First Nations Health Authority
Health through wellness

Nursing Review

November 2015

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Executive Summary

In October 2013, FNHA took on the responsibility for the design and delivery of health programs and services, including Nursing Services, for BC First Nations, formerly delivered by Health Canada's First Nations Inuit Health Branch. The programs and services were transferred "as is". A year after taking accountability for health programs and services, FNHA identified a need to perform a review of Nursing Services – its largest "direct patient care" portfolio.

Nursing services are currently provided to First Nations communities in three primary ways: by nurses employed by FNHA; by nurses employed by the community; and/or by nurses employed by regional health authorities. The underlying goal of the review is to identify opportunities for enhancing nursing services provided to First Nations people.

Specific project objectives were as follows:

1. FNHA to be recognized as a quality provider of nursing services;
2. High quality nursing services to be provided for all First Nations, whether by FNHA, community-employed nurses, or others;
3. Improve retention of nurses serving First Nations communities;
4. Encourage nursing as a career path for First Nations individuals;
5. FNHA to be considered a preferred employer by the nursing community in BC; and
6. Develop cultural competency and create a safe, aware environment for service delivery.

Data and information was gathered from several sources to support this review: focus groups were conducted with nurses; nursing surveys were developed and distributed to communities; internal documents/information was provided by FNHA; interviews were held with key stakeholders in FNHA staff, the regional health authorities, and the Ministry of Health; visits were undertaken to health facilities in communities; and interviews were held with other Indigenous health organizations.

Key findings are as follows:

- There is legacy program overlap within FNHA as similar health and wellness programs are being offered across multiple departments (including Nursing Services). Collaboration and oversight could be more streamlined and clear.

- Nurses in some communities have not been well supported by Health Canada and are not integrated with other community health and wellness resources and programs. These factors impact how care is provided and are not consistent with a holistic, patient-centred care model.
- Many communities have experienced high turnover of nurses and find it difficult to recruit new nurses. There has been a reliance on temporary nurses to fill vacancies which impacts the quality and breadth of care being offered.
- There is no systematic data collection and reporting function to support nursing. As a result, Nursing Services has operated with little operating data to help inform departmental decision making and priority setting processes.
- Regional health authorities have been supportive of FNHA and of nursing and provide many services and supports to communities. However, relationships between the regional health authorities, communities and FNHA are not always formalized and can be dependent on local relationships.
- The delivery of nursing services varies widely from community to community. However, Communicable Disease Control was identified as the service with the lowest participation rate. The availability of nursing resources, relevant training, and program materials to support Communicable Disease Control activities were identified as priorities.
- Health Human Resources activities specific to nursing are largely being offered at the community level. There is an opportunity for FNHA to play a larger role in promoting nursing as a career to First Nations people provincially.

Best practice healthcare delivery research supports a shift to interdisciplinary models that promote the integration of Public Health and Primary Care. The patient, their family and the community are at the centre of this model with care providers working collaboratively as a team to provide seamless care.

A key component to the interdisciplinary model is having the right skill mix among team members. Furthermore, economies of scale, in terms of population size serviced, can impact a community's ability to provide services.

Recommendations

Community Health Nursing is an integral component of community health and wellness resources. Overlap between Community Health Nurses and other community wellness providers is inevitable as everyone supports the same patients in the same communities. For this reason, our recommendations start with an overarching model of care that aligns with FNHA's vision, is grounded by best practices, and provides future direction to all community health and wellness disciplines. Subsequent recommendations focus on enabling strategies for aligning Community Health Nursing to this future direction.

Implementation will be a journey, will vary from community to community, and will need to take into account:

- The current status of nursing and wellness models in communities recognizing that there is a wide variation in degree of integration, resources and services;
- Community readiness for change; and
- Timelines for availability of enabling technologies required to realize full benefits.

These factors will inform decisions by FNHA, communities and regional health authorities on individual implementation approaches for communities.

Our recommendations are as follows:

1. **Service Model:** Shift to an interdisciplinary model of care (see chart below) that integrates Primary Care and Public Health in communities and that:
   - Is patient-centred and focuses on the needs of both the individual and their families and the population's health needs, and uses evidence-based practices for serving these needs;
   - Enables patients to make informed decisions on their care and to be an active participant in their care planning;
   - Utilizes interdisciplinary teams comprised of an appropriate mix of health care providers working collaboratively and to their respective full scopes of practice;
   - Integrates health services at the community level and integrates health services with other services, including traditional wellness, available in the community; and
   - Provides links to health services available outside the community.
2. **Nursing Resource Mix:** Develop a nursing resource mix model that aligns with the interdisciplinary model and that optimizes the utilization of existing nursing resources in order to provide high quality care.

3. **Enabling Technology:** Implement eHealth and health-related technologies that will support and optimize the implementation of the recommended service model.

4. **Nursing Services:** Realign the Nursing Services Department to support the Interdisciplinary model and to better integrate within the FNHA structure.

5. **Nursing Supports:** Provide supports to nurses to enable them to be able to efficiently and effectively provide care.

6. **Regional Health Authorities:** Establish effective working relationships with regional health authorities to facilitate access to services and supports for communities.

7. **Performance Measurement Reporting:** Implement performance measurement systems that supports FNHA and communities in the management of their health programs.

8. **Recruiting/Retention:** Work with communities to improve nurse recruiting efforts and to improve retention rates.

9. **Health Human Resources:** Develop regional capacity to provide nursing educational opportunities in a way that encourages students to seek employment in their communities.

Introduction

In July 2013, the BC First Nations Health Authority (FNHA) assumed responsibility of funding administration, policy, planning, and program development from Health Canada headquarters. It became, as its website states, "the first province-wide health authority of its kind in Canada." In October 2013, FNHA took on the responsibility for the design and delivery of health programs and services, including Nursing Services, for BC First Nations, formerly delivered by Health Canada's First Nations Inuit Health Branch. The programs and services were transferred "as is". A year after taking accountability for health programs and services, FNHA identified a need to perform a review of Nursing Services – its largest "direct patient care" portfolio.

Nursing services are currently provided to First Nations communities in three primary ways: by nurses employed by FNHA; by nurses employed by community; and/or by nurses employed by regional health authorities. The underlying goal of the review is to identify opportunities for enhancing nursing services provided to First Nations people.

Specific project objectives were as follows:

1. FNHA to be recognized as a quality provider of nursing services;
2. High quality nursing services to be provided for all First Nations, whether by FNHA, community-employed nurses, or others;
3. Improve retention of nurses serving First Nations communities;
4. Encourage nursing as a career path for First Nations individuals;
5. FNHA to be considered a preferred employer by the nursing community in BC; and
6. Develop culture competency and create a safe, aware environment for service delivery.

The review covers all nursing services delivered to First Nations communities and includes all FNHA nursing services:

- Home and Community Care Nursing.
- Transfer Nursing.
- Services provided at Nursing Stations & Health Centres.
- Education & Professional Practice.
- Nursing Resource Team.
- Nursing Human Resources.
- Health Protection Services.

Project Approach

The reviewer undertook a multi-faceted approach in gathering data to support the review. The work was informed by several consultations and data sources:

Consultations

1. Focus groups conducted with more than 40 nurses at the annual FNHA Nursing Forum and via teleconferences.

2. Interviews with Nursing Services management, Health Protection team members and other FNHA staff as required.

3. Six community visits:

   - Carrier Sekani Family Services;
   - Sto:lo (Seabird Island);
   - St'at'imc (Lillooet);
   - Port Simpson;
   - Intertribal Health Authority; and
   - Wuikinuxv.

4. Interviews with individuals at the five BC regional health authorities.

5. Interviews with external Indigenous health organizations:

   - The Indian Health Service (U.S.); and
   - Southcentral Foundation.

Data Sources

6. Community-based Reporting Templates (CBRT). Fiscal 2012/13 reports were used to support our current state understanding. Fiscal 2012/13 had a 56% response rate.

7. Electronic Service Delivery Reporting Template (e-SDRT) and the Electronic Human Resources Tracking Tool (e-HRTT) for Home and Community Care (fiscal 2013/14).

8. Contribution Agreement data provided by FNHA Innovation and Information Management Services (IIMS).

9. Nursing survey (developed by reviewer in consultation with FNHA Nursing Services) distributed to all Health Directors who are members of the BC First Nations Health

Directors Association. Forty-four (44) surveys were received representing a 33% response rate.

10. Review of relevant literature (both peer reviewed and grey) related to remote nursing, primary care nursing, and Indigenous nursing.

11. Various internal documents provided by FNHA.

Project Governance

Project governance was established to guide this review:

- Richard Jock, FNHA COO, Policy, Planning & Community Services and Michelle Degroot, Executive Director, FNHA COO Office, are the Executive Sponsor team charged with leading the Nursing Review and setting project goals and objectives.
- An Advisory Committee was established to provide expertise and guidance to strategy development. Advisory Committee members are as follows:
  - Penny Anguish, Chief Nursing Executive, Professional Practice and Chief Operating Officer, Northwest Health Service Delivery Area, Northern Health Authority;
  - Robin Buckland, Executive Director, Primary Care Division, Population Health and Primary Care Directorate, First Nations and Inuit Health Branch;
  - Sherry Hamilton, Chief Nursing and Liaison Office, Provincial Health Services Authority;
  - Marlene Hoover, Director of Nursing, Nursing Services, FNHA;
  - Debbie McLachlan, Director, BC Ministry of Health; and
  - Jacques Neron, Director, Primary Care Division, Population Health and Primary Care Directorate, First Nations and Inuit Health Branch.

An internal Nursing Working Group was established to assist in validating findings and sharing knowledge. Internal Nursing Working Group members are as follows:

- Candice Corston, Transfer Nursing Manager;
- Gary Housty, Manager Nursing Programs;
- Gulshan Khudra, Community Health Nurse;
- April MacNaughton, Nurse Manager, Health Protection;
- Avril Oullette, Policy, Policy, Planning & Community Services;
- Elizabeth Pearce, Home and Community Care Manager; and
- Leona Smith, Professional Practice Leader.

Definitions

Community Health Nursing is a recognized specialty of nursing with two practice areas: Home and Community Care and Public Health Nursing.

Home and Community Care is a system of home and community-based health care services that enable First Nations people (all ages with disabilities, chronic or acute illnesses and the Elderly) to receive the care they need in their homes and communities. Services are provided primarily by home care registered nurses and trained and certified personal care workers. Some communities employ Licensed Practical Nurses to assist in some parts of the care. Depending on community needs and available funding, additional services may be offered: rehabilitation, adult day care, meal programs, palliative care, mental health and some health promotion, wellness and fitness.

The **Public Health Nursing** program provides the following services in First Nations communities: public health nursing activities (e.g. immunization, communicable disease control), health education and promotion activities, prenatal classes, well baby clinics, newborn visits, vision screening, early hearing screening (and reproductive health, contraceptive counselling and blood tests for STIM where providers have necessary certifications). Public Health Nursing is provided by registered nurses in **Health Centres** located in First Nations communities.

Some First Nations communities are remote and do not have access to a resident physician or nurse practitioner. Physicians or nurse practitioners visiting the community periodically are generally available to provide consultations (via phone) to the registered nurse resident in the community. Health facilities are referred to **Nursing Stations** in these remote communities.

Due to their remoteness and lack of a physician or nurse practitioner, nurses working out of at Nursing Stations are required to provide **Treatment Services** in addition to Public Health Nursing services. In order to be able to provide this additional scope of practice, nurses must have Remote Nursing Certified Practice certification and take additional courses related to emergency care, contraceptive management and sexually transmitted infections. **Treatment Services,** as per the established decision support tools and supplemental training requirements, generally pertains to:

- Treatment of minor diseases and illnesses;
- Contraceptive management;

- Sexually transmitted infections;
- Well women clinics (BSE, Pap tests, vaginal smears, blood tests, menopause teaching)
- Well men clinics (prostate screening checks, testicular exams), and
- Emergency and after-hours care.

In addition to Health Centres and Nursing Stations, there are four **Treatment Health Centres** and one **Diagnostic Centre**. These facilities provide the full scope of Public Health Nursing and a limited scope of Treatment Services.

Background

Nursing services are delivered to 203 BC First Nations communities in a number of ways. Funding for nursing resources is based on historic formulae developed by Health Canada that takes into account both community population size and degree of remoteness or isolation.

In the current nursing model, First Nations communities are supported by Community Health Nurses, Community Health Representatives and various visiting service providers.

Funding Models

Depending on the arrangement with each community, FNHA will either use the funding to hire nurses to provide direct care, or will transfer the funding, via Contribution Agreements, to the communities who, in turn, hire nurses to provide care for their members.

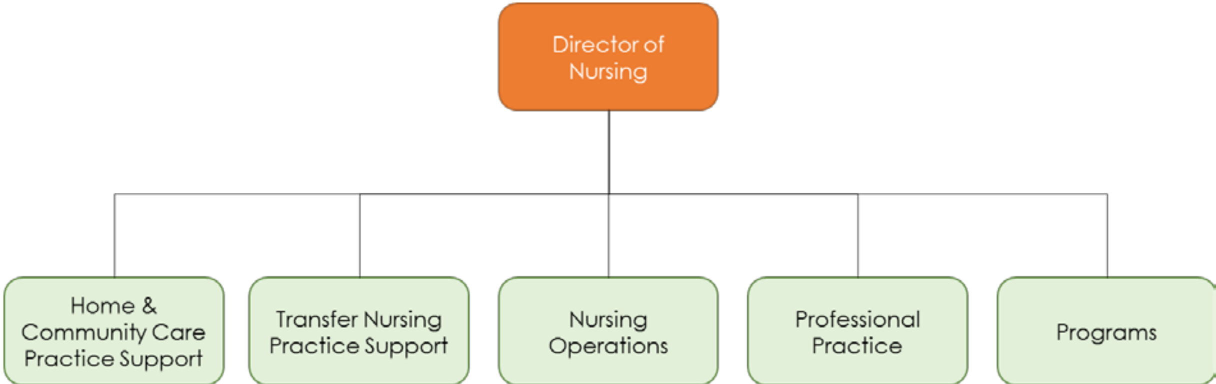
Generally, funding for Home and Community Care is provided to communities via Contribution Agreements with each community responsible for hiring and managing its own resources.

The funding practice for Public Health Nursing is mixed. Many communities have opted to receive funding for nursing services as part of their Contribution Agreements and, as a result, employ and manage their own nursing resources. These community-employed nurses are referred to as "Transfer Nurses". In other instances, FNHA retains the Health Canada funding and employs nurses to provide Public Health Nursing services on behalf of communities.

FNHA Nursing Services Department

As of June 2015

Current to June 2015, FNHA Nursing Services consisted of the following functions:



Home and Community Care Practice Support

The FNHA Home and Community Care team consists of four Nurse Advisors, one Practice Consultant and a Health Programs Officer. The team does not provide direct patient care, but rather provides support and advice to Health Directors, Home Care Nurses, and other community-based home care staff related to professional practice requirements, competencies, and other administrative and clinical issues.

The following table summarizes the staffing resources employed by communities for the Home and Community Care programs as at October 2014:

Position/Role	FTEs (Pos)	Full-time Staff	Part-time / Casual Staff	Total Staff
Administration/Clerical Support	12.26	7	62	68
Allied Professionals	2.22	1	7	8
Home Management Support	26.44	20	117	137
Licensed Practical Nurse	23.57	21	32	51
Personal Care Provider	81.2	74	166	220
Program Support	20.28	12	70	82
Registered Nurse	49.49	40	142	168
TOTAL	**215.46**	**175**	**596**	**734**

Source: e-HRTT Report (October 2014)

Transfer Nursing Practice Support

The FNHA Transfer Nursing team consists of five (four full time and one casual relief) Practice Consultants. The team does not provide direct patient care, but rather provides consultations supporting the development, implementation, and management of community-based nursing programs where communities employ the nurses directly (Transfer Nursing communities). The level of support provided varies by community:

Direct consultation: Provision of consultation services directly to Community Health Nurses in the communities.

Senior consultations: Certain communities have joined together to form "collectives". These communities pool their nursing funding and hire resources to service all collective members. These collectives typically employ senior nurses who provide supervision and support to the collective nursing pool. The FNHA Transfer Nursing Manager provides consultations to these senior nurses and not to the Community Health Nurses in communities.

General inquiries: Certain communities receive their nursing services from regional health authorities. Nurses in these communities receive professional nursing consultation from their employer (the regional health authorities). These communities connect with the Transfer Nursing Manager for general program issues.

The following table summarizes the number of communities (including number of nurses and facilities in these communities) that are supported by each level of support:

Support Level	Communities	# of Nurses	Facilities
Direct consultations	51	42	50
Senior consultations	87	69	69
General inquiries	23	22	20
TOTAL	**161**	**133**	**139**

Nursing Operations

FNHA operates 12 Health Centres and 8 Nursing Stations servicing 42 BC First Nations communities and employs 31 FTE nurse positions. Due to high vacancy rates in Nursing Stations, a Resource Team of 18 FTEs is maintained to support temporary staffing requirements (e.g. vacation relief, vacancies) for the Nursing Stations.

Two Nursing Operations Managers (one responsible for Health Centres; one responsible for Nursing Stations) and the Resource Team Manager (responsible for Resource Team staff) provide professional support, leadership, advice and direction to FNHA-employed nurses working in the FNHA-operated Health Centres and Nursing Stations. Areas of support include: policy, practice and programs. The total number of nurse positions (FTEs) is summarized below:

Position	Health Centres	Nursing Stations	*Sub-Total*	Resource Team	TOTAL
Nurse in Charge	3	7	*10*	4	14
Community Health Nurse	11	10	*21*	14	35
TOTAL	14	17	*31*	18	49

Professional Practice

The Professional Practice team consists of a Nurse Manager, two Practice Consultants and a Diabetes Practice Consultant. The team provides practice support for Nursing Operations (FNHA-employed nurses). This team is responsible for identifying education and training requirements for both Public Health Nursing and Remote Certified Practice Nursing.

Programs

FNHA nursing programs are overseen by four Clinical Nurse Specialists positions, each with a specific program focus:

- Maternal Child;
- Adolescent Mental Health;
- Healthy Living / Chronic Disease; and
- Public Health.

Each Clinical Nurse Specialist role has a research, clinical practice, best practices, and education component. Key functions of these Clinical Nurse Specialists are to:

- Deliver programs and expertise in support of clinical skills development; and
- Advise and consult on clinical practice services.

These program supports are provided to both Transfer Nurses and FNHA-employed nurses.

Nursing Services Budget

The Nursing Services budget is shown by function in the table below.

Nursing Services Budget (2014-2015)		
Direct Nursing		
Home and Community Care		$16,798,000
Transfer Nursing		9,768,000
Nursing Operations [1]		5,545,000
	SUBTOTAL	32,111,000
Nursing Support		
Home and Community Care		1,074,000
Transfer Nursing		722,000
Professional Practice & Education		468,000
Director of Nursing Office		2,960,000
Recruitment and Retention [2]		533,000
	SUBTOTAL	5,757,000
	TOTAL	**$37,868,000**

[1] Includes Nursing Resource Team
[2] Includes Nursing Programs

FNHA Health Protection Department

The FNHA Health Protection Department is a separate, distinct department within FNHA that also employs nurses. The department was transferred from Health Canada "as is" and is comprised of a Director (Public Health Physician), a Nurse Manager and six Nurse Coordinators.

The primary focus of the Health Protection team is to ensure the current practices and new developments in communicable disease control and prevention are delivered with a First Nations focus. Program support and delivery by the Health Protection team includes prevention and control of many prevalent communicable diseases, including:

- Tuberculosis;
- Vaccinations for preventable diseases;
- Sexually transmitted and blood borne infections;
- HIV/AIDS;
- Pandemic influenza; and
- Other communicable disease emergencies.

The team provides up-to-date information and best practices of communicable disease control and outbreak management to Community Health Nurses, Community Health Representatives, Community Health Workers and Health Directors working within First Nations communicable disease programs.

Findings

Context for Findings

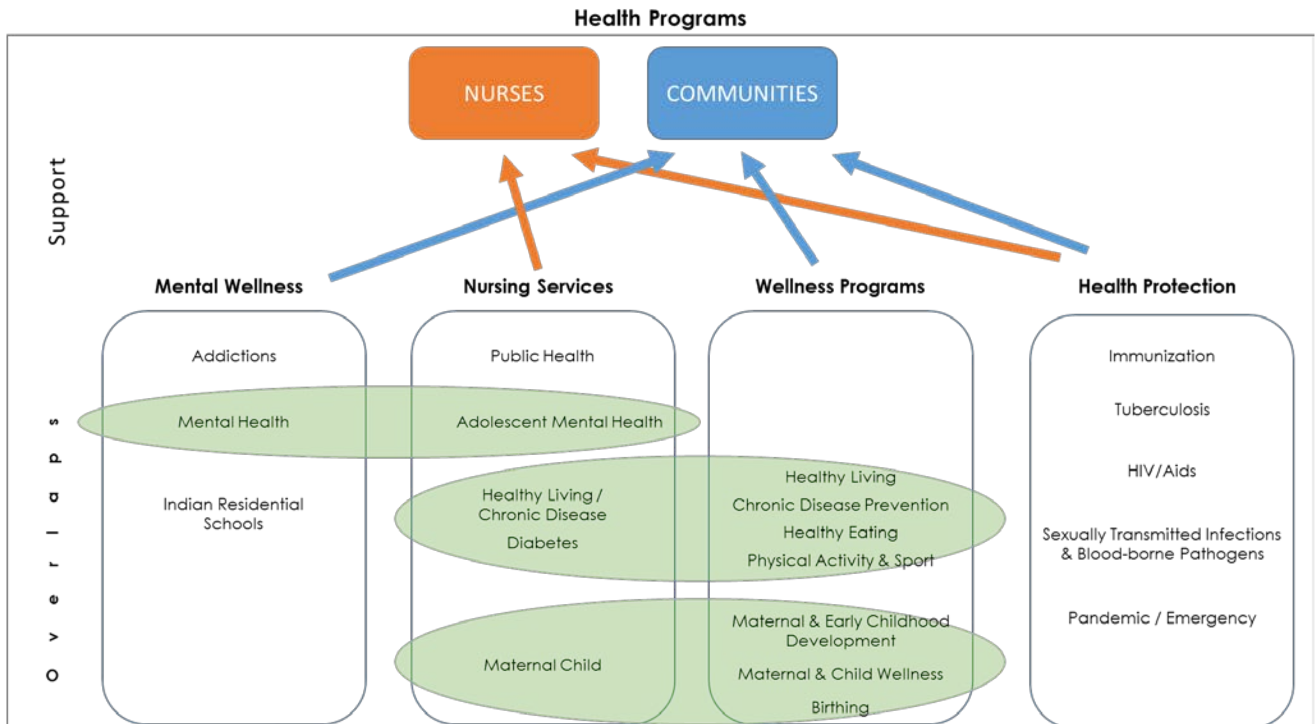
Findings provided in this report reflect issues that were identified by many communities/ stakeholders. It should be recognized that the delivery of nursing services varies widely from community to community. As such, the findings listed below may apply in varying degrees to specific communities.

Findings are organized under the following key headings:

1. Health Programs
2. Nursing Issues
    - Nursing Integration
    - Support for Nurses
    - Recruiting and Retention
    - Critical Incident Reporting Culture
    - Scope of Practice
    - Data Collection and Reporting
3. Interactions with Regional Health Authorities
4. Services and Resources
    - Public Health Services Provided
    - Health Care Resource Available in Communities
5. Health Human Resources
6. Nurse Focus Group Summary
7. Nursing Survey Summary

1. Health Programs

Various FNHA departments have responsibility for health programs:



There is program overlap between Nursing Services and the Wellness Programs and Mental Wellness departments.

In addition, Nurse Coordinators in Health Protection have responsibility for programs that support both nurses and communities.

The impact of this structure on FNHA is threefold:

- There is no single home or reporting for like programs;
- Departments can work in silos and do not collaborate effectively; and
- Structure can create confusion for communities in accessing services.

2. Nursing Issues

Nursing Integration

Legacy nursing services in many communities are not well integrated with community resources, regional health authority resources and other health care providers. Several examples were cited where:

- FNHA nurses did not communicate with community-employed nurses;
- Community Health Nurses were not working effectively with Home and Community Care Nurses
- There was poor communication between nurses and other community-based health resources (e.g. mental health, Community Health Representatives) and with visiting health resources (e.g. physicians, nurse practitioners).
- Access to and use of space in health facilities was not shared amongst community care providers but was utilized based on employer (i.e. community employee space vs FNHA employee space).

Privacy rules and the need for information sharing agreements are impacting the integration of care within communities and with regional health authorities. There is a need to educate care providers on sharing patient information in a care setting (e.g. case management; case conferencing).

It is important to highlight that there are examples of high functioning, better integrated care models and of innovative practices. However, there is no formal forum for sharing these practices across communities.

Support for Nurses

Nurses providing services to First Nations communities receive support from various sources:

- FNHA (Education, Practice Support, Program Support);
- Regional health authorities (ER, GPs, NPs, Education, Practice Support, Program Support); and/or
- Communities (Practice Support, Program Support).

There is no single consistent approach in which communities access support for nurses. However, the ability to access support from multiple sources (e.g. FNHA; regional health authority; community) is seen as a benefit.

From an FNHA perspective, support for nurses is not consistent:

- There is little support for new nurses in how to set up and run public health clinics.
- Examples were cited where nurses are not made aware of existing FNHA resources and develop their own materials, leading to inconsistent practices. High turnover of health directors in communities is also a contributing factor to low awareness.
- Community members are not always aware of supports provided by FNHA. Some communities do not know who to contact at Nursing Services in order to access

services. Examples were cited where email inquiries to Nursing Services required shorter response times.

- FNHA does not provide formal mentoring and/or peer networks. There is limited opportunity for nurses to interact with their nursing colleagues.
- Most felt that the education opportunities/courses provided were excellent. Nursing Services provides access to the Course Catalogue Registration System used by Vancouver Coastal Health, Providence Health, Fraser Health and Island Health. Nurses also have access to the *Connecting Learners with Knowledge* website for wound care courses.

Ultimately, nurses felt it was up to them to seek out the required supports and to establish their own professional connections and relationships.

Recruiting and Retention

Many communities have experienced high turnover of nurses regardless of whether they are serviced by FNHA-employed nurses or Transfer Nurses. There are several factors contributing to this issue:

- Geographic isolation in remote communities with few amenities available.
- Few employment opportunities for spouses in communities.
- Professional isolation with no formal peer or mentor support programs in place.
- Limited professional support for new hires in establishing clinics.
- Limited on-reserve accommodation and significant travel between communities
- Competition for nurses from other organizations (e.g. regional health authorities, Doctors Without Borders, cruise ships).
- Preference for part-time work in order to raise families and/or to slow down as approaching retirement. (During the last 8 months of 2014, FNHA received 27 nurse applications – 1 applicant was interested in full-time work, with the balance seeking part-time work).
- Some communities are paying nurses well below the unionized rates (PIPSC) for FNHA-employed Community Health Nurses. The following salary information was provided from the Nursing Survey responses:

	CHN3 (PIPSC)	Lowest Reported Salary- HCC (per nursing survey)
Salary Range	$72,000- $83,000	$49,000
Benefits	22%	0

Due to the limited number of survey responses providing compensation information, it is difficult to conclude on how many communities are compensating their nurses at below unionized wages and on how large an issue wage disparity is. However, this finding is consistent with comments received in the Nursing Survey and feedback received from the Nursing Focus Groups.

Generally, salaries for FNHA-employed nurses are below those offered by the regional health authorities (closest position to an FNHA CHN4 Nurse in Charge is a CH3 per consultation with HEABC). However, when additional allowances are factored in for education, advanced practice training, leadership and retention, the FHNA total compensation exceeds that of a CH3. Some of these allowances, however, are meant to address specific issues that are not required for a CH3 – namely isolation and advanced training qualifications.

	CHN4 (PIPSC)	CH3 (BCNU)
Highest Salary Grade	$87,000	$94,000
+ Education Allowance	$3,300	0
+ Expanded Professional Role	$6,000	0
+ NIC Allowance	$6,000	0
+ Retention Allowance	$5,500	0
TOTAL	**$107,800**	**$94,000**

CHN4 salary based on collective agreement March 31, 2014

The recruitment challenge is not entirely financial. The larger challenge is the ability to find and retain nurses who are willing to work in remote settings.

The impact of an unstable workforce significantly impacts nursing services provided:

- Vacant positions are often staffed with short-term resources (e.g. Resource Team, agency nurses), while permanent hires are being sourced. Positions can remain vacant for long periods of time which can result in multiple nurses filling a position. This results in a loss in the continuity of care in communities with patients being seen by a different nurse each time they visit a health facility.
- Temporary nurses do not always have the trust of the community, which can lead to community members not seeking care. This trust is viewed as important to an effective care provider/patient relationship, especially when patients are presenting with public health issues and/or longer term chronic disease issues.
- Many nurses come from acute care settings and are not well trained or comfortable with the community health scope of practice.
- It is difficult for FNHA to support standardized care and to effectively roll out and manage nursing programs on a consistent basis from community to community.

- Reliance on agency nurses adversely impacts services:
  - Many nurses have limited remote and/or First Nations experience and do not possess the cultural competency/safety attributes that are desirable for working in First Nations communities.
  - Nurses do not always have Remote Nursing Certified Practice credentials required to work in Nursing Stations. (CRNBC allows use of RNs if all efforts fail in locating a Remote Nursing Certified Practice nurse)
  - Costs are significantly higher: FNHA nursing management estimates the cost per week for an agency nurse is $5,000 (includes travel, accommodation, meals) or more than double the cost of a nurse who is an employee. This estimate is consistent with a Health Canada report (Health Canada, Final Audit Report, 2010) estimate that each agency nurse adds $106,000 in costs annually for an FTE equivalent work effort.
  - FNHA estimates that it spent over $2 million last year on agency nurses. This estimate does not include the amount spent by Transfer Nurse communities on agency nurses.

Nursing Services has identified nurse recruiting and retention as a priority and is taking steps to address this issue:

- Increasing flexibility for filling historic full-time positions with part-time nurses.
- Establishing a casual pool for short-term relief to reduce reliance on agency nurses.
- Revising new nurse orientation to provide experience/training for public health nursing.

Critical Incident Reporting Process

The critical incident reporting process for FNHA-employed nurses is not well understood by the nurses in the field. (Communities are responsible for this process for their nurse employees).

Scope of Practice

Remote Nursing Certified Practice

Nurses working in Nursing Stations in remote communities require a broader range of knowledge and skills than those nurses working in Health Centres. Due to geography and practitioner preference to work in larger communities, there is no resident physician or nurse practitioner and, as a result, nurses are required to operate in an expanded scope of practice.

CRNBC requires all nurses working in Nursing Stations to obtain their Remote Nursing Certified Practice training and to take supplemental courses to prepare them for working in these remote communities. In addition, nurses in these communities are supported remotely via the phone, and in person via periodic visits, by physicians and nurse practitioners. When physicians and nurse practitioners are not available for consultations, nurses rely on phoning Emergency Room physicians at designated hospitals.

Remote Nursing Certified Practice is supported by Decision Support Tools which provide guidance for certain conditions. Some identified a need to improve access to physician and nurse practitioner supports for these instances.

Nurse Practitioner

Nurse Practitioners have a broader scope of practice as compared to Registered Nurses and Remote Nursing Certified Practice Nurses. They have advanced nursing practice competencies at the graduate level of nursing education and are able to diagnose, prescribe and order diagnostics for client care and work independently without direct supervision. They collaborate with physicians as required and are able to use their own clinical judgement and decision-making.

Nurse Practitioners' broad scope of practice, in-depth knowledge of public health (health management, health promotion, disease/injury prevention), and their clinical judgement capabilities make them well suited to practice Public Health and to practice in remote communities. Currently, Nurse Practitioners provide services, via partnerships with regional health authorities, to many rural and urban First Nations communities.

Two studies further support the role of Nurse Practitioners:

- Public Health: The presence of a Nurse Practitioner in Public Health models improved chronic disease management (Russell et al 2009).
- Remote Communities: Remote Nursing Certified Practice implemented in remote First Nations communities may promote continuation of inequities in primary care as Remote Nursing Certified Practice has a narrow scope of practice and the needs of remote First Nations are more aligned with the scope of practice of Nurse Practitioners (Tarlier and Browne 2011).

NPs currently focus on treatment and diagnostic focus is medication management. Shifting NPs to practice to their full scope would enhance public health, health promotion and prevention of chronic disease. It should be noted that Nurse Practitioners would require certified practice designation in order to provide urgent/emergency nursing.

Consideration should be given to shifting NPs to practicing to their full scope and increasing the use of Nurse Practitioners in supporting remote First Nations communities in order to improve health outcomes.

There is an additional cost for employing Nurse Practitioners as compared to Remote Nursing Certified Practice nurses. However, it may be difficult to attract Nurse Practitioners as regional health authorities provide competitive salaries and do not require additional education certifications or work to be performed in remote communities.

	CHN4 – NIC (Remote Nursing Certified Practice)	NP (CHN4)	NP (per PHSA)
Base Pay CHN4	$87,000	$87,000	$108,000
+ Education Allowance	$3,300	$3,850	$5,000
+ Expanded Professional Role	$6,000	n/a	0
+ NIC Allowance	$6,000	n/a	0
+ NP Allowance	n/a	$18,000	0
+ Retention Allowance	$5,500	$5,500	0
TOTAL	**$107,800**	**$114,350**	**$113,000**

Nurse Practitioners are classified as CHN4s in the PIPSC Collective Agreement. Nurse Practitioners require professional practice support, administrative support, a physician partner for patient referrals and clinical consultations and potential infrastructure investment.

Data Collection and Reporting

There is no systematic data collection and reporting function to support nursing. Data does exist but it is largely recorded on paper-based nursing logs in communities. Some communities have Electronic Medical Records (EMRs) so will have more sophisticated electronic reporting. However, the information for Transfer Nursing communities is not shared with FNHA. Nursing statistics for former Health Canada nursing facilities have been generated but, historically, no action has been taken to compile the data for analysis purposes. In late 2014, Nursing Services started to analyze existing data for its facilities.

Most communities report out basic nursing information on their annual Community-based Reporting Templates. However, some have noted that this information is not always complete or accurate. Historically, the information collected on the Community-based Reporting Template was sent to Health Canada and never shared directly with Nursing Services.

The Home and Community Care program is supported by mandatory service delivery and human resource reporting templates. Detailed information is available on resource deployment and services provided.

Due to challenges in collecting data, it is difficult to establish baseline measures upon which progress can be measured. Many interviewees noted that the nursing information collected for all programs is input-based and is not tied to performance-based outcomes.

As a result of the above circumstances, Nursing Services has operated with little operational data to help inform departmental decision-making and priority-setting processes.

3. Interactions with Regional Health Authorities

Based on interviews with regional health authorities staff and community members, regional health authorities are generally supportive of FNHA and of nursing. Some communities have formal MOUs for service with their respective regional health authority. However, the quality of many community/regional health authority relationships is dependent on the local relationships with regional health authority services provided on an informal or as requested basis.

There is not a consistent understanding of the roles of FNHA nursing, communities and regional health authorities. This has led to inconsistent practices across the province.

At the onset of this project, none of the regional health authorities had a full, centralized picture of the services and supports provided to First Nations communities. For the most part, regional health authorities provide many of the following resources to support communities:

- Family physician sessions.
- Visiting Primary Care team (e.g. physician, nurse, mental health nurse, dietician, diabetes educator, rehab staff).
- Nurse Practitioners.
- Remote nursing clinics (basic primary care).
- Aboriginal Liaisons.
- Immunization clinics.
- Community Health Nurses – both FTE and relief.
- Home and Community Care Nurse – both FTE and relief.
- Program teams (Healthy Eating, Diabetes).
- Occupational Therapists.
- Physiotherapists.

In support of this project, Island Health undertook an inventory of services provided to Aboriginal people in BC. This inventory is included as Appendix 1. Interior Health indicated

that they plan to develop a similar services inventory in the spring of 2015. Northern Health attempted to gather a services inventory but the results remain incomplete to-date. However, Northern Health published a Northern Region Aboriginal Health Services Directory in 2012 that provides information on all health facilities, services and resources for First Nation communities in the North.

Regional health authorities offer many communities the same nursing support services provided by FNHA - nurse consultations, professional practice support and education/training opportunities. Examples were cited where regional health authorities provided their existing public health program materials to nurses in communities to assist with their clinic work.

Other observations:

- The overlap in services provided by FNHA and a regional health authority can create confusion for communities and nurses seeking support.
- There are opportunities to improve the patient discharge planning process:
    - Discharge plan information does not always follow the patient back to the community.
    - Acute centres do not always inform communities that patients are being discharged.
- The Aboriginal Liaison position is highly valued by communities. However, as there are few positions, the Aboriginal Liaisons carry a large workload and do not have the capacity to support all First Nations patients under regional health authority care.
- Some regional health authority staff do not have the necessary cultural competencies required when treating First Nations patients. Due to past negative experiences, some community members do not seek help from regional services.

4. Services and Resources

Public Health Services Provided

Community-based Reporting Templates collect data on "awareness and education activities" offered in each community during the year for the various Public Health services. An analysis of this data shows the percentage of communities that offered each Public Health service. The following table shows the program participation rates for fiscal 2012/13 by:

- FNHA Health Centres;
- FNHA Nursing Stations; and
- Transfer Nursing Health Centres.

Services	FNHA Health Centres *(based on 24 responses)*	FNHA Nursing Stations *(based on 7 responses)*	Transfer Nursing Health Centres *(based on 83 responses)*
Health Child Development			
Nutrition Screening, Education & Counselling	71%	100%	78%
Maternal Nourishment	88%	100%	77%
Breastfeeding Promotion, Education and Support	67%	100%	73%
Chronic Disease and Injury Prevention			
Physical Activity	75%	100%	80%
Nutrition	75%	100%	78%
Diabetes	63%	100%	75%
Communicable Disease Control			
HIV/Aids-Blood Borne and Sexual Transmitted Infections	33%	43%	49%
Tuberculosis	17%	14%	37%
Immunization	17%	14%	47%
Pandemic Planning	29%	29%	33%
Infection Prevention and Control	21%	14%	42%

Source: CBRT Data (2012-13)

The participation rates for communicable disease control services is very low. This finding is consistent with the Nursing Survey results where communities identified additional training and support for communicable disease services as an issue.

Health Care Resources Available in Communities

The Community-based Reporting Templates collect data on the number of health care workers in each community. An analysis was performed on this data to determine the number and types of health team resources that work in First Nations communities in addition to nurses. Community-based health workers include Community Health Representatives and various program workers (NNADAP, AHSOR, etc.). Administrative staff includes janitorial and housekeeping.

The following table outlines the staffing levels for non-nursing resources employed in communities during fiscal 2012-13 (e.g. 62% of reporting communities had between 0-3 full-time community-based health workers).

No. of Resources	Community-based Health Workers - Full-time (%)	Community-based Health Workers - Part-time & Visiting (%)	Administrative Staff - Full-time (%)	Administrative Staff - Part-time & Visiting (%)
0 - 3	62%	75%	94%	99%
4 - 8	26%	21%	4%	1%
9+	12%	4%	2%	0%

Source: CBRT Data (2012-13)

Most communities employ and/or have access to a number of health care workers and a limited number of administrative staff. Based on our community visits, we noted that some roles (e.g. Community Health Representatives, NNADAP worker) are common, but specific roles, responsibilities, and qualifications of individuals in these roles vary from community to community.

5. Health Human Resources

Provincial Context

FNHA Health Human Resources' goal is to promote and support First Nations and Aboriginal people in pursuing careers in health care delivery. There are many stakeholders and existing partnership groups in BC that share the mandate of increasing support for post-secondary education opportunities for First Nations (e.g. BC Aboriginal Post-Secondary Education and Training Partners Group, Indigenous Adult Higher Learning Association).

FNHA does not hold formal agreements with any post-secondary institutes and is not involved with the above mentioned larger partnership groups. The priorities of these larger bodies do align with FNHA priorities, but are broad-based while FNHA has a specific interest in health programs.

FNHA Context

FNHA has undertaken activities and initiatives in Health Human Resources that are tailored to its mandate. A summary of these initiatives are provided in Appendix 2.

During the course of the review, the following observations were made related to nursing:

- Communities have traditionally been responsible for career promotion on behalf of their members. Many communities have programs that promote and support careers in various fields, including healthcare. FNHA's Health Human Resource Team provides resources/materials and actively supports health career promotion, including nursing, at communities' requests.

- Communities have negotiated relationships with post-secondary institutions for community specific training/education programs. Some examples:
  - Carrier Sekani Family Services negotiated an agreement with UNBC to start an Aboriginal Health Science Program to provide sciences support to allow Aboriginals to bridge to a university setting.
  - ITHA has been working with Vancouver Island University and with UBC Aboriginal Health and Community Administrative Program in developing a new non-degree program proposal for a Community Health Promotion for Aboriginal Communities Certificate.
  - Seabird Island began operating a College on reserve in 2009 that offers many vocational courses to community members (including BC Adult Dogwood high school equivalency). For nursing, Seabird Island partnered with Nicola Valley Institute of Technology to offer Home and Community Care course and partnered with Vancouver Community College to offer Licensed Practical Nurse training and certification. The college may look at ways to offer laddering education to allow Licensed Practical Nurses to pursue their Registered Nurse certification. The college model addresses traditional barriers to pursing education by offering daycare, pre-school, transportation, housing and food.
- Some models have been successful. Others have not be sustainable due to:
  - Lack of critical mass in a community to support ongoing demand for training
  - Over reliance on key individuals; if they leave the community, the program loses critical supports.
- FNHA currently does not play a role in developing these post-secondary relationships and training opportunities.

6. Nursing Focus Group Summary

Focus groups were conducted in November 2014 during the Annual Nursing Forum. In addition, communities contacted WMC to conduct additional focus group discussions with their nurses via teleconference. Appendix 3 provides a detailed summary of issues raised during these discussions. A summary of these issues is provided below:

- Nursing operates in silos with little interaction or communication between FNHA, Nursing Services management, Transfer Nursing communities and the nurses.
- Many clinics feel understaffed which contributes to nurse burnout and attrition (especially true for Nursing Stations where nurses are required to be on call)
- Nurses require additional training on programs and available tools prior to being placed in a health facility. These program materials should be made available online
- Education opportunities are excellent as compared to the provincial health authorities.

- There are pay inequities with some community-employed nurses receiving lower wages than unionized nurses
- Many nurses had good experiences with the mentor program in the past. Funding is no longer available to support this program
- There is pressure at Nursing Stations to focus on Treatment services at the expense of Public Health services. Most believed that both services could be delivered if there was flexibility in clinics schedules to set aside time for Public Health consultations
- Most nurses felt that training for cultural competencies is well done.
- Nurses are passionate about what they do. They believe they have not had a say in the future direction of nursing under FNHA. They want to see nursing represented at the senior leadership table and want to be excited about their futures. They would like to see more communication and engagement with FNHA and Nursing Services management.

7. Nursing Survey Summary

A Nursing Survey was developed with the assistance of FNHA Nursing Services. The survey was distributed to all Health Directors who are members of the First Nations Health Directors Association. A total of 132 surveys were sent out and 44 were completed and returned (representing a 33% response rate). Not all surveys were fully completed.

The largest single theme identified in the survey responses is that nursing is underfunded for many communities. Respondents identified two implications stemming from underfunding: communities are unable to offer market wages for nurses; and communities are unable to offer a full breadth of health programs due to lack of nursing resources.

Appendix 4 provides a detailed summary of survey findings. A summary of these findings is provided below:

- There is a high turnover in nursing which impacts both the breadth and quality of services delivered. Temporary nurses are often utilized and are not always culturally competent.
- A greater focus needs to be placed on health prevention, health promotion and communicable disease programs. It is felt that these programs will have the greatest impact on health outcomes.
- There needs to be more program and training resources made available to nurses and to other community healthcare providers. These resources should be made readily accessible online.
- The communication and process for discharging patients from regional care back to the community needs to improve. Often, patient care information is not available to

care providers in the communities and/or communities are not notified when patients are to be discharged.

- Communities felt that existing community resources (Community Health Representatives, Medical Office Assistants, receptionists) could be better utilized to better support health and wellness activities.

Best Practices in Nursing

This section outlines current best practices in nursing with a focus on areas applicable to FNHA - Indigenous nursing, community/public health nursing, and remote nursing. These findings are based on a review of literature (both peer reviewed and grey literature). In addition, we interviewed two Indigenous health organizations to better understand their nursing models.

Best practices findings are organized as follows:

1. Literature Review
   - Interdisciplinary Care
   - Integration of Primary Care and Public Health
   - Optimizing Skills Mix
   - Rural/Remote Communities – Economies of Scale
2. Indigenous Health Organizations
   - Southcentral Foundation
   - The Indian Health Service (U.S.)

These best practices will inform the specific strategies recommended for FNHA.

1. Literature Review

Interdisciplinary Care

Interdisciplinary team models are teams with different healthcare disciplines working together towards common goals to meet the needs of a patient population. Team members divide the work based on their scope of practice; they share information to support one another's work and coordinate processes and interventions to provide a number of services and programs. The effectiveness of a team is dependent on the team members' knowledge of one another's roles and scopes of practice; mutual trust and respect amongst team members; commitment in building relationships; willingness to cooperate and collaborate; and the extent to which the team has organizational supports (Virani, 2012).

At the centre of these teams is the patient, their family and community. Patient-centred care recognizes that the patient is the most important consideration in health care (Canadian Nurses Association, 2013). Patient-centred care is seamless access to the continuum of care in a timely manner, based on need that takes into consideration the

individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity (Canadian Medical Association, 2010).

Fundamental to this model is an underlying recognition that better health status and patient outcomes stem from productive interactions between informed patients and interdisciplinary teams of prepared providers. The patient is a proactive leader and manager of individual care needs (Canadian Nurses Association, 2013). Also critical to this model is the role and interaction of the patient and provider with the broader community (Health Canada, 2012).

Integration of Primary Care and Public Health

There is a growing interest in collaboration between Primary Care and Public Health, and how it can improve the health of populations and quality and effectiveness of health care systems. Evidence supports the benefits of collaboration between Primary Care and Public Health in the following areas: maternal-child programs; communicable disease prevention and control; health promotion and health protection; chronic disease prevention and management; youth health; women's health; and working with vulnerable populations (Valaitis, 2012).

Collaboration between Primary Care and Public Health aligns with the BC Ministry of Health's priorities, evidenced by a Ministry-developed "Primary Health Charter" that encourages the integration of primary and community system health services (Ministry of Health, 2015). The Ministry supports integrated and comprehensive person-centred health care with service delivery in communities and with clear referral pathways outside of communities to access services not offered in communities.

Nurses play integral roles in both Primary Care and Public Health. Given their backgrounds in each service, nurses are a logical resource to build and support collaboration in an integrated model.

Optimizing Skills Mix

Critical to the implementation of an interdisciplinary model is having the right skill mix. From a nursing perspective, there are gains to be made by having nurses working to their full scope of practices (New Brunswick Health Council 2010) and selecting the nursing categories (e.g. Nurse Practitioner, Registered Nurse, Licensed Practical Nurse) by aligning scope of practices to the types of services being offered. This alignment enables the shifting of administrative and/or inappropriate levels of work to appropriate members of the team (e.g. Licensed Practical Nurse, Medical Office Assistant, Community Health Representative). The team mix will depend on the needs of each community, and to an extent, the availability of care providers in that community.

The most common approaches for optimizing staff mix are adjusting the number of personnel, mixing qualifications (e.g. including both basic and advanced professionals),

balancing senior and junior staff members, and mixing disciplines (i.e. interdisciplinary care team). There is evidence that richer staff mix approaches may be associated with better outcomes and fewer adverse events (Dubois and Singh, 2009).

Please refer to Appendix 5, an analysis of scopes of practice for Nurse Practitioners, Remote Nursing Certified Practice Nurses, Registered Nurses and Licensed Practical Nurses overlaid on existing FNHA nursing functions. Based on this analysis, there does appear to be opportunity to optimize skills and resources across nursing programs.

Rural/Remote Communities - Economies of Scale

Remote communities face unique challenges in accessing healthcare. Remote areas tend to have low population density, small settlements, large distances between settlements, transient populations, and high capital costs per capita for infrastructure. Variations in the degree of isolation results in differences in a community's needs and ability to sustain health services.

Successful remote models are those which have addressed the diseconomies of scale through aggregating a critical population mass, whether it be a discrete population in a town or a dispersed population across a region. Evidence indicates that a minimum population base of about 5,000 for rural and 2,000 to 3,000 people for remote communities is required to support an appropriate, sustainable range of Primary Health care activities. Communities of less than these populations will require some degree of population aggregation within an appropriate model (Wakerman et al, 2006).

In smaller communities with few providers, long-distance teamwork may help address skill gaps (Martin-Misener & Bryant-Lukosius, 2014). The use of hub and spoke models and telehealth have been used to fill resource gaps and to create virtual teams that are integrated with care providers located in remote communities.

2. Indigenous Health Organizations

Southcentral Foundation

Southcentral Foundation was formed in 1982 when it assumed management of the Primary Care system in Alaska previously run by the Indian Health Services on behalf of Alaska Native people. Southcentral Foundation has transformed its healthcare model to a "customer-owned" system over the past 30 years and it is recognized as a leader in performance excellence. Highlights of its Primary Care model are provided below:

- Southcentral Foundation's Nuka model is based on the notion of relationship – getting to know and recognize the uniqueness of the individual customer-owner, employee or provider in order to develop flexible strategies that fit individual needs (Blash et al, 2012).

- Southcentral Foundation has a centralized Primary Care model with multiple integrated care teams located in Anchorage. Each care team is assigned approximately 1,300 customer-owners, comprised of mainly local customers but may include 1 to 2 remote villages.
- Each integrated team is comprised of:
    - 1 FTE Provider*:* Either a physician, Nurse Practitioner or Physician's Assistant.
    - 1 FTE Registered Nurse Case Manager*:* Registered Nurse usually does not have direct customer-owner interaction. They work behind the scenes as case managers on prevention and chronic disease management. Registered Nurses manage the referrals, take patient calls and do triage.
    - 0.5 FTE Case Management Support*:* Provides administrative support to the team, particularly to the Registered Nurse Case Managers.
    - 1.5 FTE Medical Assistants*:* Certified Medical Assistants do the daily clinical work, and they are the staff members that connect with and build relationships with the customer owners.

Integrated care teams are supported by ancillary professionals that are shared with other teams (e.g. dietician, physiotherapist, occupational therapist, etc.)

Fundamental to this model is that staff are trained to work at the top of their license in small teams. All but the most critical tasks were delegated to non-providers and the role of Registered Nurse shifts to case management and chronic disease management. Registered Nurses' day-to-day clerical tasks are delegated to Certified Medical Assistants.

The Health Education and Wellness Centre, located in Anchorage, partners with the integrated care teams in providing a variety of promotion and disease prevention programs. These services are delivered by Health Educators and Exercise Specialists. The centre does not employ any nurses to deliver Health and Wellness courses.

Resources in rural communities:

- Small remote communities have community-employed Health Aides that utilize Decision Support Tools and are linked to and supported by Integrated Teams. Larger communities may have a Nurse Practitioner or a Physician's Assistant available to provide chronic disease and prevention services.

Other Attributes:

- The co-location of teams promotes team building and improves supervision, which allows for greater delegation of tasks.
- Team members are trained in how to work in teams, integrated care, and quality improvement measures.
- New hires are mentored until they are ready to work on their own (2-6 weeks).

- The organization has a career ladder as part of a "grow-your-own" strategy to promote from within to develop leaders.
- Southcentral Foundation has invested in evidence-based practices, is supported by a common EMR, and maintains extensive data to measure progress in a number of areas.

The Indian Health Services (U.S.)

The Indian Health Service, an agency within the U.S. Department of Health and Human Services, is responsible for providing a comprehensive health service delivery system for American Indians and Alaska Natives who are members of 566 federally recognized Tribes across the United States. The Indian Health Service has three models:

1. Federal facilities: Health facilities are owned by the Indian Health Service and staff are employees of the Indian Health Service.
2. Tribal facilities: The Indian Health Service provides funds directly to Tribes and each Tribe manages and hires its own health workforce.
3. Urban facilities: The urban model is similar to the Tribal model in that the Indian Health Service provides funds to the Urban facility and it hires and manages its own health workforce. Urban facilities are meant to provide services to any Aboriginal and is not Tribe-specific.

There are also a few joint venture arrangements where facilities are owned by the Indian Health Service and are staffed and managed by Tribes. Tribal facilities currently make up approximately 50% of all facilities. It is the view of some within the Indian Health Service, supported by recent trends, that all facilities will eventually move to the Tribal model.

Primary Care teams support approximately 1,100 people and are comprised of:

- 1 FTE Provider Family Physician;
- 1 FTE Nurse Practitioner;
- 1 Registered Nurse (performing higher level nursing duties); and
- 1-2 FTE Nurse Assistants.

Public Health Services are provided through the Division of Public Health using an Advanced Practice model that employs Nurse Practitioners. Nurse Practitioners are supported by Community Health Representatives for non-medical duties. These positions are not licensed.

The Indian Health Service has direct supervision and program input into Federal sites but does not have this mandate for Tribal and Urban facilities. The Indian Health Service makes all its services and supports available to Tribal and Urban facility staff but participation is not

mandatory. The Indian Health Service will influence and negotiate with Tribes on nursing policies but ultimate decision making is in the hands of the Tribes.

In facilities with multiple employers, governance structures were created with representation from all disciplines (medical, mental health, public health, etc.). The purpose of these governance structures is to discuss how care is being delivered (patient-centred), and to promote communication and collaboration amongst all health care providers. The Indian Health Service has seen positive impacts of this governance model on team-based care.

Nurse Practitioners have been promoted to leadership positions within the organization and are running major programs and product lines.

Recommendations

Context for Recommendations

Community Health Nursing is an integral component of community health and wellness resources. Overlap between Community Health Nurses and other community wellness providers is inevitable as everyone supports the same patients in the same communities. For this reason, our recommendations start with an overarching model of care that aligns with FNHA's vision, is grounded by best practices, and provides future direction to all community health and wellness disciplines. Subsequent recommendations focus on enabling strategies for aligning Community Health Nursing to this future direction.

Implementation will be a journey, will vary from community to community, and will need to take into account:

- The current status of nursing and wellness models in communities recognizing that there is a wide variation in degree of integration, resources and services;
- Community readiness for change; and
- Timelines for availability of enabling technologies required to realize full benefits.

These factors will inform decisions by FNHA, communities and regional health authorities on individual implementation approaches for communities.

1. Service Model

Strategy

Shift to an interdisciplinary model of care (see chart below) that integrates Primary Care and Public Health in communities and that:

- Is **patient-centred** and focuses on the needs of both the individual and their families and the population's health needs, and uses evidence-based practices for serving these needs;
- **Enables patients to make informed decisions** on their care and to be an active participant in their care planning;
- Utilizes **interdisciplinary teams** comprised of an appropriate mix of health care providers working collaboratively and to their respective full scopes of practice;
- **Integrates health services** at the community level and integrates health services with other services, including traditional wellness, available in the community; and

- **Provides links** to health services available outside the community.

Interdisciplinary Model of Care

This strategy will involve:

- Establishing clear roles and responsibilities for team disciplines, and guidelines and tools to support safe and effective practices. This will enable nursing to better integrate with other health care providers in communities.
- Providing training to teams to learn to work as teams and to understand the integrated care model.
- Focusing on health prevention and health promotion in order to promote patient self-management.
- Defining roles in governance to facilitate team collaboration, recognizing that teams may be comprised of staff employed by FNHA, communities, regional health authorities and private practitioners (e.g. physicians).

- Working with communities and regional health authorities to map current resources by community, to identify gaps and to establish interdisciplinary teams that will service each community in a hub and spoke model. This may require aggregation of communities to achieve certain economies of scale and/or sharing of team members between communities.
- Working with communities and regional health authorities to establish linkages for each community to acute, specialist and other health services not available in communities.
- Utilizing technology to support the interdisciplinary model.
- Working with the Ministry of Health and health authorities to align the interdisciplinary model and linkages with their key planned initiatives.

2. Nursing Resource Mix

Strategy

Develop a nursing resource mix model that aligns with the interdisciplinary model and that optimizes the utilization of existing nursing resources in order to provide high quality care. This strategy will involve:

- Working with communities to explore opportunities to build capacity by leveraging a wider array of professional and support staff: e.g.
  - Leveraging Community Health Representatives and Medical Office Assistants to support administrative and lower skill level Public Health activities.
  - Establishing programs for community members to train for entry level health and administrative support positions.
  - Establishing career development pathways for Medical Office Assistants and Community Health Representatives to upgrade their training to become Licensed Practical Nurses.
- Reviewing scopes of practice for all nursing certifications relative to the communities' health needs with a view to promoting all nurses (regardless of certification or their employer) working to their full scopes of practice. This will require enhancing the skills of existing community-based staff to be able to perform delegated tasks.
- Increasing the number of Nurse Practitioners servicing remote communities to complement and/or replace Remote Nursing Certified Practice Nurses in order to enhance the level of Public Health and Primary Care services and knowledge supporting these communities. The Nurse Practitioner role would also serve to mitigate the current risk associated with Remote Nursing Certified Practice Nurses performing treatments out of their scope of practice. Consideration should be given

to upskilling existing Remote Nursing Certified Practice Nurses to obtain their Nurse Practitioner certification.

3. Enabling Technology

Strategy

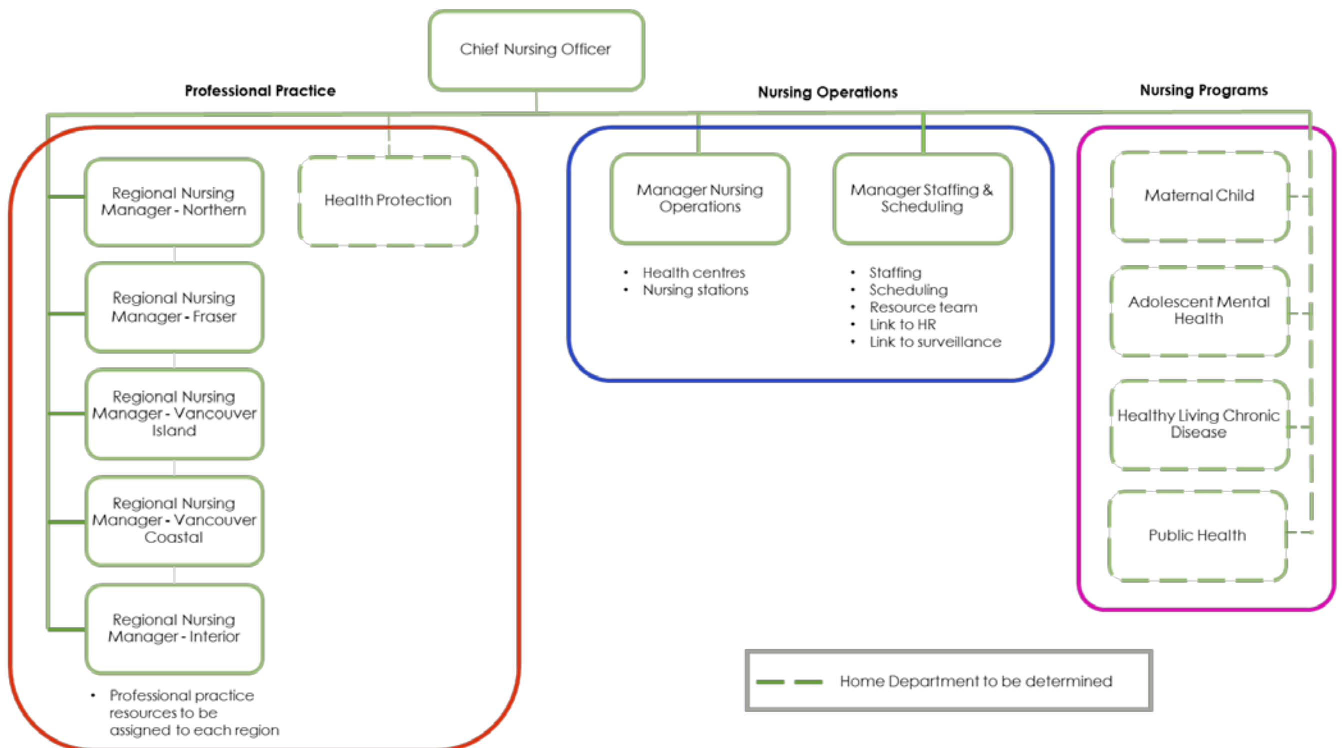
Implement eHealth and health-related technologies that will support and optimize the implementation of the recommended service model. This strategy will involve:

- Implementing an integrated community /primary care EMR to enable the use of a common record. Shared access to a common patient record will promote increased collaboration and communication by Interdisciplinary team members in delivering care.
- Working with communities to standardize EMR workflows in order to realize efficiencies and improved patient outcomes.
- Integrating the EMR with regional health authorities and physician systems, where possible, to capture patient information for treatments received outside the community. This integration will promote a more complete view of a patient's history, improve discharges from acute care to community, and assist with community-based care planning.
- Implementing Panorama (Communicable Disease Surveillance and Management system) and providing access to all communities to allow care providers with integrated tools that assist in monitoring, managing and reporting on Public Health. Panorama should be integrated with the EMR.
- Accessing EMR information to support quality, evaluation and surveillance initiatives.
- Implementing telehealth capabilities, where possible, to communities. Having access to telehealth capabilities will allow communities to:
  - Establish virtual care teams in remote regions, thereby increasing capacity in health teams.
  - Access many more clinical services for patients close to home.
  - Provide additional educational opportunities for care providers close to home.
- Developing Information Sharing Agreements amongst FNHA, communities and regional health authorities, as required, to document the terms and conditions of the exchange of personal information in compliance with the provisions of the Freedom of Information and the Protection of Privacy Act.

4. Nursing Services

Strategy

Realign the Nursing Services Department to support the Interdisciplinary model and to better integrate within the FNHA structure. The diagram below provides a functional view of the recommended realignment:



Note: June 2015 FNHA Nursing diagram provided in Appendix 6

Significant functional changes to the existing structure and issues for consideration are as follows:

- Nursing Services to be led by a Chief Nursing Officer reporting to the FNHA COO to strengthen the nursing leadership team.
- Creation of Regional Nursing Managers with a regional mandate for:
  - Being a proactive presence in the region as a primary FNHA contact for support, working collaboratively with communities and regional bodies.
  - Providing consultative support to communities in establishing Interdisciplinary teams (practice guidelines, tools).
  - Identification and sharing of innovative and best practices for nursing and integrated care.

- Managing regional professional practice, education and program support for nurses, regardless of employer. Develop support as new nursing positions are approved (e.g. Licensed Practical Nurse, Nurse Navigator, Nurse Practitioner).
    - Developing and reporting on performance measures and working closely with communities on program evaluation/surveillance.
    - Facilitating engagement between communities and Nursing Services on community needs and on nursing programs.
- Practice support consultants to be allocated to regions/communities.
- Nursing Operations responsibilities be divided into two distinct roles:
    - Management of FNHA health facilities; and
    - Staffing and scheduling for FNHA facilities, including the Nursing Resource Team.
- Review of all health programs in Nursing Services, Health Protection, Wellness Programs and Mental Health Programs departments to determine optimal FNHA structure.
- Given their health knowledge and experience, FNHA should consider developing nurses for senior leadership positions across the organization (including for health programs).
- Enhance nursing capacity to introduce robust risk management, performance measurement, reporting and quality improvement functions and to support accreditation.

5. Nursing Supports

Strategy

Provide supports to nurse to enable them to be able to efficiently and effectively provide care. This strategy will involve:

- Developing and distributing program materials to all nurses to promote consistent practices from community to community.
- Developing training for new nurses on how to run a Public Health clinic and include this training as part of nurse orientation.
- Introducing a formal mentorship program for new nurses to better transition them to working in their new working environments. Mentorship should include a cultural safety component to assist nurses in integrating into their communities.
- Developing a catalogue of resources, supports and program materials available to nurses in communities and make these resources available online.
- Communicating the role of FNHA, key nursing contacts, and available supports to both nurses and to communities to encourage greater consistency in nursing practices and policies.

- Offering mandatory and non-mandatory education and training via telehealth and/or online to reduce the travel out of community.
- Developing standardized guidelines and tools to support an interdisciplinary model of care and provide the necessary training in communities to nurses and other team members.

6. Regional Health Authorities

Strategy

Establish effective working relationships with regional health authorities to facilitate access to services and supports for communities. This strategy will involve:

- Establishing a better understanding of each stakeholder's role (FNHA, regional health authorities, communities) in providing nursing and other services and supports to communities.
- Working with communities and regional health authorities to identify referral networks to regional services and to identify potential resources to support interdisciplinary care in communities.
- Addressing issues experienced when patients are discharged from regional hospital care to communities to ensure continuity of care. Consider including providers in communities in the care planning process.
- Formalizing services and supports in MOUs based on these common understandings.
- Identifying opportunities for cultural competency training for regional health authority care providers.

7. Performance Measurement Reporting

Strategy

Implement a performance measurement systems that supports FNHA and communities in the management of their health programs. This strategy will involve:

- Working with communities to develop objective, measurable data to be collected. Indicators should be linked to anticipated program objectives and outcomes.
- Establishing baselines for outcome measures as a basis for measuring progress towards outcome goals.
- Working with communities to determine the process for data collection & reporting and roles & responsibilities of FNHA and communities in this process.

- Utilizing the EMR to facilitate the collection of agreed-to data in a way that is convenient for communities to provide and feasible for analysis, including for program evaluations and surveillance.

8. Recruiting/Retention

Strategy

Work with communities to improve nurse recruiting efforts and to improve retention rates. This strategy will involve:

- Addressing wage disparities for community-employed nurses so that communities remain competitive in attracting nurses.
- Providing flexible employment terms in the recruiting process e.g. consider part time positions. Flexibility should also be used to retain existing nurses as circumstances change in their lives and/or careers.
- Implementing a nursing casual pool to support Nursing Operations as a way to provide a stable source of experienced, culturally competent nurses and a way to reduce agency nursing costs. Consider expanding the scope of the casual pool to cover Transfer Nursing communities.
- Implementing a career laddering program whereby nurses can improve their skills (e.g. Licensed Practical Nurses can train to become Registered Nurses who in turn can train to become a Nurse Practitioner). A laddering program will improve retention rates as nurses are provided with career paths within the organization.
- Implementing mentoring programs for new nurses and peer support/network programs for existing nurses as a way of providing additional professional support, and to promote better communication and learning.
- Changing the culture of the Nursing Services to a "no blame" culture where nurses are supported in dealing with practice issues. This change in culture will make FNHA a more attractive employer option for nurses.
- Providing additional practice and program supports to nurses so that they do not have to develop their own programs.
- Supporting communities to develop orientation programs and community specific cultural competency training in order to improve nurse retention rates.
- Working with communities to establish and respect work/life boundaries to allow nurses to enjoy personal time, thereby reducing stress levels.

9. Building Human Resources Capacity

Strategy

Develop regional capacity to provide nursing educational opportunities in a way that encourages students to seek employment in their communities. This strategy will involve:

- Working with communities to build regional capacity to provide nursing training close to home. Elements of the Seabird Island College model could be leveraged to provide entry level health care and nursing certification in other regions of the province. Infrastructure and supports (e.g. daycare, accommodation, transportation, scholarships) should be considered to enable First Nations people to pursue training.
- Engaging with the post-secondary community to establish provincial and regional partnerships in support of regional nurse training initiatives. These partnerships would not be community-specific and could be leveraged by many communities.
- Upskilling existing resources within communities (e.g. Medical Office Assistants, Care Aides, Community Health Representatives) to nursing careers. Upskilling existing resources is viewed as beneficial as they are from communities and more likely to want to pursue careers in their communities. This initiative would assist in recruiting and retention issues.

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Appendix 1 -
Island Health Inventory of Primary Health Care Services Provided to First Nations Populations

Overview of Island Health Operated Primary Health Care Services Targeted Specifically to First Nations Populations**

February 5, 2015

***** Does not include primary health care services provided by the 1013 Family Physicians and 24 Nurse Practitioners within VIHA boundaries who operate clinics and services for all populations, which may include First Nations populations***

Position Title	FTE	Location	Hours of Service	Description of Service
North Island Health Service Delivery Area				
Family Physician Sessions	52 sessions @ 3.5 hrs each	Zeballos	Once a week	Full service family physician service provided at Zeballos Health Centre
Aboriginal Liaison Nurse (ALN)	0.8	Port Hardy Hospital (Port Hardy)	0800-1540 Monday-Thursday	As a member of the hospital interdisciplinary team, the ALN plans, organizes, implements, and evaluates nursing for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings.
North Island Fly-In Teams	3.0 + 1 FP	Kingcome Guildford	Every 2 weeks (Tuesdays)	Family physician and primary health care nurse visit consistently and bring 2 other professionals (limited by plane space) that rotate between disciplines to include mental health nurse, rehab staff, Dietician, Diabetes Educator.

Position Title	**FTE**	**Location**	**Hours of Service**	**Description of Service**
Nurse Practitioner	1.0	Port Hardy Medical Clinic (PHMC) Fort Rupert Quatsino Gwa'Sala Nakwaxda'xw	0830-1630 PHMC-Mon Quatsino-Tues G& N- Wed Fort Rupert-Thurs PHMC-Fri	The Nurse Practitioner supports Primary Health Care delivery with an emphasis on prevention and management of chronic conditions to North Island First Nation communities.
Nurse Practitioner (2)	?	Port Hardy Medical Clinic		Primary care provided to all populations out of Port Hardy Medical Clinic. Outreach to Salvation Army, Port Hardy, which is predominantly First Nations. Outreach prenatal care provided at Sacred Wolf Friendship Centre, Port Hardy.
Aboriginal Liaison Nurse (ALN)	0.2	Namgis Health Centre (Alert Bay)	0930-1030 1430-1530 Monday-Friday	As a member of the hospital interdisciplinary team, the ALN plans, organizes, implements, and evaluates nursing for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings.
Zeballos Health Centre	1.5 + 1 day/month NP service	Zeballos	0830 - 16:30 M-F + 24 hour call	Remote Nursing Clinic. Basic primary health care and urgent care services to residents of Zeballos and surrounding First Nations communities.
Kyuquot Health Centre	1 + 1 day/month NP service	Kyuquot	0830 - 16:30 M-F + 24 hour call	Remote Nursing Clinic. Basic primary health care and urgent care services to residents of Kyuquot and surrounding First Nations communities.
Aboriginal Liaison Nurse (ALN)	1.0	St. Joseph's General Hospital (Comox)	0800-1540 Monday - Friday	As a member of the hospital interdisciplinary team, the ALN plans, organizes, implements, and evaluates nursing for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings.
Aboriginal Liaison Nurse (ALN)	0.8	Campbell River General Hospital (Campbell River)	0800-1540 Tuesday - Friday	The ALN plans, organizes, implements, and evaluates care transition plans for all West Coast residents in community and hospital settings.

Position Title	FTE	Location	Hours of Service	Description of Service
Aboriginal Health Dietitian	1.0	Comox to Port Hardy	0830-1610 Monday – Friday	Working as part of an interdisciplinary team, the Dietitian provides leadership and works in collaboration with other VIHA programs to support an Aboriginal population health approach to program planning and service delivery to improve access to safe, nutritious, affordable and culturally appropriate foods.
Nurse Practitioner	1.0	Campbell River	0830 – 1630 Monday - Friday	The Nurse Practitioner supports Primary Health Care delivery with an emphasis on prevention and management of chronic conditions to North Island First Nation communities
Nurse Practitioner	1.0	Courtenay	0830 – 1630 Monday - Friday	30% of patients are of identified First Nations ancestry. NP works with ALN at St. Joseph's General Hospital to connect Aboriginal patients who are being discharged and don't have primary care. Liaises with the Wachiay Friendship Centre to provide care to unattached patients they serve.
Central Island Health Services Delivery Area				
Family Physician Sessions	364 sessions (not FTE)	Ahousaht Cowichan Penelakut Halalt Malahat	2 days/week 2 days/week 1 day/week 1 day/week 1 day/week	Full service family physician services provided from within existing First National Health Centres
Aboriginal Liaison Nurse (ALN)	0.8	Nanaimo Regional General Hospital (Nanaimo)	0830-1630 Monday – Thursday	The ALN, from a culturally safe perspective, and in collaboration with the health care team, plans, organizes, implements and evaluates nursing care for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings.
Aboriginal Liaison Nurse (ALN)	1.0	West Coast General Hospital (Port Alberni)	0700-1500 Monday – Friday	The ALN, from a culturally safe perspective, and in collaboration with the health care team, plans, organizes, implements and evaluates nursing care for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings.
Aboriginal Liaison Nurse (ALN)	0.8	Cowichan District Hospital (Duncan)	0800-1600 Monday – Thursday	The ALN, from a culturally safe perspective, and in collaboration with the health care team, plans, organizes, implements and evaluates nursing care

Position Title	FTE	Location	Hours of Service	Description of Service
				for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings.
Care Transition Liaison Nurse (CTLN)	1.0	Tofino General Hospital (Tofino)	0830 - 1700 Tuesday to Friday 0930 – 1800 Saturday Every 3rd Saturday off	As a member of the hospital interdisciplinary team, the CTLN plans, organizes, implements, and evaluates nursing for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings
Bamfield Health Centre	0.89	Bamfield	0900 -1500 M – F + on call 24/7	Remote Nursing Clinic. Basic primary health care and urgent care services to residents of Bamfield and surrounding First Nations communities.
South Island Health Services Delivery Area				
Aboriginal Liaison Nurse (ALN) (2)	1.0 x 2	Royal Jubilee & Victoria General Hospitals (Victoria)	0800-1542	The ALN from a culturally safe perspective, and in collaboration with the health care team, plans, organizes, implements and evaluates nursing care for Aboriginal clients with chronic, acute, palliative or rehabilitative health care needs in community and hospital settings
Diabetes Nurse Educator	1.0	Royal Jubilee Hospital Victoria	0800-1452 Monday – Thursday	The Diabetes Nurse Educator acts as a clinical resource nurse and provides clinical services including patient assessment and teaching from a culturally safe perspective for Aboriginal clients, individually and in group settings.
Aboriginal Health Dietitian	1.0	Royal Jubilee Hospital Victoria	0900-1642 Monday – Friday	The Dietitian has professional, advisory, and educational responsibilities directed towards health promotion, disease prevention and some direct service for Aboriginal communities as well as responsibility for planning, organizing, coordinating, administering and evaluating specific program components.
Integrated Health Network	3.5	Sooke	M-F 0830 – 16:00	Nurse, Dietitian and Social Worker work alongside Family Physicians to provided target services to First Nations individuals living with 1 or more chronic diseases.
Nurse Practitioner	1.0	Victoria / Beecher Bay/ Pacheedaht,	Full time 5 days a week	The Nurse Practitioner supports Primary Health Care delivery with an emphasis on prevention and management of

Position Title	FTE	Location	Hours of Service	Description of Service
		Esquimalt	Outreach: 1.5 days /week 3 days /month 2-3 days /month	chronic conditions to both urban First Nations populations and 2 remote First Nations communities. The NP also holds education groups (2 youth group meetings at Esquimalt High in November) When the NP is not in the communities, she is providing indirect care – following up on referrals, lab results, reports, case management, medication management, prescription refills.
Nurse Practitioner	1.0	Four Saanich Peninsula-based First Nations: Tseycum, Tsartlip, Tsawout, Pauquachin	5 days per week	The Nurse Practitioner supports Primary Health Care delivery with an emphasis on prevention and management of chronic conditions
Nurse Practitioner (effective March9, 2015)	1.0	Cowichan Valley: H'ulh-etun, Lyackson, Penelakut, Halalt, Stz'uminus	M-F 8-4	Primary Health Care
Nurse Practitioner	0.4	Duncan area	2+ days a week	This NP sees First Nations clients as part of her primary care family practice as well as outreach at/during the homeless shelter.
Nurse Practitioner		Access Midwifery Clinic, Victoria		A handful of clients are Aboriginal and are integrated into care in the clinic.
Nurse Practitioner	0.2+	Stz'uminus Reserve (Ladysmith)	Monday afternoon 1:30 – 5	Primary care clinic on Reserve. Aboriginal clients access care in medical clinic or outreach on reserve.
Family Practitioner Sessions	104 sessions (not FTE)	Victoria Beecher Bay Pacheedaht	1 day /week 2 days/month 2 days/month	Victoria Native Friendship Centre Beecher Bay Band Office Pacheedaht Band Office

Appendix 2 - Summary of Health Human Resources' Supports

The following is a summary of FNHA Health Human Resources' health career promotion initiatives and supports offered:

- FNHA has worked with its partners to develop a First Nations Health and Human Resources Tripartite Strategic Approach (FNHHRTSA) that identified areas of strategic focus. FNHA Health Human Resources is currently developing an "Action Summary" that identifies initiatives to be pursued to further the objectives of the FNHHRTSA.
- FNHA has health career programs aimed at increasing the number of First Nations and Aboriginal students pursuing health education. Initiatives include secondary and post-secondary classroom presentations, guest and keynote speaking, workshops at conferences, communities, employment centres and schools.
- FNHA provides community-level funding to promote health careers in First Nations communities via the First Nations Health and Science-Related Career Promotion (FNHSCP) grants, which are offered in partnership with the First Nations Education Steering Committee. The FNHSCP was created to support activities that provide students with information about health and science-related careers. Activities include: health career fairs, field trips to post-secondary institutes and math and science tutoring clubs.
- FNHA provides $200,000 per year in funding for scholarships and bursaries for First Nations students pursuing health careers. This funding is administered through the New Relationship Trust. Per the Health Human Resource Team, the priority for this funding has been for medical school and Nurse Practitioner training.
- FNHA contributes $50,000 per year to support the UBC Summer Sciences Program, a one-week cultural, health and science program for Aboriginal students in grades 8-11. The program promotes interest in health and science careers and offers a holistic education experience that includes cultural practices.

Appendix 3 - Nursing Focus Groups - Detailed Summary of Key Themes

Topic	Themes
Recruitment	▪ Recruitment and retention is not standardized across communities. Communities provide different wages and benefits. ▪ Communities have lost good nurses. There is an opportunity to explore ways to attract them back.
Orientation	▪ Nurses do not receive the guidance and support they require. FNHA suggested contacting the Health Director but they were unable to assist. ▪ Training is not consistent from community to community, with very little nurse orientation available. ▪ New orientation is good with more focus on providing public health.
Retention	▪ Need to have the same continuity of nursing staff in order to increase trust with community members. ▪ Continuity of nursing staff promotes greater consistency in program delivery. Examples were quoted with multiple nurses filling a position at a nursing station during the year. ▪ Continuity of care is an issue for some nursing stations. Temporary nurses fly into a community for 5 weeks and then never go back. ▪ Nurses within FNHA felt career paths could be better supported.
Pay Equity	▪ Several nurses cited being paid $10/hour less than what is offered by Interior Health. ▪ There is a belief that funds are given to communities but communities do not always flow full funding to nurses. ▪ First Nations nursing is not only a financial decision; it has to be a lifestyle choice.
Mentoring	▪ Many nurses had good experiences with the mentor program for new graduates. Funding for this program is no longer available.
Nursing Support	▪ Not all nurses receive adequate support and resources from Nursing Services ▪ New nurses have to develop all manuals and charts from scratch and have to set up filing systems/maps/clients. This should be standardized and better transitioned when a nurse leaves.

Topic	Themes
	▪ Nurses require training on programs and access to available tools prior to being placed in a health facility. This will reduce on-the-job stress and contribute to efficiency. ▪ Some nurses have reached out to the regional health authorities for program resources. ▪ Sections that are well supported include maternal, child care and immunization. ▪ There is a lack of program materials for child development and alcohol issues. ▪ More program materials should be provided in an online format to provide easy access. ▪ Many requests to Practice Consultants and to Clinical Nurse Specialists go unanswered.
Education	▪ Nurses felt that FNHA educational opportunities are excellent as compared to the provincial health authorities. ▪ There was a desire from nurses to increase the number of mandatory courses and include topics of interest. ▪ FNHA does not always communicate to nurses the courses being offered and the timing. ▪ Some Practice Consultants are new and have never worked in a Health Centre or Nursing Station. Nurses do not fully understand the role of the Practice Consultant.
Conferences	▪ Forums are generally viewed as valuable, especially for new graduates, to connect with other nurses and to get updates on best practices. ▪ Some felt the course materials were too basic and that more advanced topics were not offered. ▪ Some thought that forums could be used to share innovative practices with the broader group. ▪ Educational opportunities would be enhanced if better organized, e.g. agenda sent out beforehand allowing nurses to prepare and think ahead.
Communications	▪ Nursing operates in silos with little interaction / communication between FNHA, management, transfer communities and the nurses. ▪ Communications have improved since the transfer in 2013 but there are still missed opportunities for communications with nurses.
Access to Information	▪ Nurses would like access to health authority systems to support discharges to communities. This access is difficult to

Topic	Themes
	get due to privacy issues. Some nurses reported successfully being granted access to Meditech at Interior Health. ▪ Nurses would like to see Panorama implemented as it would provide good supports for Communicable Disease Management.
Patient Education	▪ Educational materials are being produced for distribution to community members. Many nurses are not made aware that these materials exist. ▪ Nursing Services should obtain input from nurses in the development of these materials.

Health Director	▪ Relationships with Health Directors varied:
	    ▪ Many nurses reported having good relationships with their Health Directors and felt well supported in their communities.
	    ▪ Some nurses had less favourable relationships with little communication between the parties.

Treatment Vs Preventative Health	▪ There is pressure to provide treatment services at the expense of Public Health programs. ▪ Many believe that both treatment and Public Health programs could be offered if clinic schedules were changed to set aside time for public health programs. ▪ Some communities expect clinics to be open the entire day and changes to schedules are not always supported by Health Director and/or community leaders.
Staffing and Scheduling	▪ Nurses are on call for 24 hours/day. Some nights they get very little sleep which impacts effectiveness in the clinic the following day. ▪ Nurses in Nursing Stations feel burnt out with no work/life balance. ▪ Due to long-term vacancies, agency nurses have been utilized. Some are not trained to do health promotion activities. ▪ Many clinics feel under-resourced. ▪ Nursing management have not treated part-time and Nursing Resource team workers with respect. There is an expectation that nurses should be working in full-time roles. ▪ Funding is based on historic population numbers and not based on current community needs, e.g. complexity of community such as elders with kidney disease.
Home and	▪ There is a perception amongst Home Care Nurses that they

Topic	Themes
Community Care	do not receive the same level of training and supports that Community Health Nurses receive. Home Care Nurses require a lot of the same knowledge that is required for Public Health nursing. ▪ Home Care Nurses would like to have more peer mentoring opportunities.
Nursing Voice in FNHA	▪ Nurses are proud of their roles and are passionate about their profession. ▪ Nurses would like a strong voice in the organization and would like a senior position representing them at the FNHA management table. ▪ Nurses feel that their managers do not have Nursing Station experience and that they do not understand the role of a Remote Nursing Certified Practice Nurse. ▪ Nurses would like more communication from both Nursing Services and FNHA. They want to be excited about FNHA and want to be more engaged with FNHA and management.
Cultural Competency	▪ Community members have experienced care providers outside of their community who do not possess the desired cultural competencies. These experiences prevent community members from seeking services off reserve. ▪ Some felt that Health Canada nurses were not culturally competent. However, this has improved under FNHA. Relationships are improving between nurses and communities. ▪ Many nurses felt the training for cultural competency is good

Appendix 4 - Nursing Survey - Summary of Results

The following table summarizes the responses for key close ended questions:

Survey Questions	Yes	No
Do you believe that there is sufficient capacity in your community for nurses to support all nursing program requirements? *(based on 20 responses)*	40%	60%
Does your community offer Home and Community Care Program? *(based on 21 responses)*	71%	29%
Do you currently use FNHA Transfer Nursing Team to support your recruiting efforts? *(based on 7 responses)*	14%	86%
Would you consider using FNHA Transfer Nursing Team to support your recruiting process? *(based on 8 responses)*	75%	25%
Does your regional health authority provide nursing services to your community? *(based on 18 responses)*	50%	50%

The following table summarizes the key themes provided for questions that required open text responses:

Topic	Themes
Funding	▪ Communities identified the need for additional resources to support comprehensive nursing services across all program areas. ▪ Communities identified the need for competitive wages in order to recruit and retain nurses.
Cultural Competency	▪ Many communities do not experience cultural competency or safety issues with nurses. ▪ Communities want to see more First Nations filling the nursing roles. ▪ Communities are more trusting of nurses that are hired by communities (vs nurses hired by FNHA or agencies). ▪ Some agency nurses are not culturally competent. ▪ Some communities felt that more recognition should be given to traditional wellness and should not focus on Western medicine. ▪ Patient education materials should be more culturally focused. ▪ Some communities' members have had bad experiences

Topic	Themes
	when seeking care from regional health authority care providers who are not culturally competent. As a result, some community members are hesitant to seek treatment off reserve. ▪ Communities acknowledge that they should develop an orientation program to welcome and integrate new nurses into the communities.
Recruiting	▪ It is difficult to backfill nurses with casuals when nurses take vacation or sick leave. ▪ High vacancy rates lead to use of agency nurses who are on reserve for short terms and are not well integrated with other health providers. ▪ Lack of accommodation in the communities is a barrier to hiring. ▪ There are inequities in what Transfer Nursing communities pay their nurses. There should be one common compensation package for all Transfer Nurses. ▪ Remote communities have few of the amenities that nurses are used to; few jobs for spouses; few entertainment options. ▪ One suggestion is for FNHA to create a pool of Registered Nurses, Licensed Practice Nurses and casual nurses that are willing to work in communities to provide vacation relief. This will result in standardized relief coverage as nurses will deliver common programs, guidelines and protocols.
Integration of Services	▪ Health providers in some communities work for different employers which can result in uncoordinated care and little collaboration. ▪ There are separate funding envelopes for community health programs. The separation of funding by program can contribute to program staff working in silos and not collaborating. ▪ Some were unclear on the specific roles of the nurse and felt that the Community Health Representatives, Medical Office Assistants and receptionists could be utilized to provide additional support and provide cultural safety aspects of care. ▪ Some communities reported good integration of services between the nurses, Community Health Representatives and dieticians.

Topic	Themes
Programs	▪ Nurses do not have time to provide Chronic Disease and Injury Prevention services as they have to spread their time across multiple communities. ▪ More emphasis should be given to Prevention and Communicable Disease services. Training should be made available on reserve. ▪ Nurses are pressured to deliver treatment services and do not have enough time to deliver all the community programs. ▪ Communities wanted nurses to put more emphasis on programs, using evidence-based care strategies, that will impact health outcomes.
Primary Care	▪ Some communities indicated that having a physician with clinical decision making capabilities on reserve would improve diagnosis and care capabilities. ▪ There is a need to work on Primary Care and how to integrate and collaborate with community health services.
Support	▪ Communities would like additional support from Nursing Services practice support to assist in developing programs. ▪ Need for regional support to support nurses working in communities. ▪ FNHA should create an online portal providing access to program and training materials. ▪ There is a need for specialized service support (e.g. via phone, telehealth) to support nurse examinations in remote communities. ▪ Many communities enjoy supportive relationships with their regional health authority. ▪ EMR would greatly improve flow of information, reporting and analysis of services and outcomes.

Topic	Themes
Home and Community Care	▪ There is a need for improved communications between regional health authorities and communities for patient discharges back to community: patient care information does not always follow the patient back to the community; communities are not always notified when patients are discharged. A patient navigator position would be useful in this regard. ▪ Communities currently provide training for Care Aides. It would be helpful if FNHA was able to provide this training ▪ There is a lack training available for program staff (Licensed Practice Nurses, Care Aides, and Home Support Workers). ▪ Support from regional health authorities is not consistently available. ▪ eSRDT reports are outdated and do not reflect the needs of the communities.

Appendix 5 - Analysis of Services by Location and by Nursing Scope of Practice

	Location Where Services are Provided			Nursing Resource Capable of Performing Service (within Scope of Practice)			
Service	Health Centres	Nursing Stations	Home and Community Care	Nursing Practitioner (with RNCP*)	Registered Nurse (with RNCP*)	Registered Nurse	Licensed Practice Nurse
Counselling	✓	✓		✓	✓	✓	
Client Education	✓	✓		✓	✓	✓	✓
Health promotion activities	✓	✓	✓	✓	✓	✓	✓
Prenatal classes	✓	✓	✓	✓	✓	✓	✓
Well baby clinics	✓	✓	✓	✓	✓	✓	
Newborn visits	✓	✓	✓	✓	✓	✓	
Vision Screening programs	✓	✓		✓	✓	✓	
Early hearing screening programs	✓	✓		✓	✓	✓	
Reproductive health education	✓	✓		✓	✓	✓	✓
Contraceptive counseling	✓	✓		✓	✓		
CDC follow-ups	✓	✓		✓	✓		
Blood tests	✓	✓		✓	✓		
Vaccines	✓	✓	✓	✓	✓	✓	
Chronic Disease management		✓	✓	✓	✓		
Acute illness management		✓	✓	✓	✓		
Complex maternal child health issues		✓	✓	✓			
School health		✓	✓	✓	✓	✓	
Sex Education		✓	✓	✓	✓	✓	✓
Medical discharge from hospital to home care		✓	✓	✓	✓		
Elder Care at home		✓	✓		✓	✓	✓
Treatment services as per the remote nursing certified practice guidelines:							
• Treatment of minor diseases & illnesses		✓		✓	✓		
• STIs		✓		✓	✓		
• CDC control		✓		✓	✓		
• School health program		✓	✓	✓	✓	✓	
• Well women clinics (BSE, Pap		✓	✓	✓	✓	✓	

	Location Where Services are Provided			Nursing Resource Capable of Performing Service (within Scope of Practice)			
Service	Health Centres	Nursing Stations	Home and Community Care	Nursing Practitioner (with RNCP*)	Registered Nurse (with RNCP*)	Registered Nurse	Licensed Practice Nurse
tests, vag smears, bld tests, menopause teaching)							
• Well men clinics (prostate screening checks, testicular exams)		✓	✓	✓	✓	✓	
• Blood Sugar		✓		✓	✓		
• Cholesterol		✓		✓	✓		
• Blood Pressure Checks		✓		✓	✓		
• Teen self-esteem		✓		✓	✓	✓	
• Emergency and after-hours		✓		✓	✓		
• Weekend Care		✓		✓	✓		

** RNCP = Remote Nursing Certified Practice*

Appendix 6 – June 2015 FNHA Nursing Structure