awareness of the role of nutrition in prevention of illness</p> <p>Resource materials relative to community nutrition needs are available and distributed</p> <p>Community programs have a nutrition component to access consultative services and implement proactive programs</p> <p>An aggressive and productive relationship exists between Kitikmeot H&SS and specialists in Yellowknife to address nutritional issues and needs</p>	<p>Availability of programs and materials</p> <p>Level of activity with community groups and programs on nutritional issues</p> <p>Decrease in illness, debilitation and death related to poor nutritional practices</p>
Leverage the Home Care Program to assume a greater preventative and treatment role as a front line interface between residents and the Center	<p>Clients can receive some monitoring and treatments in the home</p> <p>A system of early warning of declining client health is established through observation and interaction of Home Care Givers</p> <p>Home Care is included in initial client case co-ordination to provide better and more comprehensive service</p>	<p>Client service is increased resulting in more proactive treatment and reduced time frames</p> <p>Fewer clients come for treatment at advanced stages of illness or injury</p>
Promote acceptable environmental health conditions and practices to the public and regulated industry	<p>Inspections, monitoring and reports of key public environment activities are completed on a proactive basis</p> <p>Individuals and groups receive appropriate learning and education</p> <p>Appropriate environmental health practices are maintain through fair and equitable enforcement of the Public Health Act and Regulations</p>	<p>Reporting of inspection, monitoring and enforcement activities</p> <p>Number of training and education programs offered</p> <p>Number of individuals, groups and communities receiving programs</p> <p>Decrease in contravention of Public Health Act and Regulations</p> <p>Decrease in number of people who die or are injured/ fall ill to unsafe environmental practices</p>

4.2 People - Strategies Outcomes Measures

Goal We have created an environment that promotes a core of dedicated professionals, reflecting the population of Nunavut, that are committed to serving the people living in the Kitikmeot

Strategies	Outcomes	Measures
Meet the objectives of the Nunavut Human Resource Strategies	<p>The Board is meeting or exceeding the objectives for staff levels of beneficiaries</p> <p>Permanent Region residents are trained and enjoy a good career in Health and Social services</p>	By 1999, 50% of the board staff will be beneficiaries of Nunavut
Our people are kept current through creating an environment that supports and encourages ongoing education and development (personal and professional)	<p>Development of a skill and competency list that covers all jobs, professional skills, cultural sensitivity skills, management and supervision skills and administrative skills</p> <p>A proactive, user-friendly performance management process is in place</p> <p>Training and development plans are in place for every staff member to meet skill and competency gaps and personal development needs</p> <p>Staff are up to date on changing legislation and the impact on services e.g. Participation in the implementation of the new Child and Family Services Act</p>	<p>Skills and competencies for now and in the future have been identified</p> <p>All staff members are involved in the performance management process with regular reviews of performance and assessment of skills and competencies</p> <p>Staff members, through feedback, coaching and development meet the skills and competency requirements of the Board</p>
Promote and encourage long term commitment to the Region and organization through internal mobility and teamwork	<p>Staff have successfully integrated health, social and home care programs into a single comprehensive, high quality program/service</p> <p>Teams of staff from various centers take ownership for successful implementation of Tactical Business Plan</p> <p>Rotation of program responsibilities result in greater job satisfaction and cross trained personnel</p> <p>Staff professionals take on assignments in different communities or Headquarters</p>	<p>Tactical Business Plan activities are successfully implemented</p> <p>Staff achieve greater measured levels of expertise, experience, skills and competencies</p> <p>Number of staff rotating in the region</p>

4.4 Process Management - Strategies Outcomes Measures

Goal We provide a quality service which is characterized by efficiency and effectiveness in an environment where staff work together to best meet the needs of our clients.

Strategies	Outcomes	Measures
<p>A continuous quality improvement program will be in place with teamwork, characterized by the fullest possible sharing of talent and expertise with a minimum of duplication in all processes.</p>	<p>Improved guidelines, procedures, standards, monitoring and measuring of achievement</p> <p>Operating manuals describe and explain the roles and responsibilities of the people with the organization</p> <p>Improvements in accountability and efficiency</p>	<p>Guidelines and Procedures manuals up to date and in place in all Centers</p> <p>Processes are mapped and measured</p> <p>Improvement initiatives are providing positive results</p> <p>Everybody in the organization is assuming responsibility for change and improvement</p>
<p>New equipment and programs are in place to deliver high quality services</p>	<p>Hardware, software and tele-communications are state-of-the-art</p> <p>Clients receive better service with increased on-site capabilities</p> <p>Improvement in accountability and efficiency</p> <p>Common database/information system for multiple users</p> <p>Program provides better access to patient records and facilitates easier processing of files</p>	<p>By 1999 all staff and work stations will be functional in the Wellcom and Tele-medicine systems</p> <p>Access is immediate and supports integrated programs</p> <p>Files are processed more quickly and accurately</p> <p>Decrease in administration costs</p> <p>Equipment is meeting administrative and professional needs</p> <p>Fewer clients have to travel, or wait for results and do receive more immediate and specialized services at the Centers</p> <p>Everyone is working on the same, fully capable communications platform/system/network by 1999.</p>

4.5 Financial Management - Strategies Outcomes Measures

Goal Without compromising the quality of care and services, we conduct ourselves in a business like manner, through good planning and sound investment strategies.

Strategies	Outcomes	Measures
Marketing strategies will result in increased revenues generated	<p>Third party revenues are realized and applied to supporting facilities and programs</p> <p>A marketing program to identify opportunities and justify "public profitability" as a means of sustaining health and social services is in place</p>	<p>Third party revenues are increased and meet any base funding shortfalls</p> <p>Residents in the Kitikmeot understand and support the pursuit of third party revenues and appropriate charges to certain client sectors for services provided</p>
Co-locate all Community Health Center staff and administration one facility	Centers achieve greater efficiencies	<p>Decrease expenditures reflects reduction in duplication of processes and services</p> <p>Greater funds are available for investment in upgrading and improving facilities and equipment</p>
Through cost effective and efficient practices we reduce expenses and investments	<p>Successful completion of total quality program</p> <p>All cost recoveries are followed up on</p> <p>Targeted budget reductions are met through continuous implementation of cost reduction initiatives</p> <p>All non revenue producing or non value-added assets have been disposed of, eliminated, or leveraged to become profitable</p> <p>Eliminate all duplicated or unnecessarily replicated program, administrative and financial management services and procedures</p>	<p>We will reduce operating expenses by 15% by 1999</p> <p>Decrease in total health, social and home care costs</p> <p>No non-value add assets are on the books</p> <p>Processes and systems are in alignment and at optimum levels for cycle times, costs and human resources deployed</p>
Standards are in place for how we assess our capabilities and for the costs of offering new programs and services	<p>Unit costing and true program delivery expenses can be articulated to users</p> <p>Levels of service are more clearly delineated for community decision making</p> <p>Baseline data is available for benchmarking</p>	<p>Unit costing is in place</p> <p>Accurate program development and delivery costing is available</p> <p>Data acquired is analyzed and remedial actions taken for quality and efficiency improvement</p>