

# **Island Communicable Disease Control Integration Project**

A Federally Funded  
Integration Initiative

Presented by Gail Peekeekoot  
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# Steering Committee Partners

- Island First Nations Health Authorities
  - Nuu-Chah-Nulth (NTC)
  - Cowichan
  - Inter Tribal Health Authority (ITHA)
    - Kwakiutl District Council Health (KDC)
- Vancouver Island Health Authority (VIHA)
  - Child, Youth & Family – Community Health
  - Communicable Disease – Public Health
- First Nations Inuit Health (FNIH)
  - Health Protection Directorate (Communicable Disease Control)

## Over-All Goal of This Project:

- In a culturally safe way, to provide the best, integrated Communicable Disease Control Services for First Nations people living on-reserve on Vancouver Island, the Gulf Islands, the Discovery Islands, and those on the mainland with affiliations to Vancouver Island Health Authority (VIHA) and/or Inter Tribal Health Authority (ITHA).

## 3 Objectives Outlined in Proposal:

- 1) To improve the **Integration of CDC Services** between First Nations employed Community Health Nurses (CHNs) & VIHA.  
For CHNs, Communicable Disease Control (CDC) includes *both* Immunization & Communicable Disease
- 2) To develop common protocols, procedures & evaluation methodology for **Immunization Certification**
- 3) \*To develop common protocols, procedures & evaluation methodology for **Communicable Disease Competency**

# In our work we recognize that:

- For many reasons, the First Nations (FN) population can be very mobile with people moving on and off reserve and moving from community to community and within communities.
- People living on reserve may prefer to receive all or some community health service from VIHA.
- People living off reserve may prefer to receive all or some community health service from FN health authorities/services.
- Some people, who are moving on and off reserve, may receive services alternately or concurrently from VIHA and the FN health authorities/services.
- Others may not receive service from either VIHA or the FN health authorities/services.



# First Nations Health Authorities/Services:

- **Nuu-chah-nulth Tribal Council Health**
  - Nursing services to 14 communities primarily on the west coast of Vancouver Island
  - Health Transfer 1986
- **Cowichan Tribes Health**
  - Nursing services to 1 large amalgamated community in central Vancouver Island
  - Largest First Nations community in BC
  - Health Transfer 1991

# Inter-Tribal Health Authority

- Direct nursing service to 8 communities
- Nursing consultation to 29 member Nations & 5 non-member Nations
- Affiliation with 9 independent First Nations Health Services
- Affiliation with 3 other First Nations Health Authorities:
  - H'ulh-etun Health Society serving 4 communities
  - Kwakiutl District Council Health serving 8 communities
  - Namgis Health serving 2 communities



## Other First Nations Health Services:

- 2 Independent Communities:
  - Tsartlip
  - Pauquachin
- Tillicum Le-lum Friendship Centre
  
- In total, 11 First Nations communities (4 with NTC, 5 with ITHA, and 2 Independents) receive their nursing services through contracts with VIHA
- No direct nursing services by FNIH

# Health Transfer

- Prior to Health Transfer, the federal government provided direct nursing services to all First Nations people living on reserve.
- As part of a *return to self-determination*, First Nations sought the right and responsibility of *once again* shaping and offering health services and programs for their own people.
- Funding goes from the federal government to First Nations Health Authorities/Services.
  - Communicable Disease Control including Immunization is a mandated Health Transfer program.
  - Transfer Funding to First Nations includes money for nursing supervision/consultation
- Health Transfer supports Cultural Safety.

# Tripartite First Nations Health Plan

- 10 year plan signed in June 2007 by the Government of Canada (represented by Health Canada), the Government of BC, and the First Nations Leadership Council of BC
  - “Health services delivered by First Nations, when appropriate, will be effectively linked to and coordinated with provincially-funded services, such as those provided by the regional health authorities.”
  - [http://www.health.gov.bc.ca/library/publications/year/2007/tripartite\\_plan.pdf](http://www.health.gov.bc.ca/library/publications/year/2007/tripartite_plan.pdf)
- “The 10-year plan is mandated to improve the health and wellbeing of First Nations, and to close the gaps in health outcomes between First Nations and other British Columbians.” <http://www.nearbc.ca/documents/2009/gallgher-to-head-FNHS-Apr-09.pdf>
- Implementation of the plan is being done by the First Nations Health Council & their business arm, the First Nations Health Society.

# Cultural Safety

- In the case of Aboriginal [First Nations] peoples, cultural safety “depends on meaningful participation of Aboriginal people in decision-making processes that allow transfer of power to Aboriginal governments”. (National Aboriginal Health Organization Fact Sheet on Cultural Safety)
- <http://www.naho.ca/english/documents/Culturalsafetyfactsheet.pdf>

# Cultural Safety

- In health care, Cultural Safety means addressing:
  - Systemic power imbalances experienced by people accessing health services.
  - Gaps in health care program delivery for marginalized populations.
  - The professional development requirements of health care providers who serve marginalized populations.

## Without a mandate, the Island CDC Integration Project recognizes...

- As a committee, we can't make systemic changes but we can address gaps in CDC service through **Integration Initiatives** and we can better support the **Professional Development** of nurses working in First Nations who are providing immunizations and doing on-reserve clinical case management of communicable diseases.

# Objective 1: Integration of CDC Services

- VIHA ↔ First Nations ↔ FNIH
- First Nations ↔ First Nations

# Challenges to CDC Integration

- Different Organizational Contexts & Policies
- Changing Organizational Structures
  - Changing personnel
- Changing Programs and Protocols
- Different electronic Health Information Systems that are not integrated
- Communication Processes often Informal &/or Complex



# Addressing the Challenges

- Knowing Everything Will Change We Have:
  - Set up clear, straight-forward, formal communication processes through four Practice Guidelines
    - These guidelines outline the roles and responsibilities of the First Nations Health Authorities/Services, VIHA, and FNIH in Immunization and Communicable Disease Case Management on-reserve
    - The guidelines don't create any new relationships, aren't legally binding, and serve to clarify current practice.

# Practice Guidelines

- **Integrated Approach to Reportable Communicable Disease (CD) Case Management On-Reserve**
- **Integrated Approach to Immunization On-Reserve**
- **Agreement for Exchange of Immunization Records**
- **Integrated Approach to Exchange of Program Information for Immunization and Communicable Disease Services**
  
- While these Practice Guidelines can stand alone, to decrease redundancy and confusion, they are each referenced in the others.

# Integrated Approach to Reportable Communicable Disease (CD) Case Management On-Reserve Practice Guideline

- Describes the roles and responsibilities of VIHA CD Program, First Nations Health Services/Authorities, and FNIH for CD Case Management On-Reserve
- Appendices:
  - “Matrix of Responsibility”
  - Health Authorities/Services Covered by the Practice Guideline
  - VIHA Contacts for Urgent On-Reserve CD Clinical Case Management
  - FNIH Notifiable Disease Report Form

# Integrated Approach to Immunization On-Reserve Practice Guideline

- Describes the roles and responsibilities of VIHA Child, Youth & Family Program – Community Health, First Nations Health Services/Authorities, and FNIH for Immunization On-Reserve
- Appendices:
  - **First Nations Support of Immunization Competency for Nurses Working in other First Nations Communities**
  - **VIHA Support of Immunization Competency for Nurses Working in First Nations**

# Agreement for Exchange of Immunization Records Practice Guideline

- Most First Nations do not have connectivity to iPHIS, and ePanorama is still on the horizon so...
  - This Practice Guideline includes agreements and forms for regular mutual exchange of immunization information.
    - Agreements are intended to be done at the community level with each First Nations Health Authority/Service writing an agreement with the VIHA Health Centre/Office closest to them.
- iPHIS immunization module pilot in KDC has been successfully started thanks to the efforts of Dr. Charmaine Enns, Shelley Henderson, and iPHIS “Champ” Katie Hine..

# Integrated Approach to Exchange of Program Information for Immunization and Communicable Disease Services Practice Guideline

- Change is constant and there are many people involved in CDC in different organizations. This Practice Guideline addresses how we keep contact information current and accessible
- Appendices:
  - Excel Spreadsheet with contact information
  - After-hours/holiday on call form

## **Objective 2: Immunization Certification**

- 3 parts:
  - Orientation/Mentorship
  - Immunization Certification Exam & Recertification Exams
  - Observed Checklist of Skills

# Comparison of Certification Process: Beginning of Project

- VIHA
  - Orientation done by Nurse Clinician
  - Checklist done by Nurse Clinician or Nursing Supervisor for certification and recertification at **6 months** and every 3 years
- First Nations
  - Orientation done by peers or Nursing Manager
  - Checklist done by peers or Nursing Manager at certification and recertification every 3 years



# Comparison continued...

- Exam marked by Nurse Clinician at certification and recertification at **6 months** and every 3 years
- Practice support to PHNs by Nurse Clinician
- Exam marked by FNIH CDC nurse at certification and recertification every 3 years.
- Practice support to CHNs by FNIH CDC nurse

# Challenges to meeting the same Immunization Competency Standards

- Orientation/Clinical Mentorship:
  - Nurses in First Nations are often working in remote areas or small communities without experienced colleagues or busy enough clinics to have a good orientation.
  - The FNIH CDC Nursing Team provides “Introduction to Immunization” education sessions but not “hands-on” clinical experiences.

# Addressing the Challenges

- Orientation/Mentorship
  - By special arrangement, VIHA will provide Clinical Mentorship Experiences to nurses on a cost recovery basis.
    - To take part in Clinical Mentorship in a VIHA site:
      - The nurse must be covered by their First Nations employer for WCB
      - The nurse needs orientation to the immunization module of iPHIS (internet-based Public Health Information System)

The First Nations prefer to have their nurses mentored in a First Nations setting and are seeking funding for a Clinical Nurse Specialist (CNS) as part of a comprehensive support system for clinical nursing practice in First Nations communities.

# Challenges to meeting the same Immunization Competency Standards

- Immunization Certification/Recertification Exams
  - The FNIH CDC Nursing Team provides access to the exams, marks them, and works with nurses to achieve the 100% pass mark required.
    - Until April, 2008, there was an inadequate number of FNIH staff providing this service which resulted in slow turn around times
    - In the rest of BC, they don't do the 6 month re-certification exam but we have agreed that nurses in FN will meet the same standard as those in VIHA.

# Addressing the Challenges

- Exams
  - FNIH has agreed to mark the 6 month re-certification exams. A 2 week turn around for marking exams has been assured
  - VIHA would mark the exams on a cost recovery basis
  - The proposed Clinical Nurse Specialist for First Nations could also become a marker.

# Challenges to meeting the same Immunization Competency Standards

- Observed Checklist of Immunization Skills
  - FNIH supports the practice of using nursing peers who are currently certified to provide immunizations to sign off the skills checklist.
  - Not all managers of nurses in First Nations are nurses. Not all Nurse Managers are certified and current in immunization practice.
  - VIHA cannot sign-off a nurse's checklist for whom they don't have line authority

# Addressing the Challenges

- Observed Checklist of Skills
  - By special arrangement, VIHA will do the Observed Checklist of Skills for nurses on cost recovery basis
    - Since VIHA does not have line authority for the nurse working in First Nations, they can only make a recommendation to the nurse's manager for certification or for further practice before certification.

The Proposed Clinical Nurse Specialist could provide this service.

## Objective 3: Communicable Disease Competency

- In June 2007 VIHA went to centralized CD Program Services for South, Central and North Vancouver Island. There are CD Program offices (sometimes referred to as “CD Hubs”) in Victoria, Nanaimo, & Courtenay who manage most\* CDs except TB.
- Nurses working in First Nations no longer need to have the same level of CD Competency since the CD “Hub” nurses take the lead for CD Administrative Case Management and provide CD related information, resources, and support to health care providers in First Nations communities as required for CD Clinical Case Management.



# First Nations & Centralized CD Program Offices

- TB has not been centralized and direction comes from TB Services for Aboriginal Communities at BCCDC.
  - Frontline work is done by the CD Program nurses based in the 3 CD offices
  - On-reserve clinical case management is done by the nurses working in First Nations
- Follow-up for STIs continues to generate much discussion.

# CD Orientation

- FNIH offers an Introductory TB & Immunization Workshop 2 - 3 times a year
  - All CHNs can attend these sessions
- Our CHN survey indicated a strong need for STI education.
  - The course being developed by BCCDC in consultation with CRNBC may meet this need.

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# We are making progress!

- Contact: Gail Peekeekoot  
([peekee@telus.net](mailto:peekee@telus.net))
- 250-246-9923