Collaborative Care with an Indigenous Lens

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WRHA Indigenous Health – Patient Services

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Format

• WRHA Indigenous Health Overview
• Examples of a Manitoba Context
• Overview of Generalist Social Work
• Truth & Reconciliation Commission Health Related Calls to Action
• Overview of Culturally Safe Model
• Mainstream Approaches & Assumptions
• Overview of Collaborative Model
• Strategies to Repair Systemic Distrust & to Engage
• Case Studies
• Collaborative & Culturally Safe Approaches in WRHA
• Connection to Social Work Standards of Practice, Patient Safety & Health Equity
• References
What is Indigenous Health (IH)

• IH is a WRHA program that provides culturally appropriate support, services, resources and education. There are 3 streams:
  – Patient Services
  – Workforce Development
  – Education & Cultural Initiatives
• IH – Patient Services helps to reduce gaps often experienced in the provision of healthcare services due to barriers related to language, culture, jurisdiction, and communication.
• IH – Patient Services provides information and support to patients/families and the multidisciplinary team.
• IH – Patient Services supports all Indigenous people in WRHA facilities/programs.
What is Indigenous Health (IH)

Staffing:

- 2 Regional Discharge Planning Coordinators
- 2 Site Coordinators
- 12+ Interpreter/Resource Workers
- 1 Regional Patient Advocate
- 2 Spiritual/Cultural Care Providers
- 3 Centralized Services Staff (Intake)
- 1 Director
Partnership with Assembly of Manitoba Chiefs (AMC)

Staffing:
- 1 Patient Advocate Manager
- 2 Navigators
- 1 Program Assistant
- Provides resources to First Nations patients and families and assists them in navigating systems external to WRHA.
Why need an Indigenous Advocate?

• Volume of Indigenous patients is high
• Under-reporting: minorities and people with low socio-economic status are less likely to make formal complaints
• Systemic Distrust

1(Care Quality Commission, 2013)
Role of Indigenous Patient Advocate

• Works towards resolving complaints/concerns about care received at all WRHA facilities, 3 PCHs, and community programs.
• Works in partnership with Patient Relations Officers and staff from WRHA facilities.
• Collaborates with WRHA and external programs to influence policy and program development.
• Provides education to WRHA staff on issues affecting clients re: culturally safe practice, health equity, etc.
• Provides information to patients, families and WRHA staff re: resources for Indigenous people.
• Patients/family may be more open with Indigenous Staff.
Why do we need Indigenous Discharge Planning Coordinators?

• Patients who are living in Indigenous communities and who have complex/high care needs are often faced with multiple challenges/barriers.
  – Availability of resources is different from Indigenous community to community (i.e. may be no visiting nurses or HCA respite; may be short of staffing, OT might only visit every 2 months, or not at all, etc.).
  – Gaps in coverage (i.e. NIHB does not cover hospital beds, therapeutic mattresses).
  – NIHB has many rules about coverage & transportation; awareness is varied.
• The logistics of discharge to a remote/isolated community are very complex.
Role of Indigenous Discharge Planning Coordinator

- A Regional Discharge Planning Coordinator works in collaboration with the multidisciplinary team, federal, provincial and regional programs to coordinate a safe and appropriate discharge plan.
- Provides advocacy, guidance and support to the patient and family.
- Coordinates services including, but not limited to: coverage for medication and equipment, transportation, engaging community supports, facilitating training of family for safe care.
Role of Indigenous Discharge Planning Coordinator

- A detailed care plan is essential.
  - Indigenous Discharge Planners can help develop the plan and ensure it is sent to nursing station/health centre/home care.

- Need for communication is greater.
  - The extended family needs to be engaged earlier because decisions affect them directly.
  - Indigenous political, health & social service representatives can identify resources.
  - Patients/family may be more open with Indigenous Staff.
Manitoba Context

• Video description of life in isolated community, Wasagamack
  
  https://www.youtube.com/watch?v=bgySkmyho1U

• Overcrowding is the norm in many communities, especially the most isolated.
Manitoba Context

• Food prices can be as much as 2.5x higher than in Winnipeg, plus may have to travel up to 45 minutes to buy it.
• Healthy food is especially pricey.
• Processed food is more affordable.
• Infrastructure:
  – Only half of Manitoba FN homes have piped water & sewer
  – 150+ FN communities in Canada are under boil-water advisories
  – Many homes still use wood stoves for heat, or oil furnaces
  – Housing stock is generally older and in need of repair, and may have problems with mould
Overview of Generalist Social Work

Eclectic Knowledge Base:
- Systems Theory
- Ecological Perspective
- Wide range of skills
- Values
- Micro, Mezzo/Exo & Macro Interventions
- Client empowerment

(Kirst-Ashman & Hull, 1999)

Change Process:
- Engagement
- Assessment
- Planning
- Implementation
- Evaluation
- Termination
- Follow-up
Truth & Reconciliation Commission (TRC) Health Related “Calls to Action”

1) Recognize that current Indigenous conditions are a direct result of government laws, policies & practices.
2) Identify gaps in health outcomes and set goals to close those gaps.
3) Recognize distinct health needs of Metis, Inuit & First Nations people.
4) Promote funding for Indigenous healing centres.
5) Enhance access to Traditional Healing in the health care system.
6) Increase numbers of Indigenous staff in health care; and provide cultural competency training for all health professionals.
7) Require medical and nursing schools to teach about Indigenous history, rights and current issues impacting health.

(Truth & Reconciliation Commission of Canada, 2012)
WRHA Commitment to TRC

- The WRHA is committed to providing a culturally safe environment for all Indigenous peoples to learn, work or receive health care.
- The WRHA commits to building or strengthening relationships with the Indigenous communities it serves according to the Principles of Reconciliation as outlined by the TRC.
- The WRHA recognizes that the work of reconciliation cannot be achieved without the knowledge, skills and relationships of its Indigenous workforce.
Overview of Culturally Safe Model

- Cultural Safety is a recognition that there are cultural differences between groups, that our own experiences can have impacts on others, particularly when there is an imbalance of power, and there is a need to create culturally safe spaces, free of racism and discrimination where people are receiving safe care.

- Cultural safety recognizes power imbalances in healthcare, and promotes introspection and reflection on power and the importance of culture to improve care and patient experience.

- There is a recognition of systemic distrust from historical and modern interactions that can be alleviated through the provision of culturally safe care.

Cultural Safety Tools

- **KNOWLEDGE** – of historical context & of influences of cultural diversity
- **AWARENESS** – of assumptions/beliefs about Indigenous people within one’s culture & profession
- **SKILLS** – strategies & techniques for effective interactions with Indigenous people

Indigenous Cultural Values

- Collectivism (community harmony, interconnectedness of relationships and systems)
- Avoidance of confrontation
- Reluctance to show emotions
- Respect for each other and individual freedom
- Sharing
- Respect for life, human and otherwise

Talking about Racism

• Systemic Racism is a significant determinant of health for Indigenous people.

(Indigenous Health Working Group of the College of Family Physicians of Canada. 2016)
Talking about Racism

- Stereotypes = how we think
- Prejudice = how we feel
- Discrimination = how we act

What are Microaggressions?

- Implicit bias are thoughts/feelings usually outside of awareness
- Harder to deal with
- Victims blame selves, if not acknowledged
- Can form pattern of avoidance

(Wing, Capodilupo, Torino, Bucceri, Holder, Nadal, Esquilin. 2007)
Up or Down?

• “I don’t see colour”
  – Denies a person’s experiences, expects to assimilate.
• “Everyone should be treated the same”
  – Assumes everyone has had equal privileges.
• “This isn’t about race”
  – Ignores structural inequalities and ways of thinking that might be oppressive.
• “I’m not racist...I have several Native friends”
  – Immune to racism because I have friends of colour.
• “As a woman, I know what you go through as a racial minority”
  – Immune to racism because I’m a woman/social worker/socialist.
• “Everyone can succeed in society if you work hard enough”
  – Minorities are to blame for their lot in life.
“Tonsillectomy vs. Dental Hygiene”
Talking about Racism by Jay Smooth

• Longer video
• https://youtu.be/MbdxeFcQtaU

• See original video https://youtu.be/b0Ti-gkJiXc
Mainstream Approaches & Assumptions

• Engagement focusses on problem instead of person
  – Assumes trust is not an issue

• Clinician may inadvertently influence definition of priorities/goals
  – Ignores patient realities

• Sets rigid process/boundaries (e.g. 2 no shows = cancel)
  – Everyone should be treated the same; assimilate

• Labels patient “non-compliant”
  – Blames victim/ignores barriers

• Provides a number of recommendations/brochures/phone numbers
  – Assumes self-advocacy level is adequate to the task
Mainstream Approaches & Assumptions

- Conducts all meetings same way
  - Everyone should be able to participate in the same way; assimilate

- Communication style is mainly passive
  - Active listening is not practiced; places more responsibility on client to “receive”

- Takes silence as agreement
  - Expects people to ask for what they need, be comfortable to challenge authority

- Speaks mostly to client only for decision-making
  - Ignores cultural influence of collectivism and the influence of family

- Relies heavily on written info
  - Ignores differences in language, education and learning styles
Mainstream Approaches & Assumptions

• Uses brokerage model/referral model to connect other helpers
  – Assumes that they should be able to engage client readily
Overview of Collaborative Model

- Person centred
- Role clarification
- Team functioning
- Collaborative Leadership
- Interprofessional Communication
- Interprofessional Conflict Resolution
- Mutual Respect

(WRHA Collaborative Care Model)
Strategies to Repair Systemic Distrust & to Engage

• Know your client. Reach out more++, show interest. ¹
• Offer interpretation support even, if only partial language barrier.
• Be flexible; work with their schedule. ¹
• Elicit narrative with open ended questions (client’s perspective): ²
• Speak slowly...allow silence.¹
• Give a sense of control (explain how will meeting unfold, permission to ask questions, space to weigh options, next steps).²

¹ (Teal & Street, 2009, MICST, 2016)
² (Indigenous Working Group of BC Association of Social Workers, 2016)
Strategies to Repair Systemic Distrust & to Engage

• Acknowledge that there may be some degree of systemic distrust. ¹
• Be trauma informed & avoid triggers.¹
• Offer Indigenous healing and/or counselling supports. ²
• Unpack labels to uncover hidden barriers.
• Actively listen & check in for comprehension.
• Thorough psychosocial assessment.
• Assess the level of advocacy required. ¹

¹ (Teal & Street, 2009, MICST, 2016)
² (Indigenous Working Group of BC Association of Social Workers, 2016)
Strategies to Repair Systemic Distrust & to Engage

• Widen the circle, more meetings, telehealth.
• Facilitate client choosing top priorities.  
• Consider revising client information materials.  
• Partner with trusted allies and continue to collaborate past the referral point.
• Apologize if it’s deserved.

1 (Teal & Street, 2009, MICST, 2016)
The Deep Dive

VALUES
- Income and Social Status
- Employment and Working Conditions
- Biology and Genetic Endowment
- Culture

HEALTH
- Health Services
- Social Support Networks
- Social Environments
- Personal Health Practices and Coping Skills

BELIEFS
- Education
- Physical Environments
- Healthy Child Development
- Gender

ASSUMPTIONS

Winnipeg Regional Health Authority
Indigenous Health
Transforming our Language

• Use language that is non-judgmental – don’t start with “why?” ¹

• Elicit the patient narrative:
  – “How would you describe what is going on with your health right now, or over the past months/years?”
  – “What do you think you need?”
  – “What supports do you have in your life?”
  – “What are the top 3 worries in your life?”
  – “What is it like living in your First Nation community...what is the house like, population, water, heat, cost of food, method of travel?”
  – “What other information is important for me to know?”

¹ (Teal & Street, 2009, MICST, 2016)
Transforming our Language

• Unpack the non-compliant label:
  – Ask what parts of treatment they succeed in, and what is a challenge
  – Ask if there is something making it difficult to participate in treatment
  – “Help me understand why you are choosing not to stay in hospital?” (in this example, focus is on helping me, not on the “why”)

• Facilitate informed decision-making:
  – Include other important people in the discussion
  – Outline options and the risks/benefits of each, to allow client to choose
  – Consider need for both short-term and long-term planning
Transforming our Language

• Assess advocacy level needed:
  – **Resource**: if given written materials, can follow-through on own
  – **Coaching**: guide a discussion about sub-tasks, and encourage client to make notes; check in periodically on progress
  – **Walking-with**: provide outreach support to attend appointments/outings with client

• Sample statements:
  – “Do you need help with this task?”, don’t accept “Not really”, ask if they need help with some elements...break it down into the sub-tasks (coaching)
  – “Do you think you can follow the plan?”
  – “What would help you, or not?”
  – “Are you comfortable talking to agency staff?”
Strategies to Repair Systemic Distrust & to Engage

Spend more time engaging with systems beyond the individual (mezzo/exo and micro, such as family, friends & community supports)
## Trauma Informed Language

(Kitchen & Hosegood, 2015)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>What is wrong?</td>
<td>What has happened?</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Adaptations</td>
</tr>
<tr>
<td>Disorder</td>
<td>Response</td>
</tr>
<tr>
<td>Attention-seeking</td>
<td>Trying to connect in best way he or she knows how</td>
</tr>
<tr>
<td>Borderline</td>
<td>Doing the best he or she can given their experiences</td>
</tr>
<tr>
<td>Manipulative</td>
<td>Difficulty asking directly for what they want</td>
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</table>

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling</td>
<td>Trying to assert his or her power</td>
</tr>
<tr>
<td>Malingering</td>
<td>Seeking help in a way that feels safer</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Difficulty engaging with expectations</td>
</tr>
<tr>
<td>Drug-seeking</td>
<td>Trying to regulate inner state</td>
</tr>
<tr>
<td>Unpredictable</td>
<td>Seeking structure and regularity</td>
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<tr>
<td>Poor self-regulation</td>
<td>Experiencing a trauma response</td>
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Case Studies

- Advocacy
- Complex Discharge
- Medical Relocation
Case Study: Advocacy

- 60 year old First Nation man presents to ED c/o ear pain
- Given rx for anti-biotic and NSAID and sent home
- Develops rash to face & worsened pain, returns to ED
- Seen by same RN, who questions his need to return 3x
- Doctor apologizes for giving NSAID; missed sensitivities on chart
- Given injection of epinephrine & additional pain med
- Returns a 3rd time, c/o pain to injection site
- Seen by same RN, who asked repeatedly, “Why are you here?”
- Patient continually asked to see Dr. & eventually yells at RN
Case Study: Advocacy

- Patient complains to the hospital Patient Relations Department, citing racism from the RN. Describe what you think happened and make notes on your paper.
  - Patient asks for apology (given by Manager); asks RN be fired/reprimanded
  - Patient is told the RN is shocked that she was perceived to be racist
  - RN accuses patient of being verbally abusive
  - Patient is told that there is no cause for dismissal and HR is a private matter
  - When told that he is an elder, Patient Relations Officer asked patient, “You don’t expect to be treated differently, do you?”
  - Confirmed that an occurrence report was submitted for the drug error
  - Told the RN was given option to pursue Indigenous cultural awareness training
Case Study: Advocacy

- Eventually, complaint is forwarded by Patient Relations Department to Indigenous Health Patient Advocate. This is what happened next.
  - Spoke with PCM at length about microaggressions...acknowledged that the mistreatment was not intentional, but still resulted in harm...“When someone has such a large and emotional reaction to an event and it lingers for months afterwards, that says to me that there’s something to it”.
  - RN’s statement that she was “shocked to receive this feedback” is not actually a response.
  - Encouraged reflection on how her words/actions contributed to escalation & outcome. Encouraged the PCM to offer support and education to RN, including MICST.
  - Ensured that sensitivities are also updated on chart.
  - Given info on MCRN complaints process.
  - Gave feedback to Patient Relations re: meaning of “Respect your elders” is a cultural value and it does imply an expectation of more consideration/more time to listen.
Case Study: Discharge Planning

- 42 year old woman from remote FN
- Rare neurological disorder with rapid progression
- In hospital 4 months with severe deterioration & now quadriplegic
- SW is lead in coordinating discharge with FN RN
- Patient’s house in FN has ramp needing repair and doorways widened
- Lives with 2 adult sons, both employed full-time, and dtr-in-law
- Pt will need 24 hr care, hoyer transfers, totally dependent, cognitively intact
- Recommendation for PCH as FN Home Care has limited resources.
- Patient insists on returning to FN.
- FN is an island with no landing strip. Closest landing strip is 30 minute boat ride.
Case Study: Discharge Planning

- SW attempts to coordinate discharge. Describe what steps you think would have been taken and make notes on your paper.
  - SW speaks to FN FN and FNIHB TRU re: transportation logistics.
  - Arrange OT to request hoyer. Identifies funding for hospital bed.
  - Develops plan to transport to FN via air ambulance and stretcher.
  - Advocated for ramp to be built at boat dock, repairs to house ramp & doorways widened.
  - One day prior to discharge, SW talks to RN and learns equipment not in place, nor doorways widened.
  - Discharge plan is put on hold, pending further investigation.
Case Study: Discharge Planning

- Case referred to IH by hospital manager.
  - RDPC meets patient. Speaks to SW and FN Home Care. Learns of concerns with alcohol in the home and reliability of caregivers. Told Home Care has no service on evenings/wkds.
  - Upon further assessment, RDPC suggests telehealth mtg of community reps & family members. Hospital coordinates same with numerous participants. Outlines care needs, supports and risks. Patient/family decide to continue with the discharge plan.
  - RDPC realizes building a ramp to dock is not feasible. Explores alternative ways of transporting home with FNIHB TRU.
  - Arrangements are made to send by air ambulance to nearby community, and then helicopter to home community. Ensures equipment is in place prior to discharge.
  - Ensures discharge summary is sent by hospital staff to FN nursing station & home care.
  - Key is the need to coordinate communication amongst WRHA staff, Health Director, Home Care and FNIHB. Special approval had to be obtained for the provincial helicopter.
Collaborative & Culturally Safe Approaches in WRHA

- Regional policies
- Palliative Discharge Planning Guideline
- Indigenous Renal Health Collaborative Care Workgroup
- Committee on Access to Supports (IH, AMC, EIA & FNIHB)
- More referrals from community based clients/outpatients and CRC
- Staff Education (MICST, Health Equity, discharge planning webinar)
- Collaborative case management with PPH & HOCS clients
- WRHA Emergency Program (presence in the ED and CCPs)
- End Homelessness Winnipeg (Street Survey)
Collaborative Care in Medical Relocation

**Barriers:**

- FNIHB: policy allows for 3 months temporary accommodations, food and in-city medical transportation.
- Income Assistance: most First Nations continue their provision of income assistance for 3 months (and some will provide longer).
- Disadvantage: many have never obtained IDs, bank account, or had experience doing forms/advocating for self. May have fragile health, language barrier, & possibly cognitive & mental health issues.

Renal Social Workers & AMC Navigators collaborate to divide the tasks:
- Social Workers’ strengths are being part of a multidisciplinary team in hospital
- AMC Navigators strengths are in being able to “walk with” for those needing that level of advocacy
Facilitating Access to Ceremony & Traditional Medicines

- Be aware of any policies/practices that protect the right to access ceremonies for smudging/burning of sacred tobacco/medicines.
- Examples: smudge before/after surgery; use of traditional medicine (IH can be involved in communicating with traditional healer), but hospital maintains responsibility for medical reassessment.
- Be aware that there may be different practices re: retention of body parts, so they can be returned to "mother earth"\(^1\)

\(^1\)(Indigenous Working Group of BC Association of Social Workers, 2016)
IH-PS Spiritual/Cultural Care

- **Smudging**: involves burning of sacred medicines such as tobacco, sage, cedar and sweetgrass for purification of the mind, body, and spirit.
IH-PS Spiritual/Cultural Care

- **Sacred Objects**: may be carried by a person to use for healing and should not be touched by staff (i.e. a medicine bundle, pipe, smudge bowl, feather). One way to ensure respectful practice may involve posting a sign in the room to inform staff about the items.
Connection to Social Work Standards of Practice

• SW values the pursuit of social justice to “promote social fairness and the equitable distribution of resources and to reduce barriers
<table>
<thead>
<tr>
<th>SW Standards of Practice</th>
<th>Collaborative and Culturally Safe Approaches</th>
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<tbody>
<tr>
<td></td>
<td>Know your client</td>
</tr>
<tr>
<td>1: Professional Relationship</td>
<td>✓</td>
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<tr>
<td>- Client centered/driven</td>
<td>✓</td>
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<tr>
<td>- Engage with clients</td>
<td>✓</td>
</tr>
<tr>
<td>- Respect &amp; non-judgment</td>
<td>✓</td>
</tr>
<tr>
<td>2: Professional Competence</td>
<td>✓</td>
</tr>
<tr>
<td>- Know thy limits &amp; collaborate</td>
<td>✓</td>
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<tr>
<td>- Know population needs</td>
<td>✓</td>
</tr>
<tr>
<td>- Keep current on theories</td>
<td>✓</td>
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<tr>
<td>3: Integrity Professional Practice</td>
<td>✓</td>
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<tr>
<td>- Trust is key to empowerment</td>
<td>✓</td>
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<tr>
<td>- Do not discriminate</td>
<td>✓</td>
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<tr>
<td>- Build client capacity to make decisions/participate in plans</td>
<td>✓</td>
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<tr>
<td>8: Advocacy and Public Policy</td>
<td>✓</td>
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<tr>
<td>- Recognize oppressive policies/practices</td>
<td>✓</td>
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<tr>
<td>- Advocate for rights</td>
<td>✓</td>
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<tr>
<td>9: Cultural Diversity</td>
<td>✓</td>
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<tr>
<td>- Learn client’s cultural context</td>
<td>✓</td>
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<tr>
<td>- Collaborate with culturally appropriate services</td>
<td>✓</td>
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<tr>
<td>- Reflect on beliefs &amp; practices</td>
<td>✓</td>
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<tr>
<td>10: Rural &amp; Northern Practice</td>
<td>✓</td>
</tr>
<tr>
<td>- Fewer resources; engage local staff &amp; those with expertise</td>
<td>✓</td>
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Connection to Patient Safety

• “A systems approach that acknowledges that the causes of a patient safety incident cannot simply be linked to the actions of the individual healthcare providers involved. All incidents are also linked to the system in which the individuals were working.”

• “Encourages staff to report errors or near misses without fear of reprimand or punishment.”

• “Supports collaboration across all disciplines and levels of the organization to seek solutions to patient safety problems.”

(MIPS, 2011)
WRHA Health Equity Position

Health equity (“health for all”) occurs when all people reach their full health potential and are not held back by the socially determined yet modifiable barriers associated with poverty or prejudice or policies that perpetuate social inequities.

(WRHA Health for All: Discussion with programs, sites & teams, 2016)
Indigenous Health proposes that this can be accomplished by:

- Cultural Safety
- Trauma Informed
- Collaborative Care

(WRHA Health for All: Discussion with programs, sites & teams, 2016)
Contacts for IH & AMC Patient Advocate Unit

- Go to www.wrha.mb.ca and select Indigenous Health for program information and publications
- Referral form – coming soon to www.wrha.mb.ca
- Call Centralized Services at 204-940-8880 or toll-free at 1-877-940-8880, Fax 204-943-1728
- Sign up for our Connect Me e-news by emailing connectme@wrha.mb.ca
Thank you for this opportunity

Questions?
References


References

References


