

Community-Based Emergency Care

An Open Report for Nishnawbe Aski Nation

March 2014



Community-Based Emergency Care



*This report is dedicated
in memory of Jack Tait of
Sachigo Lake First Nation.*



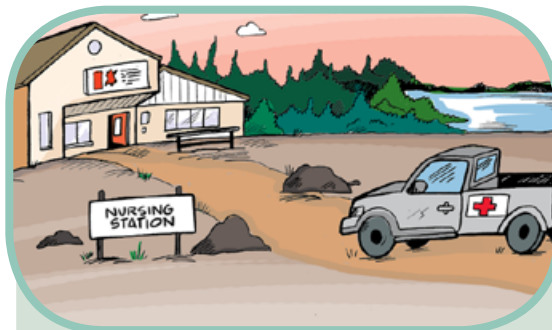
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People in remote and isolated First Nation communities should have access to excellent community-based first response emergency care.

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INTRODUCTION & KEY TERMS

This report summarizes the learnings of the Community-Based Emergency Care Roundtable, a two-day *multi-jurisdictional* meeting held in October 2013 in Sioux Lookout, Ontario. The purpose of this meeting was to discuss and address pre-nursing station emergency care needs in remote and isolated First Nation communities in Ontario. Representatives of First Nations' governance and community organizations, Ontario Provincial and Canadian Federal governments, nursing and paramedical services, and non-governmental organizations joined together to develop shared understandings and a vision for the future of emergency care in remote and isolated settings. This report offers a *Vision*, *Key Recommendations* and *Guiding Principles* with which to improve emergency care for all injured and ill people in remote and isolated First Nation communities in Nishnawbe Aski Nation.



Emergency Care

Management of urgent health conditions where timely care is critically important. For example: heart attacks, strokes, mental health crises, and severe injuries. Effective emergency care is an important part of local emergency management capacity, and it is a key element of an equitable health care system.



Remote and Isolated Communities

Communities with no permanent road access and communities that are more than two hours by road from an Emergency Department. Many of these communities lack local paramedical and 911 dispatch services. Transportation to an Emergency Department is most often by airplane.



Pre-Nursing Station Care

The initial component of pre-hospital care in remote First Nation communities. This care takes place outside a nursing station and involves the initial on-scene management and transportation of ill or injured patients to a nursing station. "Nursing station" is used interchangeably with "health centre" or "clinic".



STATUS OF REMOTE EMERGENCY CARE

COMMUNITIES WITHOUT PARAMEDICAL & 911 SERVICES

- COMMUNITIES WITHOUT PARAMEDICAL & 911 SERVICES
- ◆ MAIN REFERRAL HOSPITALS FOR REMOTE COMMUNITIES
- ROADS

Map data sources: *Statistics Canada, Ministry of Health and Long-Term Care, KNET Keewaytinook Okimakanak*

25,000

Ontarians who need to board a plane to access an emergency department¹

2,000

Medical evacuations from remote First Nation communities in Ontario in 2012

29

Remote communities in northern Ontario with no formal paramedical or 911 service (as shown on map)

15%

Trauma deaths that can be reduced by pre-hospital services²

4

The number of times more likely First Nations people are to experience severe trauma relative to the average Canadian³

1. Glazier RH, Gozdyra P, Yeritsyan N. Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities: Report to the Ontario Ministry of Health and Long-Term Care. Toronto: Institute for Clinical Evaluative Sciences; 2011. http://www.ices.on.ca/file/Geographic_Access_to_Care_Eng.pdf

2. Mullins RJ, Mann NC. Population-based research assessing the effectiveness of trauma systems. J Trauma. 1999 Sep;47(3Suppl):S59-66. <http://www.ncbi.nlm.nih.gov/pubmed/10496613>

3. Karmali S, Laupland K, Harrop AR, Findlay C, Kirkpatrick AW, Winston B, Kortbeek J, Crowshoe L, Hameed M. Epidemiology of severe trauma among status Aboriginal Canadians: a population-based study. CMAJ. 2005 Apr 12;172(8):1007-11. <http://www.ncbi.nlm.nih.gov/pubmed/15824405>

EXISTING INITIATIVES

First Nations Emergency First Response Program:

Provincially funded medical training for First Nation communities. The program relies on community support by way of a Band Council Resolution and a team coordinator to recruit volunteers from the community to be trained in emergency first response, first aid and CPR. The program provides medically vetted training, required medical and communications equipment.

James Bay Ambulance Services:

An accredited paramedic service in Northeastern Ontario that provides paramedical services to five remote communities with dispatch services provided by the Timmins Central Ambulance Communication Centre. The program also supplies host support services to Weeneebayko Area Health Authority First Response Teams in surrounding communities.

Sachigo Lake Wilderness Emergency Response Educational Initiative:

A community-based emergency care pilot project in Sachigo Lake First Nation. This collaborative program aimed to build community resilience and local emergency care capacity by delivering and evaluating a comprehensive approach to pre-nursing station health emergencies, including mental health crises. The program trained 6.5% of people in Sachigo Lake.

Community experiences enabling first aid training programs shared by health leaders

"The proper support and coordinations of a team is required to ensure any measure of longevity. Community support is also incredibly important. The Emergency First Response group are dedicated volunteers trained to respond to every medical emergency, it is a daunting task for many citizens."



Capacity Building from Emergency Care Training

"A young woman from Sachigo Lake First Nation participated in a five-day course that was a part of the Sachigo Lake Wilderness Emergency Response Education Initiative. Before the training, she'd been uncertain about whether she'd feel comfortable – the sight of blood had never been her favourite. But, being involved in the simulated health emergencies helped and motivated her. She decided to go to college to train to be a paramedic. When she graduates, her goal is to work in remote First Nation communities like Sachigo Lake."





EXISTING NEEDS

Emergency Care:

Remote First Nation communities face elevated rates of emergency conditions, such as heart attacks, stroke, injury and mental health crises^{4,5}.

Human Resources:

Nursing stations are staffed by nurses and occasionally by visiting physicians. Many First Nation communities in the Nashinawbe Aski Nation (NAN) region do not have local paramedic or 911-dispatch services (*see map*). It is often the case that healthcare providers are unable to leave the nursing station to provide care.

Layperson Training:

Community members provide first response care and transportation for injured and ill people in these areas. Some communities have sought first aid and CPR training. Resource limitations and distance mean that training is infrequent, inconsistent or unavailable.



4. Fantus D, Shah BR, Qiu F, Hux J, Rochon P. Injury in First Nations communities in Ontario. *Can J Public Health*. 2009 Jul-Aug;100(4):258-62. <http://www.ncbi.nlm.nih.gov/pubmed/19722337>.

5. Tjepkema M, Wilkins R, Goedhuis N, Pennock J. Cardiovascular disease mortality among First Nations people in Canada, 1991–2001. *Chronic Diseases and Injuries in Canada*. 2012 Sept; 32(4). <http://www.phac-aspc.gc.ca/publicat/cdic-mcbc/32-4/ar-04-eng.php>.

Challenges shared by health leaders in remote First Nation communities.

“Our community doesn’t have a program to address emergency response. We don’t have an ambulance response service, and that is required. We make use with what we have. We’ve been lucky so far.”

“There is willingness to pay for janitors to clean schools, but not in paying for first responders to save lives.”

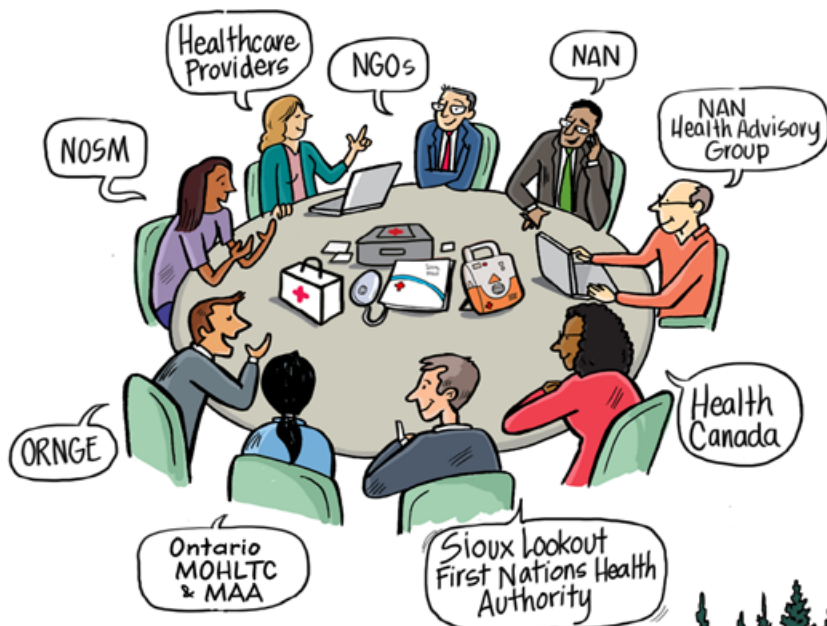




ROUNDTABLE VISION

All attendees of the Community-based Emergency Care Roundtable, including participants from the Nishnawbe Aski Nation, Health Canada First Nations and Inuit Health Branch, the Ontario Ministry of Health and Long-Term Care and the Ministry of Aboriginal Affairs, formed consensus and voiced shared commitment around a vision:

People in remote and isolated First Nation communities should have access to excellent community-based first response emergency care.



Potential Benefits of Community-Based Emergency Care:

- Reduced preventable morbidity and mortality from a wide variety of illnesses and injuries.
- Safer, more resilient communities.
- More local health knowledge, local health workers, and local leadership in health services.
- Enhanced emergency response and crisis management capacity.
- Personal and economic development from related service and job opportunities.



RECOMMENDED ACTIONS

These recommendations emerged directly from the conversations that took place at the Roundtable between key partners.

1. Build a Working Group:

The Nishnawbe Aski Nation lead a collaboration with Health Canada and the Ontario Ministry of Health and Long-Term Care to build a Working Group mandated to advance the *Roundtable Vision*. This process will require funding considerations from government partners. Further attention will be needed to develop a framework for this process and to define the relationships of all partners.

2. Represent key partners in this Working Group:

The Working Group considers the following priority representatives: representatives from Nishnawbe Aski Nation communities, the Sioux Lookout First Nations Health Authority, Weeneebayko Area Health Authority, Health Canada First Nations and Inuit Health Branch, Aboriginal Affairs and Northern Development Canada, Ontario Ministry of Aboriginal Affairs, ORNGE Air Ambulance, The Northeast and Northwest Ontario Local Health Integration Networks, Sioux Lookout Regional Physician Services Incorporated, the Northern Ontario School of Medicine, university researchers, and the non-profit sector.

3. Follow Guiding Principles to advance Community-Based Emergency Care:

The Working Group's efforts should be rooted in six *Guiding Principles*: 1. Community-based; 2. Sustainability; 3. Capacity Building; 4. Collaboration; 5. Integration; 6. Excellence.

4. Plan and Test a Model for Community-Based Emergency Care:

Based on these guiding principles, develop, deliver and evaluate a community-based emergency care program in partnership with a selection of remote or isolated First Nation communities.

Perspectives of Roundtable Participants

"Spirit of giving and life exists in the communities. Celebration of doing something is important to bring about ownership."

"There are champions in the community and conveners who are eager to start something. Look at the room, everyone is willing to start something!"

"Sachigo took the plunge, we should all do it. Part of that was the community; leadership being involved in establishing the process."





GUIDING PRINCIPLES

Six key principles emerged during the Community-Based Emergency Care (CBEC) Roundtable as central when advancing solutions in pre-nursing station care in remote First Nation Communities.

1. COMMUNITY-BASED

Identify, respect, and learn from the diversity of remote and isolated First Nation communities. Address individual and population health needs by building on local priorities, relationships, skills, strengths and culture. Develop, deliver and evaluate programs with the community, and for the community.

2. SUSTAINABLE

Strive for lasting and scalable community-based emergency care programs, rooted in sound health, human resources, economic, and community planning. Build on opportunities to develop community resilience and health services as a sustainable and renewable local resource.

3. CAPACITY-BUILDING

Build capacity by providing emergency care training across a large cross-section of community members. Explore opportunities to develop employment opportunities for local emergency care and training.

4. COLLABORATION

Work with partners in healthcare delivery, such as community health workers, nurses, paramedics and physicians in the design, delivery, evaluation and funding of community-based emergency care programs. Develop programs as a collaboration between First Nations and local, provincial and federal governance organizations.

5. INTEGRATION

Ensure that CBEC programs integrate with emergency health services provided by nurses, paramedics and physicians, as well as other community emergency management strategies including Canadian Rangers and Crisis Response Teams.

6. EXCELLENCE

Evaluate and study programs in collaboration with communities, to bring high-quality, equitable, innovative and evidence-based emergency care to ill and injured patients in remote communities.





RECOMMENDED STRATEGIES

Where do we go from here? Building upon the four *Recommended Actions*, Nishnawbe Aski Nation, First Nation communities, federal and provincial governments, as well as other partners should consider the following strategies to develop community-based emergency care (CBEC).

1. DEVELOP GUIDELINES FOR APPROPRIATE EMERGENCY CARE IN REMOTE SETTINGS:

Lead initiatives with remote and isolated First Nation communities to identify appropriate educational and patient care strategies for pre-nursing station emergencies. Standard first aid and emergency medicine guidelines face limitations in remote settings.

2. INVESTIGATE THE HEALTH EFFECTS OF CBEC PROGRAMS:

Study the effectiveness of CBEC programs to understand their impact on community and individual health and wellbeing. Innovative research in remote communities can uncover the best ways to develop CBEC programs to save lives and reduce illness in these settings.

3. UNDERSTAND AND BUILD ON THE ECONOMIC COSTS AND BENEFITS OF CBEC:

Build sound financial strategies for program development and sustainability. Explore and understand the cost-effectiveness of these initiatives as well as their economic and financial impacts on communities.

4. EVALUATE EFFORTS TO DEVELOP AND DELIVER CBEC PROGRAMS:

Work with communities to create and evaluate CBEC systems that address health needs by building on local priorities, skills, strengths and culture. Evaluate programs to improve quality and maintain excellence.

5. DEVELOP PARAPROFESSIONAL POSITIONS FOR CBEC PROVIDERS AND TRAINERS:

Explore opportunities to partner with post-secondary educational institutions to develop and deliver an emergency paraprofessional educational program for residents of remote and isolated First Nation communities. This program could establish a new community emergency health worker, emphasizing CBEC delivery and education. Consider deploying and employing these new paraprofessionals in remote and isolated First Nation communities.





FORCES FOR AND AGAINST PROGRESS

What is working in favor of change? What needs to be overcome? This force field analysis identifies factors that will promote change towards excellent community-based first response emergency care, and factors that might make positive change challenging.

✓ CHAMPIONS:

Community leaders and members, government officials and academics are dedicated to the *Roundtable Vision*.

✓ EXISTING INITIATIVES:

Two established *programs and a pilot project* enhance emergency care in remote communities.

✗ MULTI-JURISDICTIONAL ISSUES:

Lack of clarity regarding responsibility for funding and delivery of pre-nursing station care.

✗ RESOURCE LIMITATIONS:

Human and financial infrastructure is needed to build a sustainable system.

✓ BODY OF KNOWLEDGE:

There is existing knowledge about the importance of emergency care, and community-based efforts

✓ EXISTING COMMUNITY SERVICES:

Volunteer Firefighting, Nishawnbe Aski Police Services, Canadian Rangers, First Response Teams, and Crisis Response Teams can guide ongoing efforts.

✓ NEW TECHNOLOGIES:

Telehealth, Global Positioning Systems (GPS), internet and mobile phone services enhance opportunities for training and care.

✗ RESOURCE-INTENSITY:

Scale-up could be costly.

✗ SPORADIC EMERGENCY CARE DEMAND:

Communities have a low volume of high acuity cases to maintain first response knowledge and skills.

✗ DIVERSITY OF COMMUNITY NEEDS:

Regional efforts must be adapted to community-specific needs.



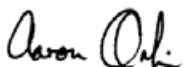





ACKNOWLEDGEMENTS

The Community-Based Emergency Care Roundtable was hosted by researchers at the Northern Ontario School of Medicine in partnership with the Nishnawbe Aski Nation. We thank all the participants and communities for contributing to this initiative, and are grateful for the generous support of many other organizations.

This report summarizes the many discussions from the Community-Based Emergency Care Roundtable and was developed in close consultation with with many of the Roundtable participants. While the Roundtable participants' many ideas and voices are represented in this document, it cannot capture all of the important details from this gathering. Ultimately, the Report's specific language is that of the Roundtable Organizing Team and should not be attributed individually to any of the Roundtable participants or the institutions and organizations that they represent.

- The Roundtable Organizing Team





 Dr. Aaron Orkin Dr. Dave VanderBurgh Stephen Ritchie Melanie Fortune

Questions or Feedback?

Contact: Aaron Orkin MD CCFP, Principal Investigator,
Community-Based Emergency Care Roundtable,
Assistant Professor, Northern Ontario School of Medicine
aorkin@nosm.ca

How to cite this report:

Orkin A, VanderBurgh D, Ritchie S, Fortune M.
Community-Based Emergency Care: An Open Report for Nishnawbe Aski Nation. Thunder Bay:
Northern Ontario School of Medicine, 2014. www.nosm.ca/cbec

Report Illustrator: Liisa Sorsa of ThinkLink Graphics
Report Graphic Designer: Shannon Loomer of ThinkBank



Northern Ontario
School of Medicine
École de médecine
du Nord de l'Ontario
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Nishnawbe Aski Nation



Sachigo Lake First Nation



DIGNITAS



NORTHERN ONTARIO
ACADEMIC MEDICINE
ASSOCIATION



ROUNDTABLE PARTICIPANTS

Alvin Fiddler	Nishnawbe Aski Nation
Ambrose Fiddler	Sandy Lake First Nation
Annette Schroeter	Sioux Lookout Meno Ya Win Health Centre, Sioux Lookout First Nations Health Authority
Archie Mekanak	Northern Ontario School of Medicine
Chris Giles	Sioux Lookout Regional Physician Services Incorporated
Cindy Hunt	Health Canada
Claire Goldie	First Nations and Inuit Health Branch, Health Canada
Corrie Neufeld	Ontario Ministry of Health and Long-Term Care
Emmay Mah	Dignitas Internationalsal
Francine Pellerin	Matawa First Nations
Gail Winter	Independent First Nation Alliance
Hanita Tiefenbach	Ontario Ministry of Aboriginal Affairs
Jack Tait	Sachigo Lake First Nation
Jackson Beardy	Sachigo Lake First Nation
James Morris	Sioux Lookout First Nations Health Authority
Janet Gordon	Sioux Lookout First Nations Health Authority

Jason Beardy	Nishnawbe Aski Nation
Jenn Maki	Sioux Lookout Meno-Ya-Win Health Centre
Jethro Tait	Windigo First Nations Council
Joanne Plaxton	Ontario Ministry of Health and Long-Term Care
John McIntosh	James Bay Ambulance Services-Weeneebayko Area Health Authority
Keith Conn	First Nations and Inuit Health Branch, Health Canada
Len Kelly	Sioux Lookout Regional Physician Services Incorporated
Lorena Legary	Shibogama First Nations Council
Mike Kirlew	Sioux Lookout Regional Physician Services Incorporated
Orpah McKenzie	Keewaytinook Okimakanak
Penny Carpenter	Keewaytinook Okimakanak
Ron Laverty	ORNGE
Sol Mamakwa	Shibogama First Nations Council
Stuart Mooney	Ontario Ministry of Health and Long-Term Care
Terri Farrel	Sioux Lookout First Nations Health Authority
Terry O'Driscoll	Sioux Lookout Meno Ya Win Health Centre & Sioux Lookout Regional Physician Services Incorporated
Warren Kapashesit	Mushkegowuk Council

Roundtable Organizing Team

Aaron Orkin	Principal Investigator, Northern Ontario School of Medicine
David VanderBurgh	Co-Investigator, Northern Ontario School of Medicine
Stephen Ritchie	Co-Investigator, Laurentian University
Melanie Fortune	Research Coordinator, Community-Based Emergency Care Roundtable

Roundtable Facilitators

Karen Born	Process Organizer and Facilitator, Community-Based Emergency Care Roundtable
Liisa Sorsa	Graphic Recorder, Community-Based Emergency Care Roundtable

