Conseil des dirigeants du RLISS de SNM

Mise à jour nº 12-8 | 14 novembre 2012

Équipe mobile d'évaluation et de soutien des aînés (EMESA)

- ***Vivian Damien, directrice principale, services cliniques et renouvellement du système, Muskoka Algonquin Healthcare***
- ***Dre Vickie Dechert, médecin responsable de l'EMESA***

Durant ses six premiers mois d'activité, l'EMESA s'est avérée un service utile pour les résidents de Muskoka Sud. Vivien Damien et Dre Dechert ont présenté au Conseil des données démontrant que leur programme a aidé les résidents de 65 ans et plus de Muskoka Sud à recevoir des soins et à rester chez eux, à quitter l'hôpital, à réduire leurs visites à l'urgence et à éviter les admissions à l'hôpital. Établie à l'Hôpital Memorial de Muskoka-Sud à Bracebridge, l'équipe travaille avec les médecins locaux pour identifier les patients susceptibles de profiter de ses ressources. Équipe interdisciplinaire, l'EMESA comprend une infirmière autorisée, un ergothérapeute, un travailleur social et un médecin-conseil. Un programme semblable de gestion intégrée et intensive de cas exploité par l'Équipe de santé familiale Algonquin est offert par Muskoka Nord.

Pour visionner l'information présentée par Mme Damien et Dre Dechert, voir la présentation annexée à la fin de ce document (en anglais seulement).

Priorités de santé des Autochtones

- ***Germaine Elliott, présidente, cercle de santé autochtone***

Les fournisseurs de SNM veulent que les communautés hétérogènes reçoivent les soins dont elles ont besoin. Avec l'aide du cercle de santé autochtone, nous avons cerné les priorités de santé des communautés autochtones :

- Santé mentale des enfants et adolescents
- Gestion du diabète et des maladies chroniques
- Santé mentale et toxicomanies
- Santé des aînés

En outre, trois priorités pour le système de santé ont été cernées :

- Reconnaissance des pratiques de guérison traditionnelles
- Déplacements au sein du système
- Transport

Deux projets clés sont en cours au sein de la communauté autochtone. Le premier est la mise en œuvre d'un outil commun pour gérer le contact initial et l'acheminement des patients auprès des fournisseurs et organismes autochtones. Le second est l'adaptation de l'outil d'évaluation des besoins et des forces des enfants et adolescents pour assurer qu'il est adapté à la culture, valable et efficace pour les familles autochtones. Ce travail procède en collaboration avec le concepteur de l'outil, Dr John Lyons, et la Coalition des services à l'enfance, aux jeunes et à leurs familles du comté de Simcoe.

Enfin, le cercle de santé autochtone planifie pour la nouvelle année un forum communautaire qui traitera des pratiques de guérison traditionnelle.

Pour visionner l'information présentée par Mme Elliott, voir la présentation annexée à la fin de ce document (en anglais seulement).

Connexions des soins

Rapports trimestriels des conseils de coordination

Conseil de la capacité à domicile et dans la collectivité (CCDC)

- ***Elisabeth Riley, présidente***

Mme Riley a mentionné que le Conseil s'est réuni pour discuter d'un remaniement des comités directeurs de projet pour mieux répondre aux besoins et priorités de SNM et de la province. Ce travail est en cours et sera

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expliqué au Conseil à la prochaine réunion. Dan McGale, directeur général, Independent Living Services of Simcoe County a présenté au CCDC un exposé sur les logements avec services de soutien et l'aide à la vie autonome. Pour consulter l'exposé de M. Gale, voir l'information annexée à la fin de ce document (en anglais seulement).

Conseil de la chirurgie

- ***Linda Davis, présidente***

M[me] Davis a mentionné les points prioritaires du conseil pour le dernier trimestre :

- Approbation des éléments d'un programme chirurgical pour le RLISS
- Approbation de cinq indicateurs de qualité d'un programme musculo-osseux (MO) pour le RLISS
- Élaboration d'un cadre de proposition d'intégration pour un programme orthopédique de trois emplacements pour le RLISS
- Approbation du rapatriement des patients atteints de traumatismes orthopédiques débutant en septembre 2012 et prenant fin d'ici août 2013

Récemment, les membres du comité directeur du programme MO du conseil ont présenté le plan de programme orthopédique du RLISS aux 13 autres RLISS. Chaque RLISS doit présenter son plan de capacité orthopédique au ministère d'ici la fin de février 2013.

Conseil des ressources humaines en santé intégrées

- ***Tammy McLennan, présidente***

M[me] McLennan a parlé du dévouement des membres du conseil – bon nombre d'entre eux ont interrompu leurs vacances pour assister en juillet à une séance de réflexion d'un jour sur l'allure des RHS au sein d'un système de santé intégré. Le conseil s'est engagé à focaliser trois priorités clés pour SNM :

- Portail centralisé pour les chercheurs d'emplois
- Plan de recrutement intégré
- Politiques et procédures de RH normalisées pour tous les employeurs de SNM (p. ex., millage, accessibilité, descriptions communes de postes)

Conseil des communications

- ***Susan French, présidente***

Le conseil élabore actuellement un programme de communications qui intégrera les concepts inhérents à un système de santé intégré au matériel de communication de chaque organisme. En outre, il a accepté d'intégrer un élément de partage du savoir dans chacun de ses programmes pour partager les outils de communication nouveaux ou innovants.

Questions nouvelles / émergentes

Le point sur les soins primaires

Comme la ministre l'a mentionné dans son discours au congrès de l'AHO, le ministère lancera une nouvelle orientation pour les soins primaires dans les prochaines semaines. Les fournisseurs de services de santé au sein d'une communauté, y compris de soins primaires, hospitaliers et communautaires, collaboreront en tant que réseau pour mieux coordonner les services aux patients. On mettra tout d'abord l'accent sur les grands utilisateurs du système de santé – les 1 à 5 % des gens qui coûtent environ 15,2 milliards de dollars au système de santé dans la province.

Cette nouvelle approche misera sur les organismes de prestation actuels, utilisant la capacité actuelle et les meilleures pratiques. D'autres renseignements suivront.

meilleureAPPROCHE

Qualité des services de santé a récemment lancé son projet meilleureAPPROCHE dont le but est d'améliorer les résultats pour les soins cliniques, l'expérience des patients et la qualité du système en assurant la prestation de soins accessibles et coordonnés aux Ontariennes et Ontariens atteints de maladies chroniques complexes. L'approche vise à fournir des soins de santé centrés sur la personne, appropriés, en temps voulu. Elle offrira à tous les secteurs du système de santé un ensemble de soutiens et d'outils d'amélioration de la qualité qui les aideront à mettre en œuvre les meilleures pratiques en matière de soins.

Prochaine réunion

- Le mercredi 12 décembre 2012 – de 16 h à 19 h

Pour toute question, prière de contacter le RLISS à northsimcoemuskoka@lhins.on.ca.

MUSKOKA ALGONQUIN HEALTHCARE

Seniors Assessment & Support Outreach Team

Second Quarter
Statistical Report
July to September 2012

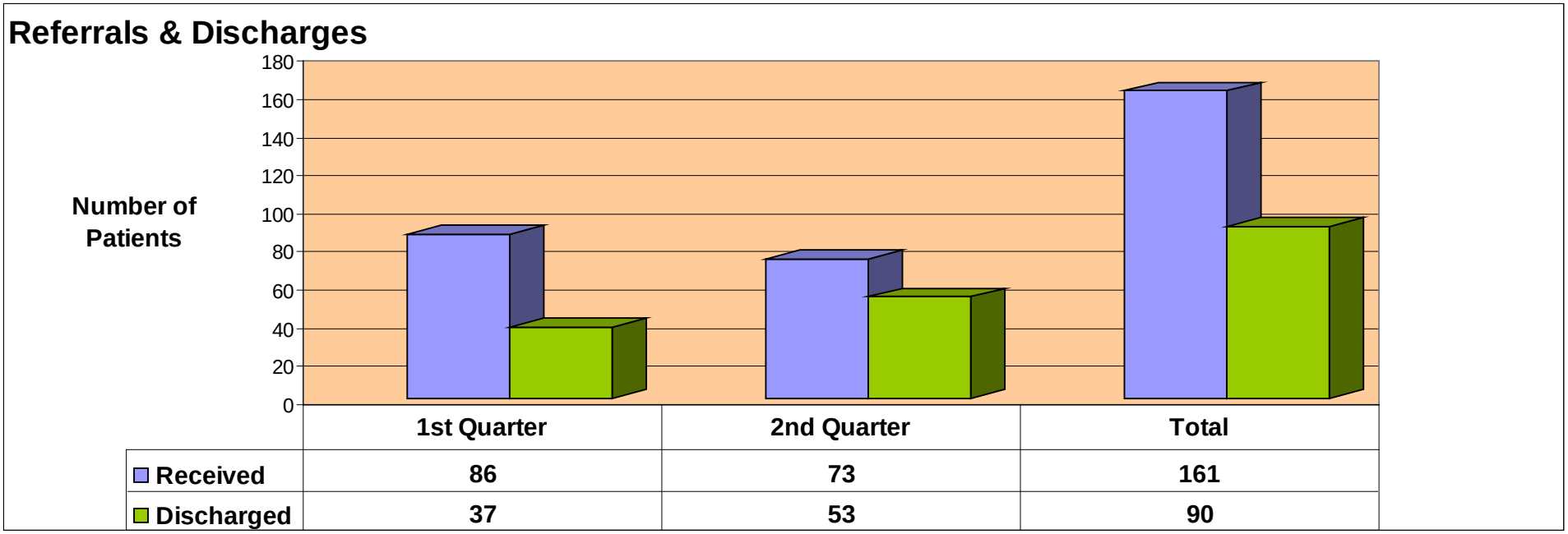
Who We Are

- SASOT is an interdisciplinary team consisting of a Registered Nurse, Occupational therapist, Social Worker and Physician (in the role of Medical Advisor).

- SASOT assesses and provides outreach support to people aged 65 and older residing within the region of South Muskoka.

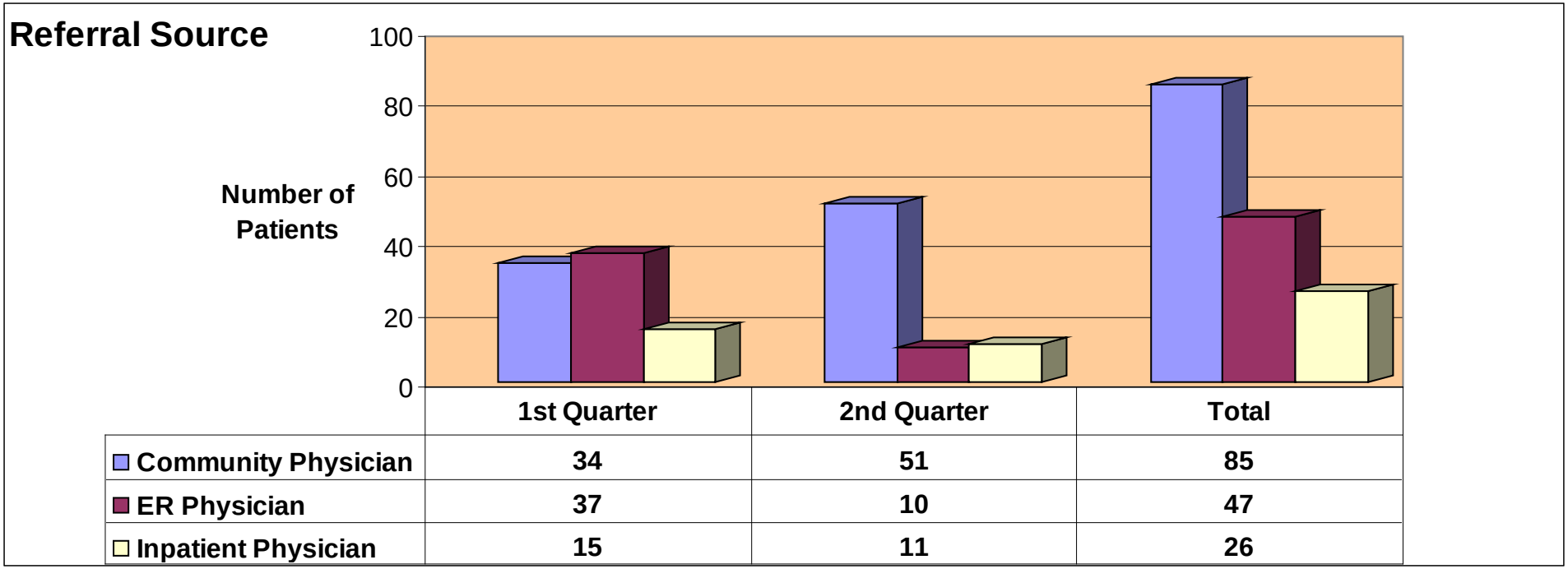
- The goal of the team is to:
  - ✓Help maintain people within their home
  - ✓Facilitate successful hospital discharge
  - ✓Reduce emergency department visits
  - ✓Avoid unnecessary hospital admissions

Referrals & Discharges



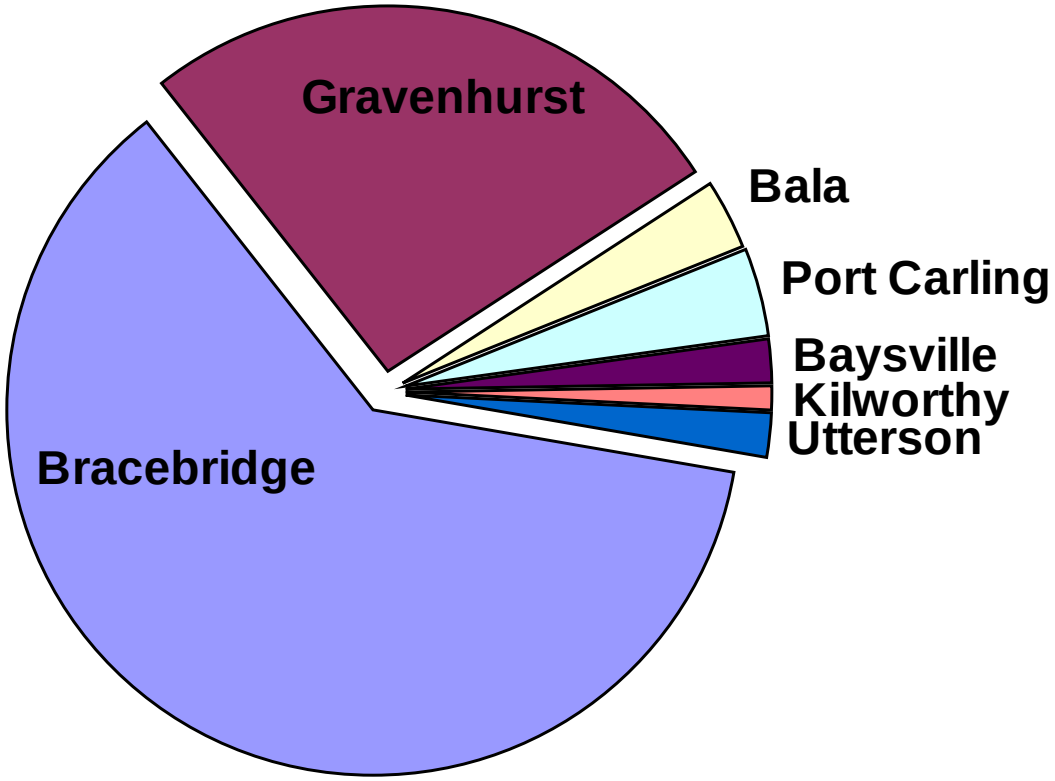
	1st Quarter	2nd Quarter	Total
Received	86	73	161
Discharged	37	53	90

Referral Source

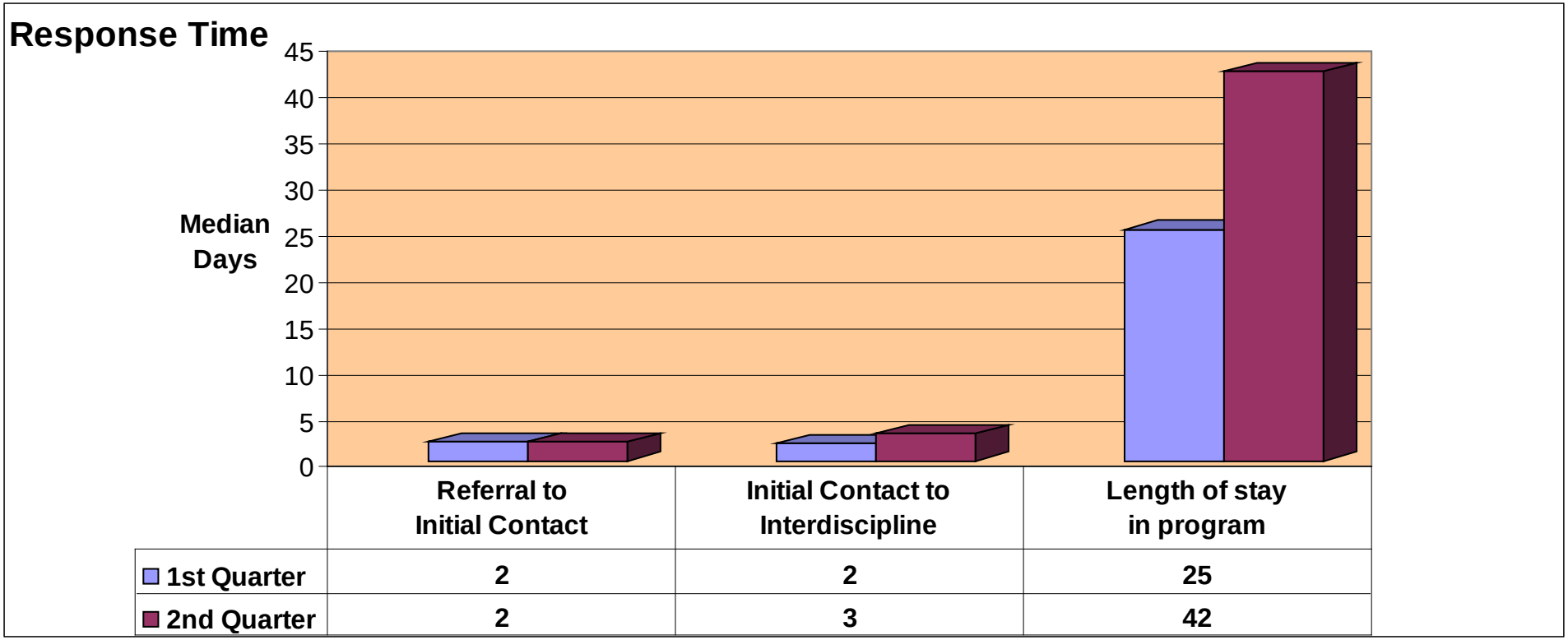


	1st Quarter	2nd Quarter	Total
Community Physician	34	51	85
ER Physician	37	10	47
Inpatient Physician	15	11	26

Geographic Distribution

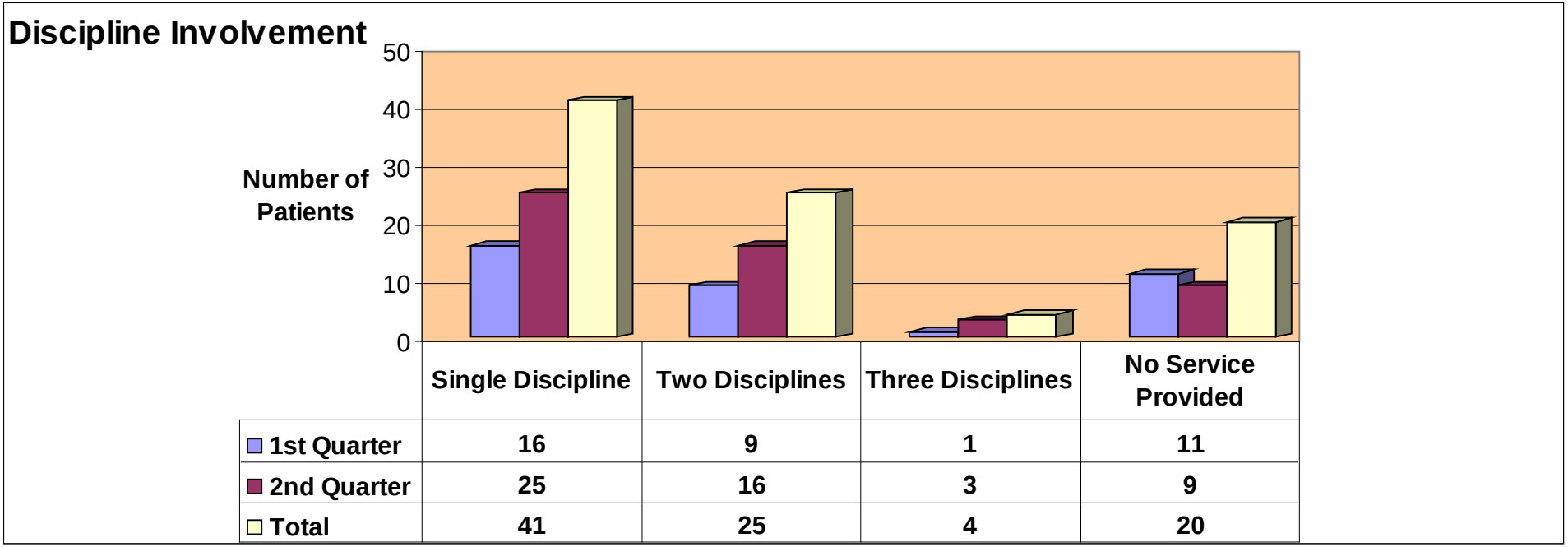


Response Time



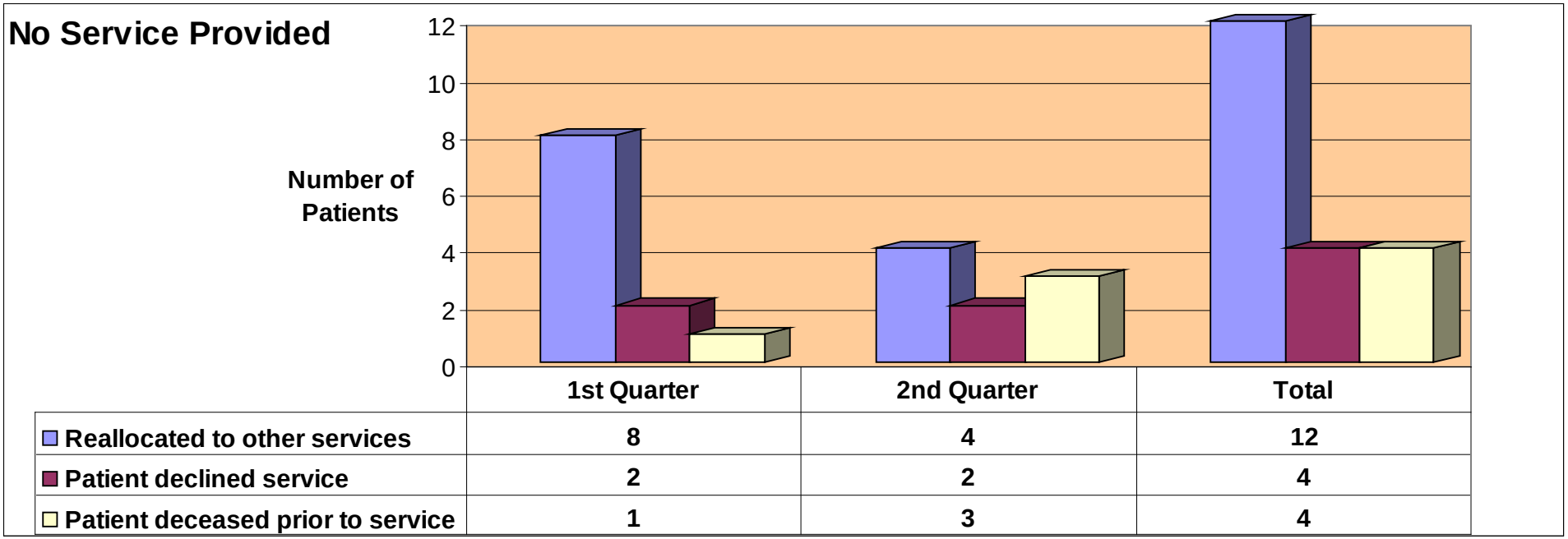
	Referral to Initial Contact	Initial Contact to Interdiscipline	Length of stay in program
1st Quarter	2	2	25
2nd Quarter	2	3	42

Discipline Involvement



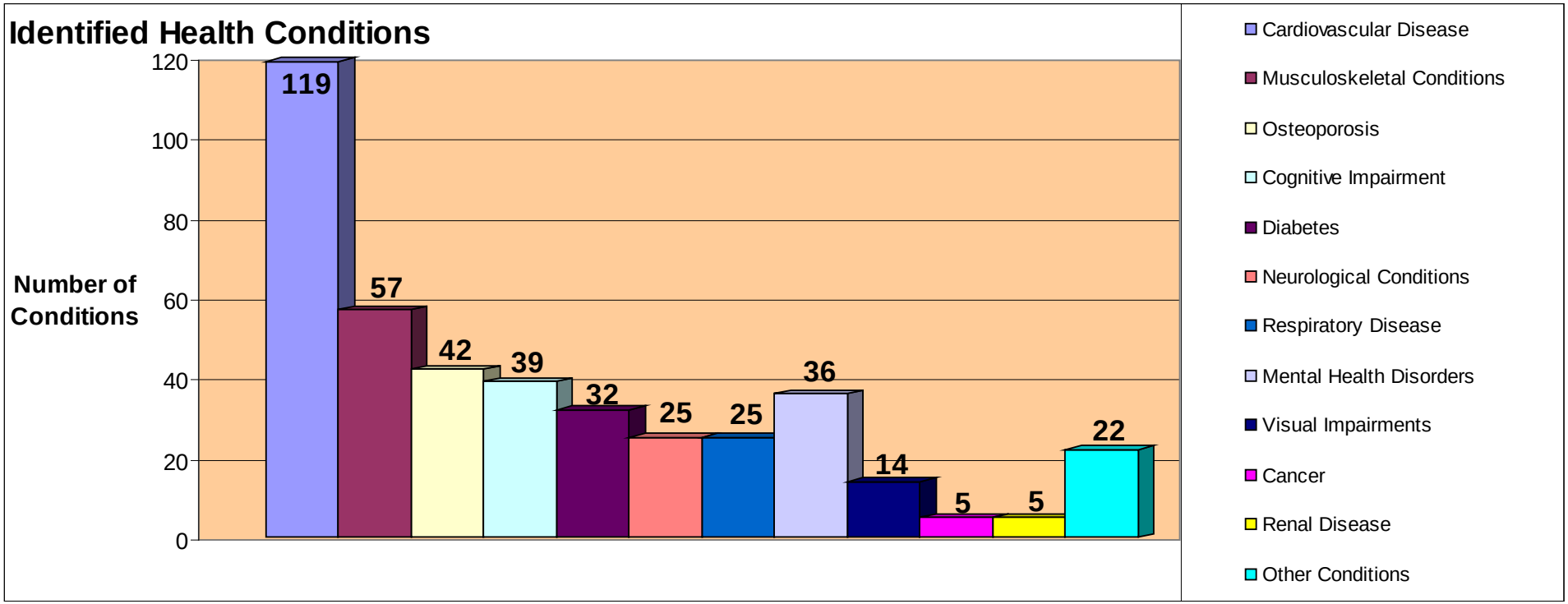
	Single Discipline	Two Disciplines	Three Disciplines	No Service Provided
1st Quarter	16	9	1	11
2nd Quarter	25	16	3	9
Total	41	25	4	20

No Service Provided

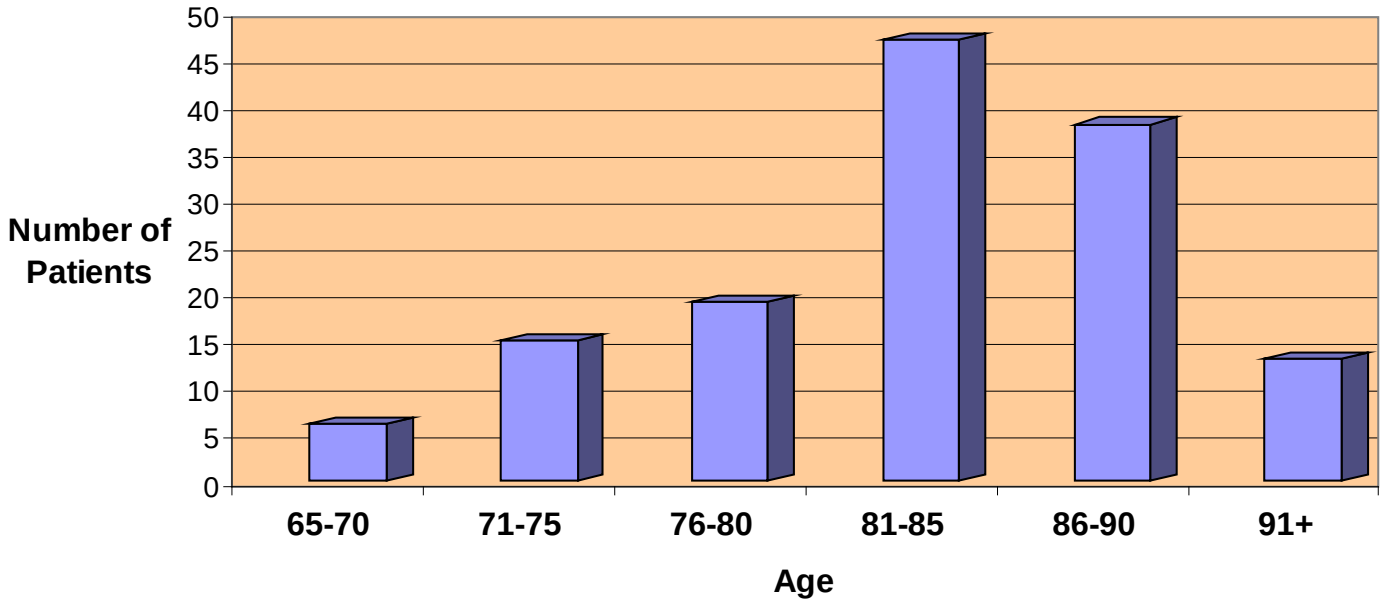


	1st Quarter	2nd Quarter	Total
Reallocated to other services	8	4	12
Patient declined service	2	2	4
Patient deceased prior to service	1	3	4

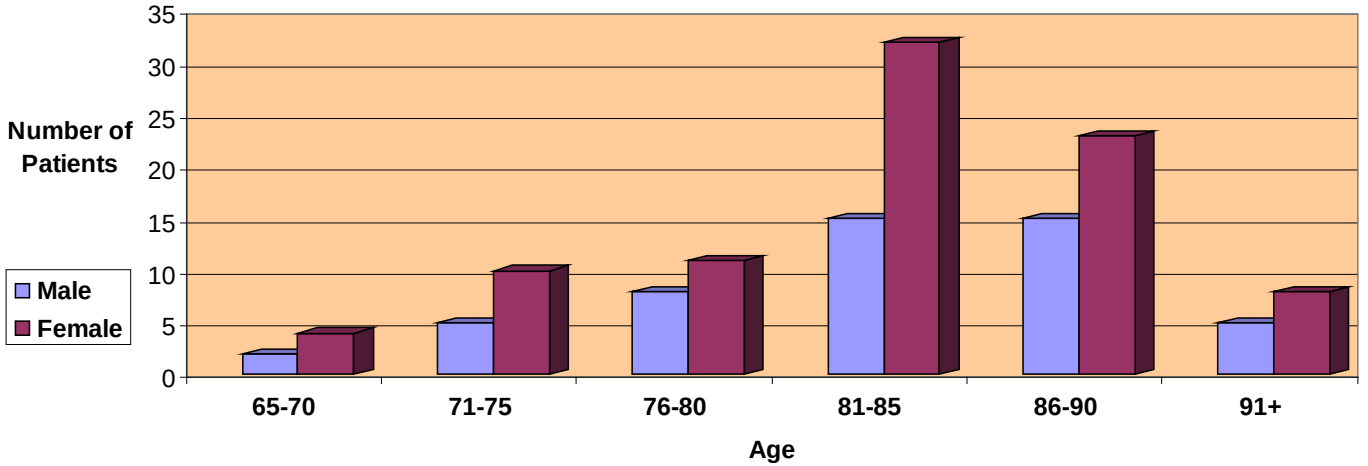
Identified Health Conditions



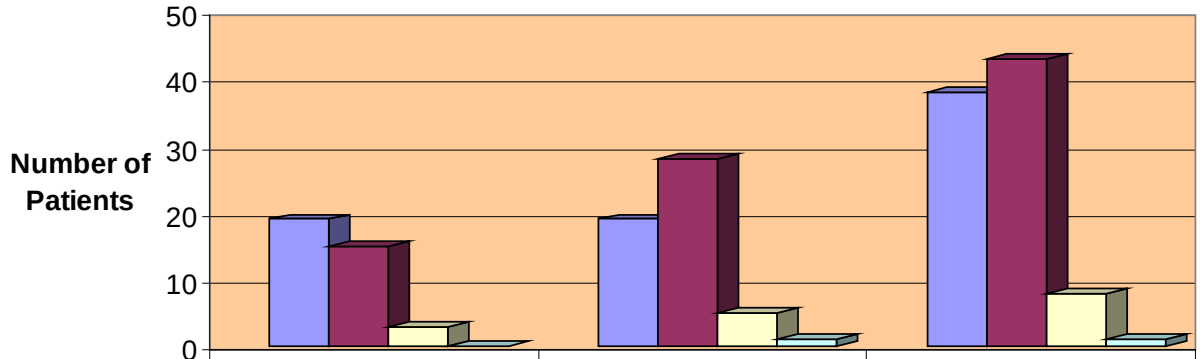
Age Category



Age Category by Gender

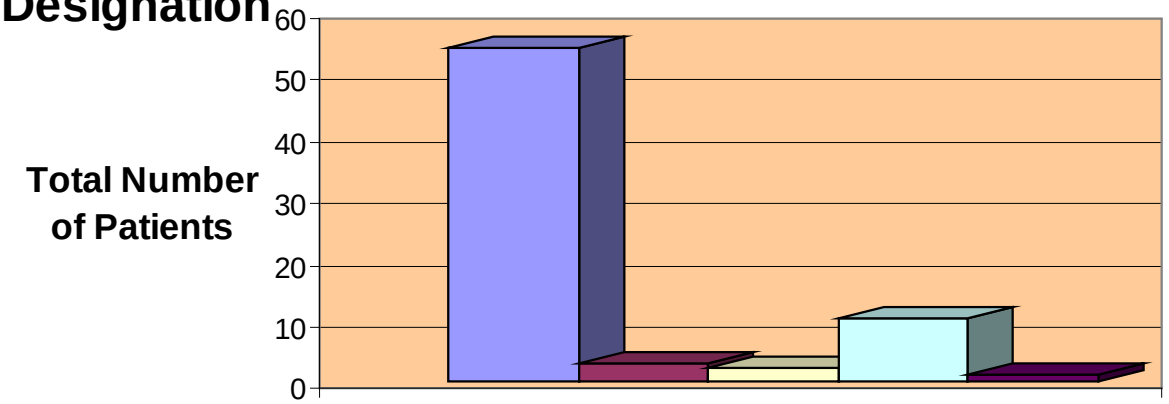


Living Situation



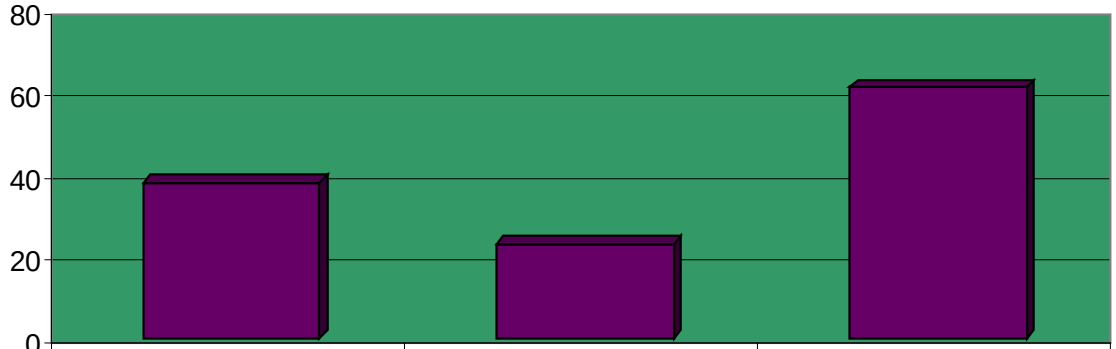
	1st Quarter	2nd Quarter	Total
Alone	19	19	38
With Others	15	28	43
Retirement Home	3	5	8
Other	0	1	1

Discharge Designation



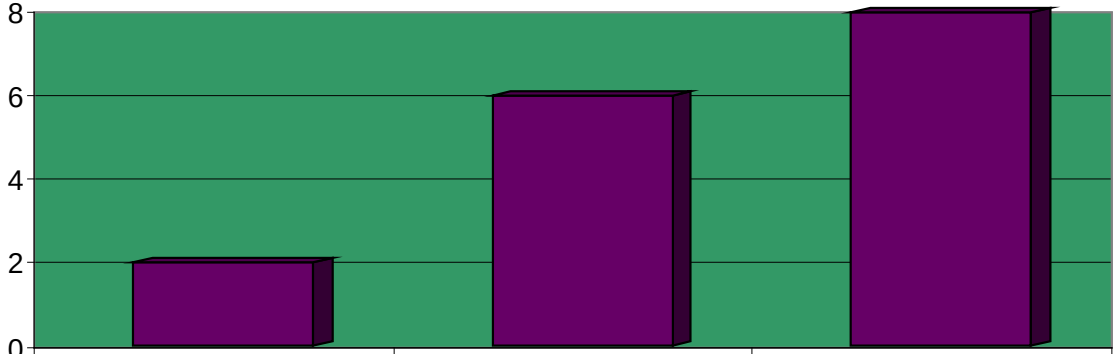
Remaining at home	54
Admitted to hospital	3
Admitted to LTC	2
Admitted to Retirement Home	10
Deceased	1

Referred Patients with CCAC services Prior to SASOT Involvement



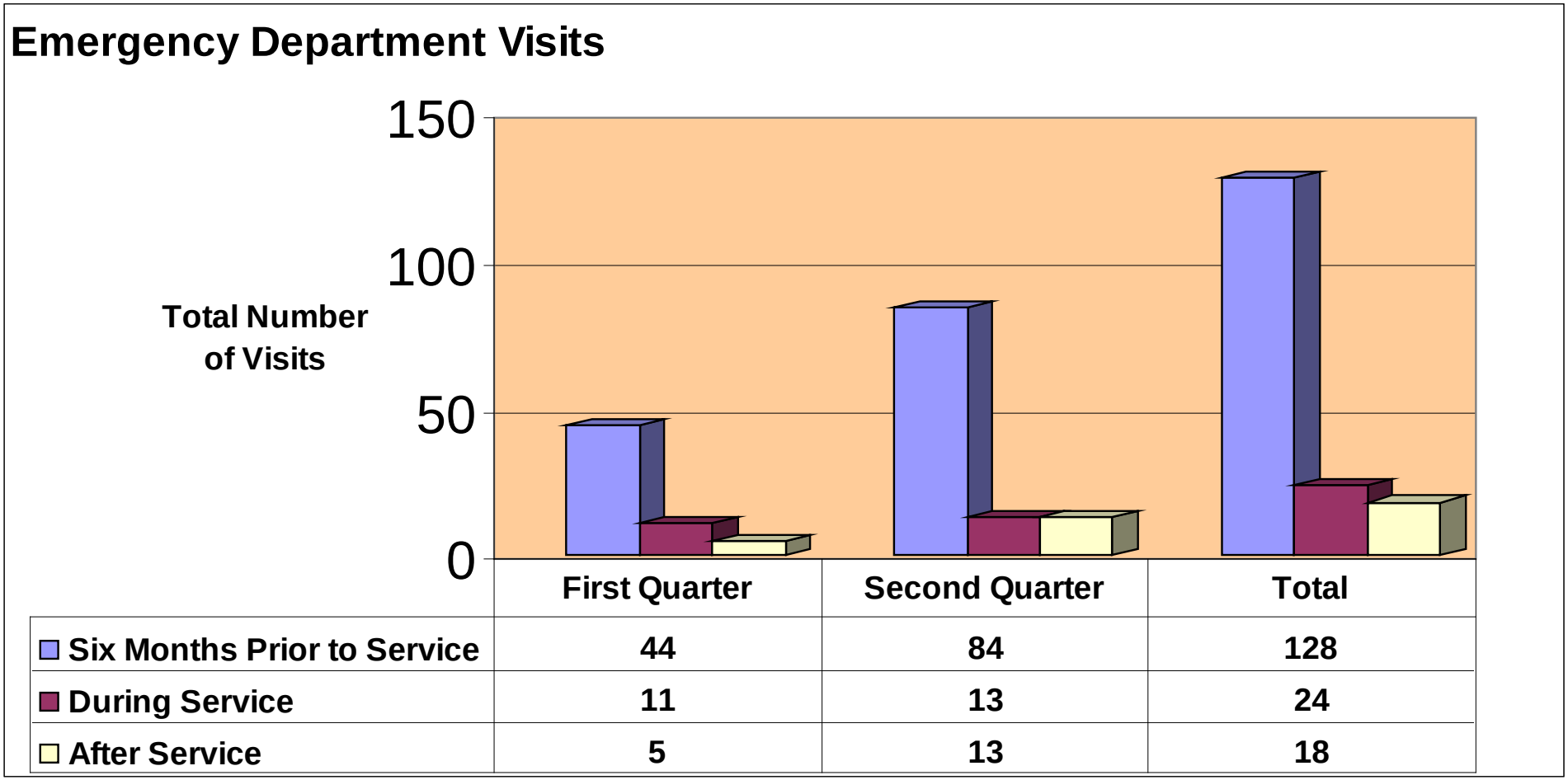
	First Quarter	Second Quarter	Total
Number of Referred Patients with CCAC services Prior to SASOT	38	23	61

Discharged Patients Referred to CCAC



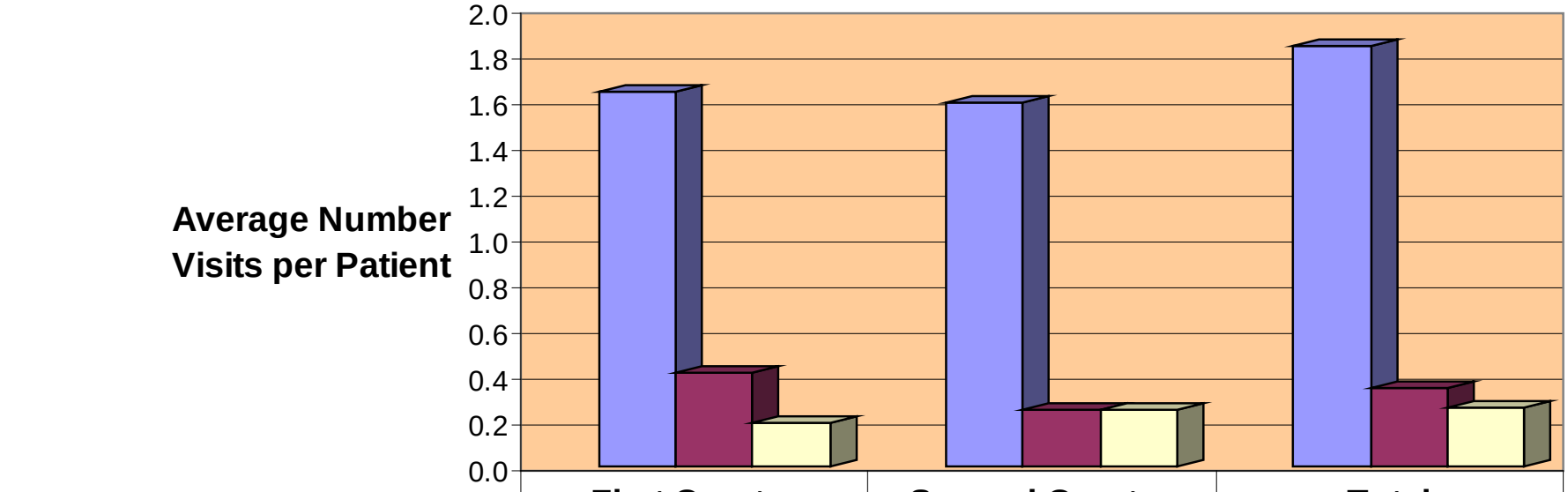
	First Quarter	Second Quarter	Total
Discharged patients referred to CCAC	2	6	8

Emergency Department Visits



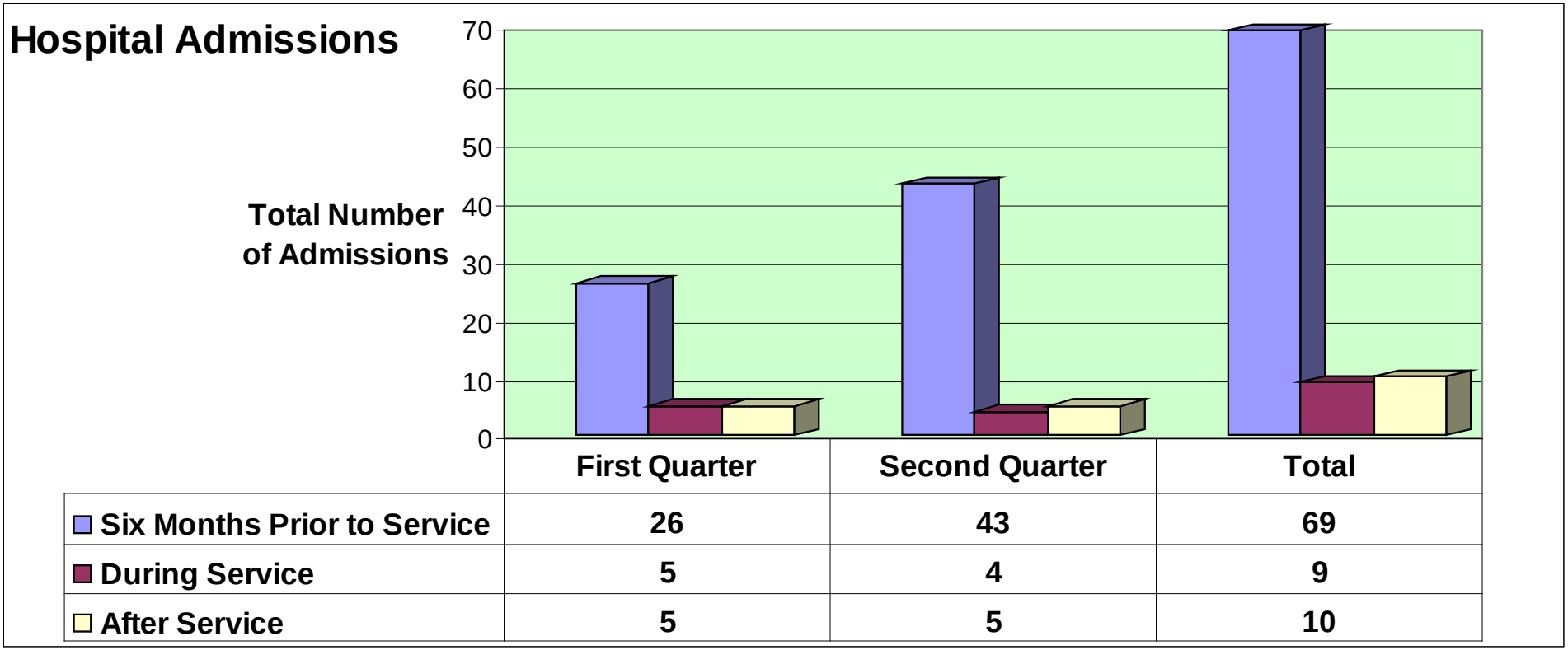
	First Quarter	Second Quarter	Total
Six Months Prior to Service	44	84	128
During Service	11	13	24
After Service	5	13	18

Emergency Department Visits Average Per Patient



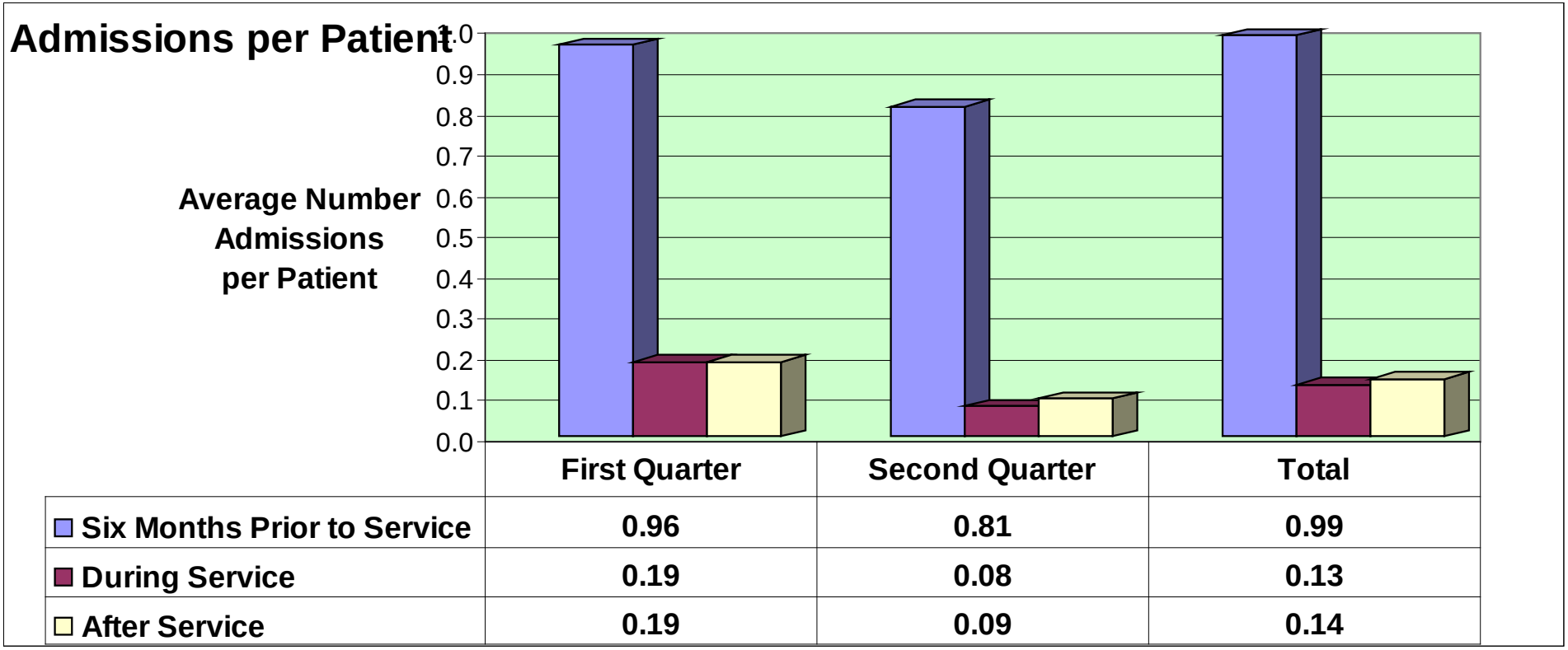
	First Quarter	Second Quarter	Total
Six Months Prior to Service	1.63	1.58	1.83
During Service	0.41	0.25	0.34
After Service	0.19	0.25	0.26

Hospital Admissions



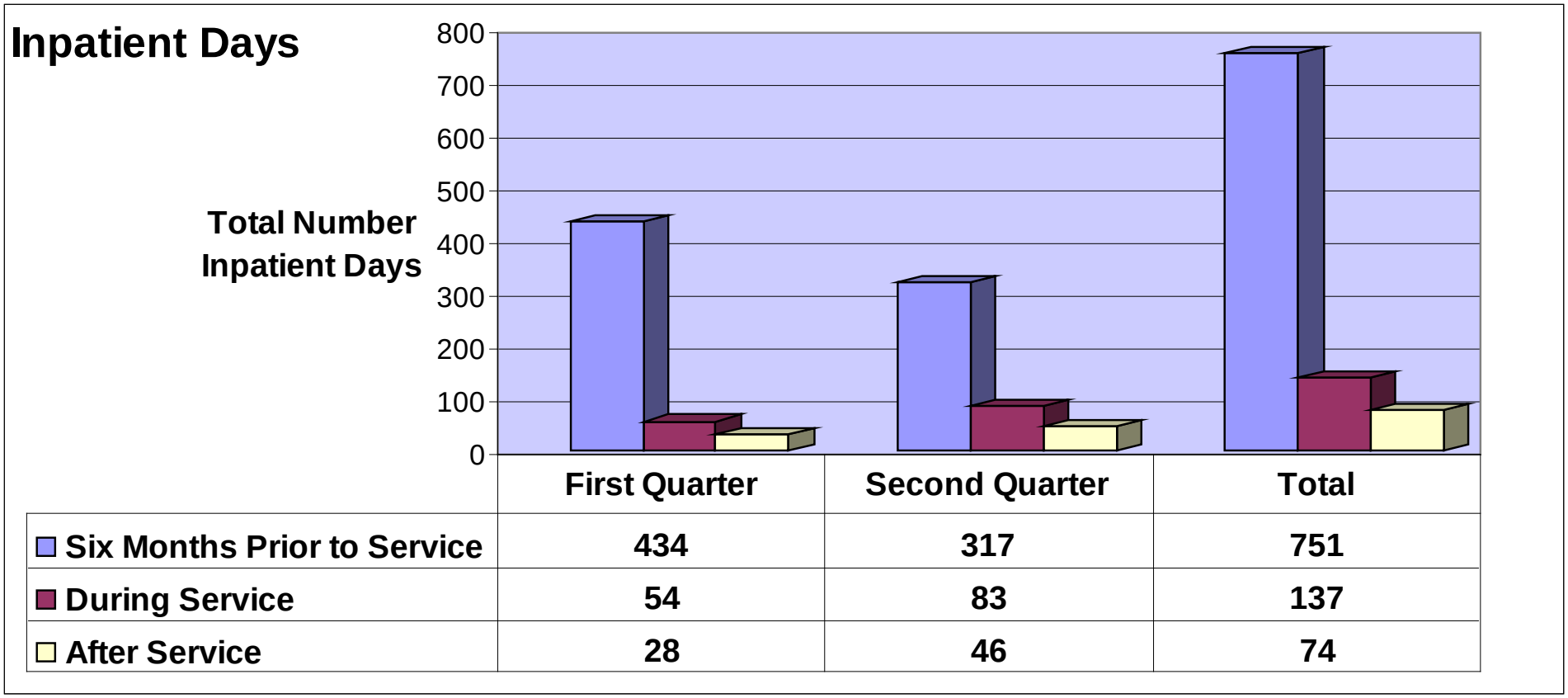
	First Quarter	Second Quarter	Total
Six Months Prior to Service	26	43	69
During Service	5	4	9
After Service	5	5	10

Hospital Admissions Average per Patient



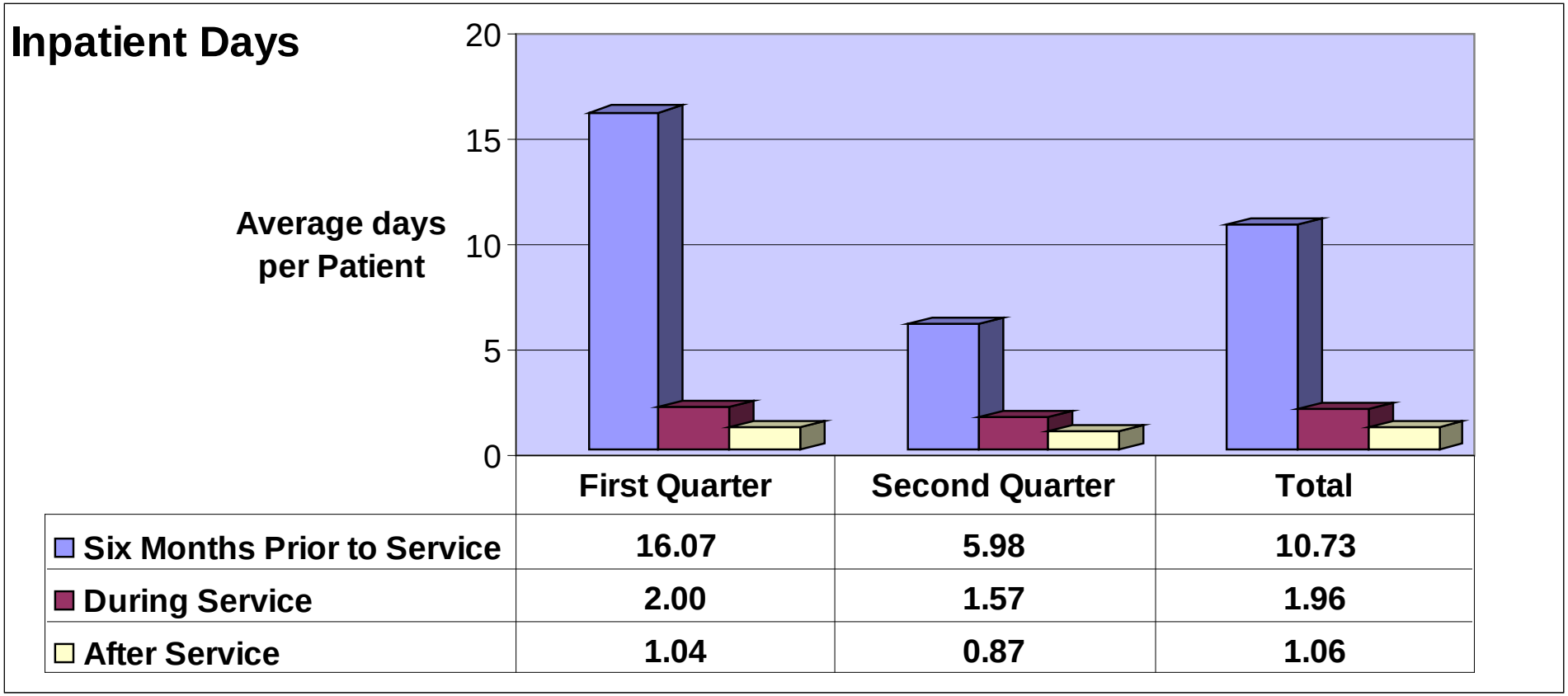
	First Quarter	Second Quarter	Total
Six Months Prior to Service	0.96	0.81	0.99
During Service	0.19	0.08	0.13
After Service	0.19	0.09	0.14

Inpatient Days



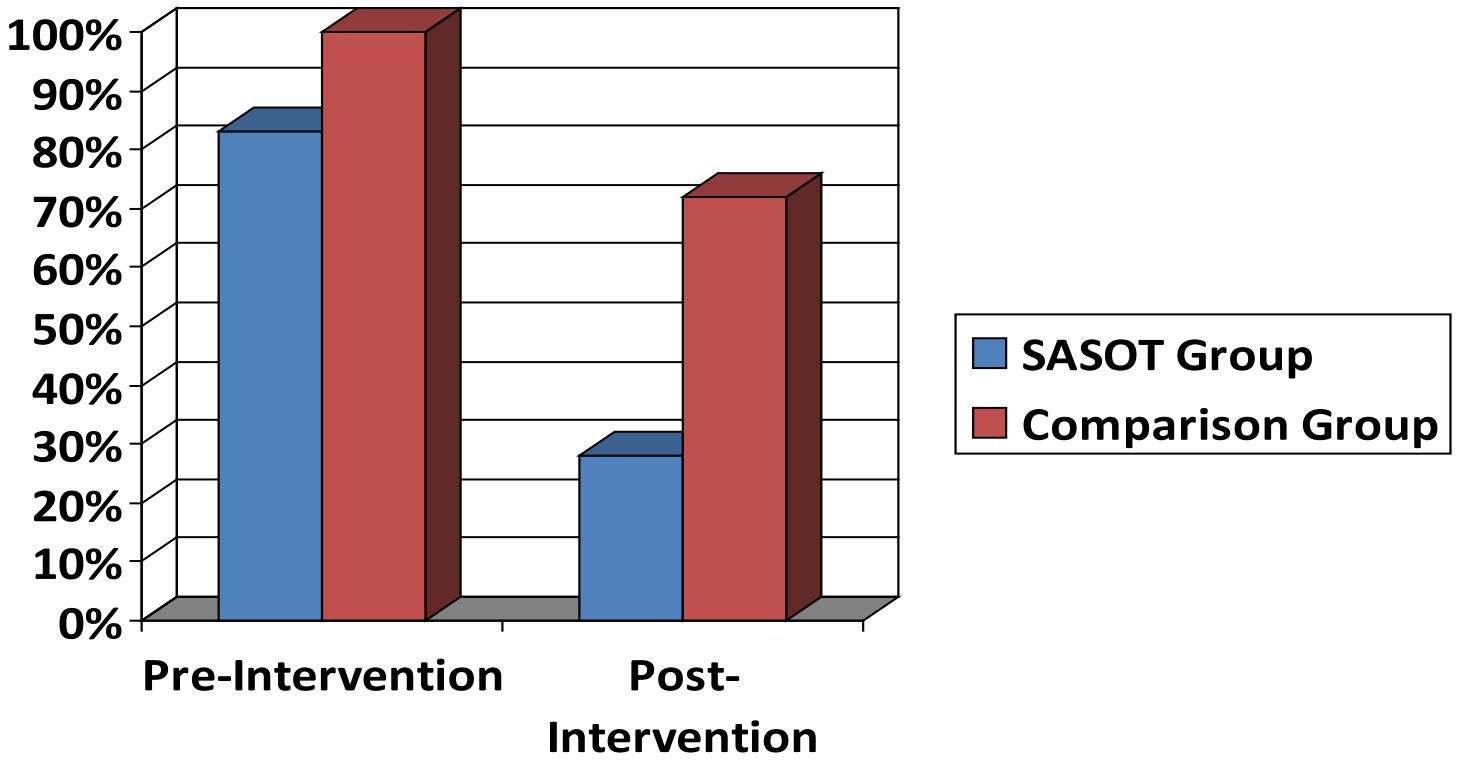
	First Quarter	Second Quarter	Total
Six Months Prior to Service	434	317	751
During Service	54	83	137
After Service	28	46	74

Inpatient Days
Average per Patient

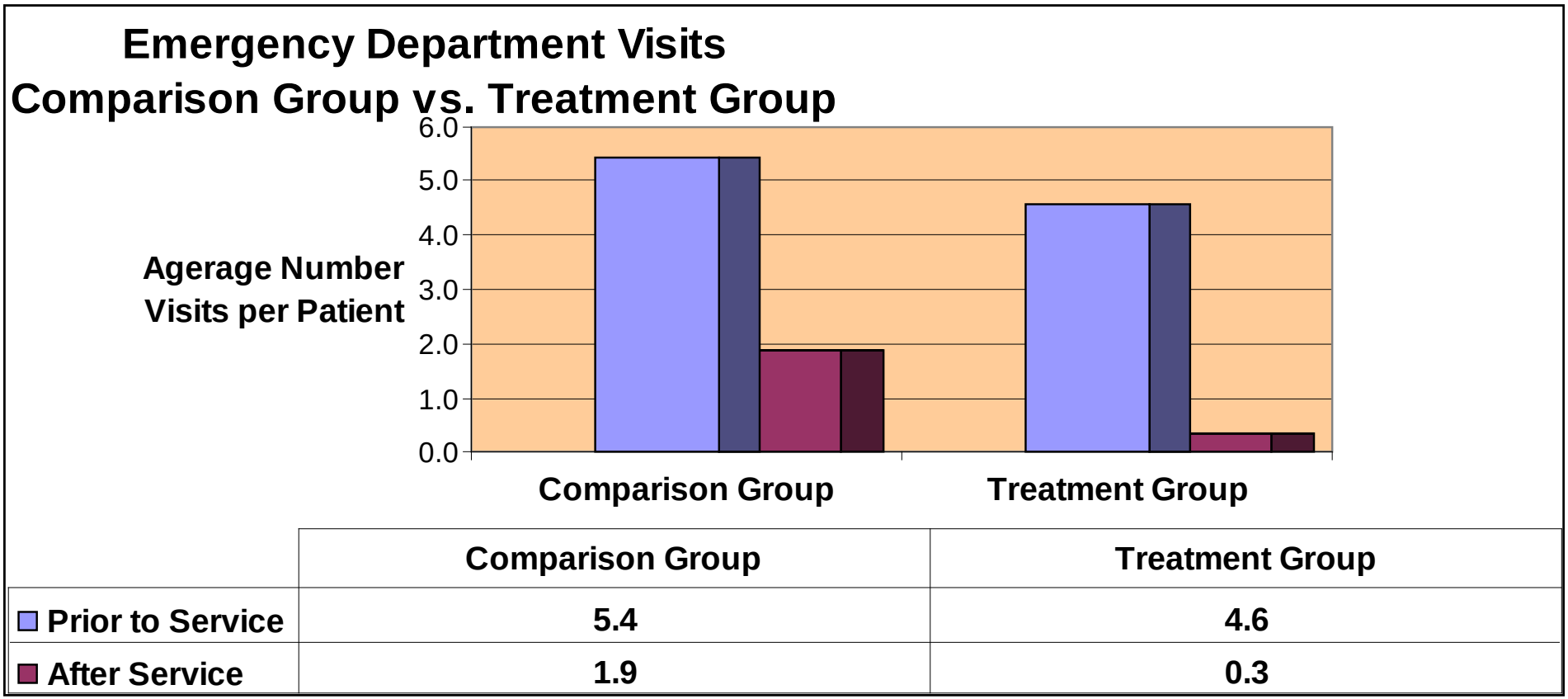


	First Quarter	Second Quarter	Total
Six Months Prior to Service	16.07	5.98	10.73
During Service	2.00	1.57	1.96
After Service	1.04	0.87	1.06

Percentage of Patients with Emergency Department Visits: Comparison vs Treatment Group

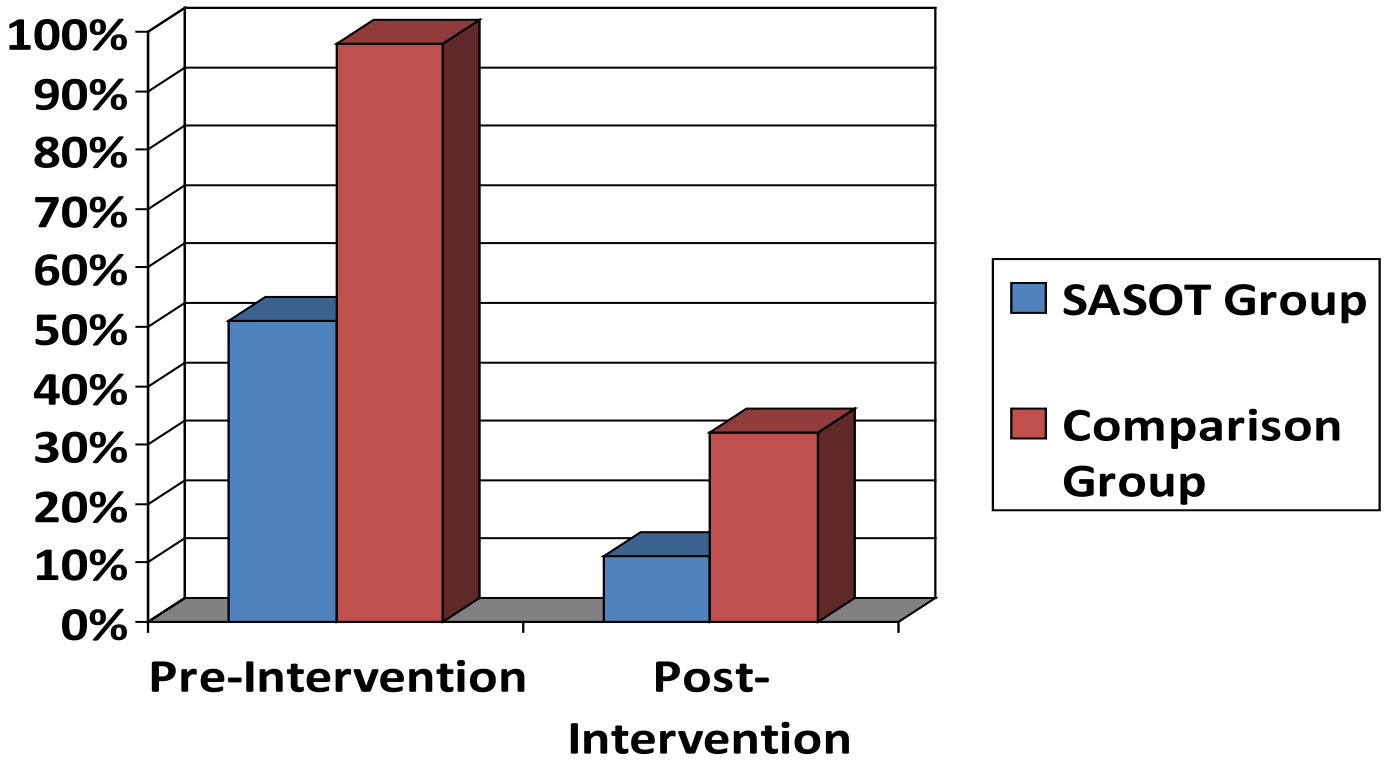


Emergency Department Visits Comparison vs Treatment Group

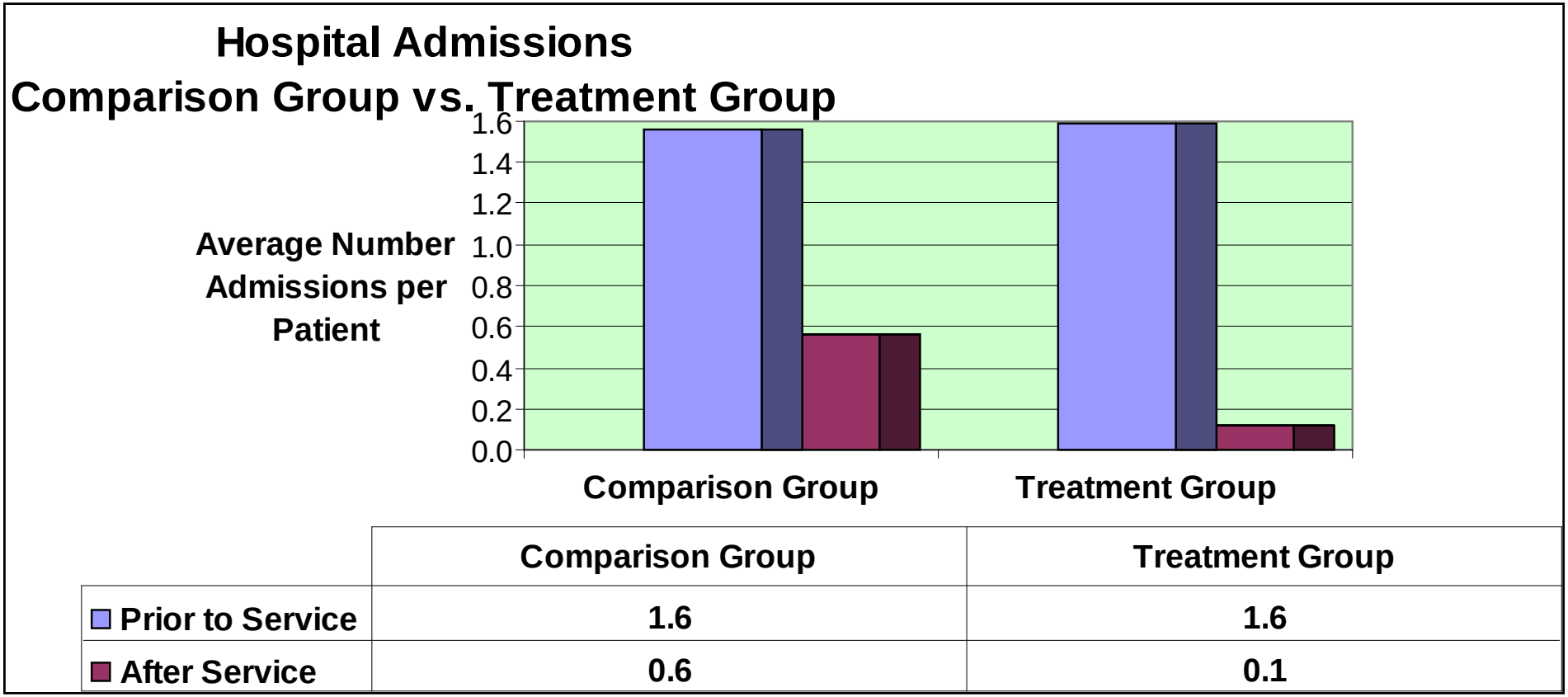


	Comparison Group	Treatment Group
Prior to Service	5.4	4.6
After Service	1.9	0.3

Percentage of Patients with Hospital Admissions: Comparison vs Treatment Group

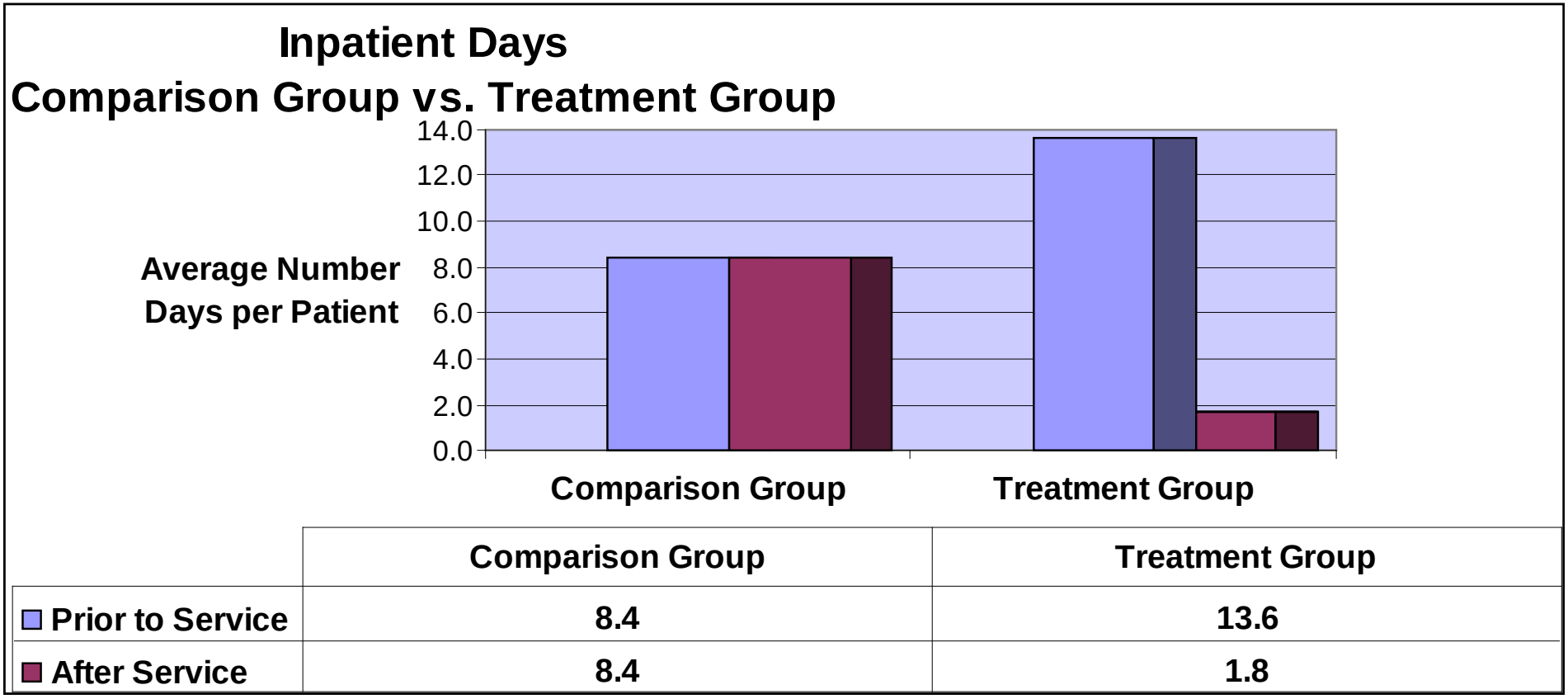


Hospital Admissions
Comparison vs Treatment Group



	Comparison Group	Treatment Group
Prior to Service	1.6	1.6
After Service	0.6	0.1

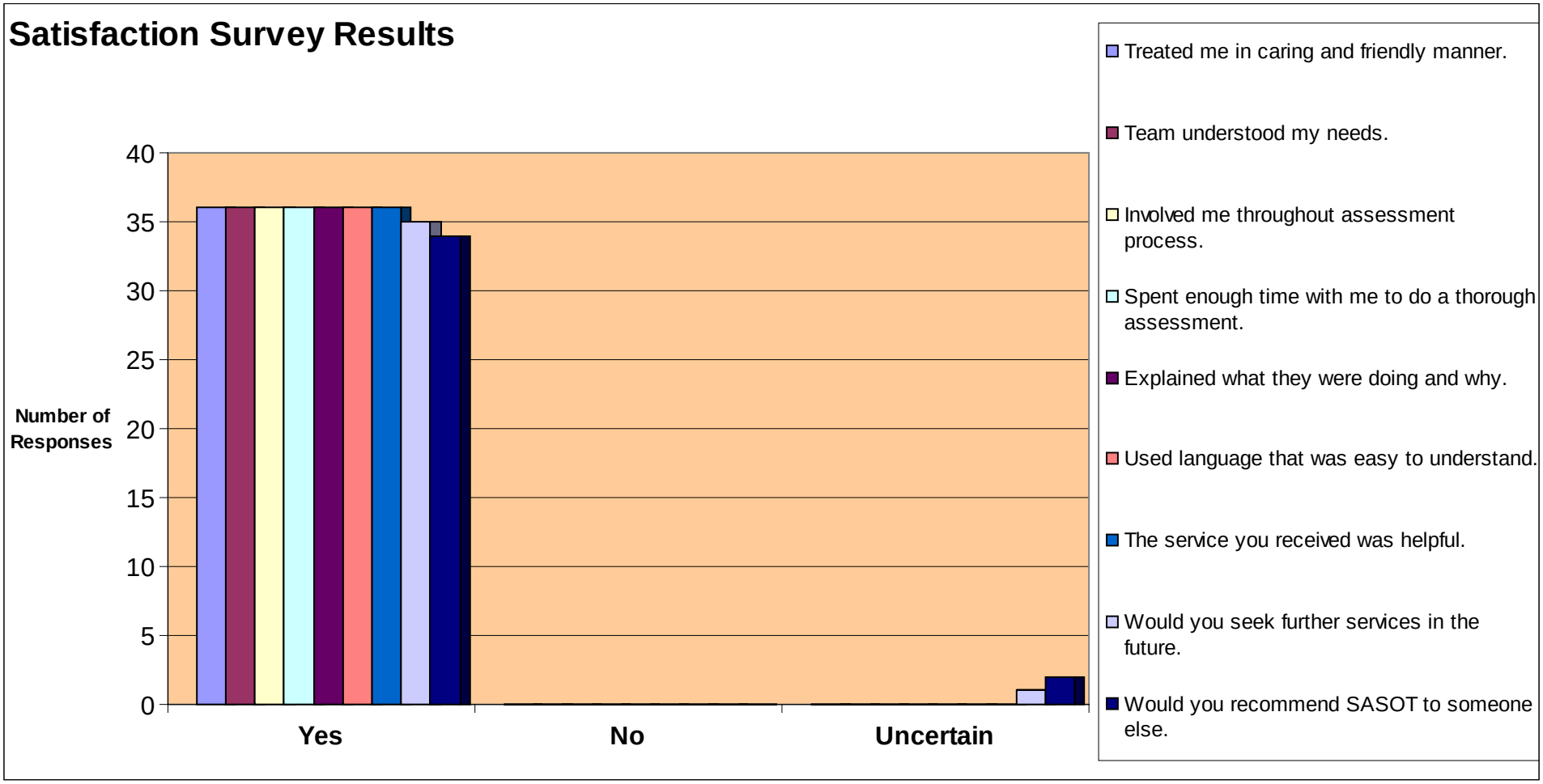
Inpatient Days
Comparison vs Treatment Group



	Comparison Group	Treatment Group
Prior to Service	8.4	13.6
After Service	8.4	1.8

Satisfaction Survey Results

Based on 81% response rate, 36 of 44 responses received.



Satisfaction Survey Responses

- Thank you very much, I felt I really mattered.
- I felt very secure in what I was doing with the team. I plan to carry on all the exercises as I can see it helping. Many, many thanks.
- The SASOT team are very helpful. I would recommend them to anyone in need of this type of assistance.
- Overall, very helpful, patient-centered care provided.
- I appreciate all the help that this team has given me and would highly recommend your assistance to any of my friends.
- Thank you for a lot of information and support I wasn't aware of.
- We appreciated the friendly and helpful visits from your team and for demonstrating the devices available when needed. Thank you very much it was great to have you visit our home.

Aboriginal Health Priorities: An Address to the LHIN Leadership Council

Aboriginal Health Circle

November 2012

The First Nation, Metis and Inuit Community in NSM LHIN

For a detailed description of the Aboriginal community located within the boundaries of the NSM LHIN, please refer to the report, "A Snapshot of the Aboriginal Population in Simcoe county and Muskoka District" produced by Susan Lalonde Rankin of the Centre for Addiction and Mental Health in June 2012.

Highlights of this report are as follows:

- The 2006 Census Data records 14,450 people who identify as Aboriginal in Simcoe County and Muskoka districts, which comprises about 3% of the total population which is higher than the provincial average of 2%.
- The Aboriginal population in our LHIN is younger when compared with the rest of the region's population.
- Statistics from the 2006 Census indicate that the Aboriginal population has a much higher proportion not completing high school and a smaller percentage completing university.
- Median earnings for Aboriginal people in Simcoe Muskoka is $24,579, which is lower than the median for the total of the population of the area which is $27,986.
- In Simcoe Mukoka, a larger percentage of Aboriginal rent, as compared to the rest of the population and a larger percentage of the dwellings they live in require major repair.

There are four First Nation communities in this LHIN: Moose Deer Point First Nation, Wahta Mohawk First Nation, Beausoleil First Nation and Chippewas of Rama First Nation. There are two Native Friendship Centres at Barrie and at Midland. There are three Native women's groups: Orillia Native Women's Group, Midland Native Women's Group, and the Biminaawzogin Regional Aboriginal Women's Circle (BRAWC). There is one regional Metis organization, the Georgian Bay Metis Council and one healing lodge, which is Enaahtig. The Barrie Area Native Advisory Circle is a regional Aboriginal planning body. The Medicine Horse Program is a new service, providing support to Aboriginal youth and families through land-based activities.

A variety of services are delivered to the Aboriginal community through agencies such as CAS and the Simcoe County Board of Education. CMHA and Kinark have some Aboriginal liaison staff connected to their programmes. The Chigamik Community Health Centre provides primary care through a blended model of both Aboriginal and Francophone considerations.

Health Priorities

The identification of health priorities for the Aboriginal community in our region is a result of a review of past research and initiatives (Mental Health Task Force 2005) and the Aboriginal Community Engagement report (2006). Information was obtained from priorities identified at the Aboriginal Health Symposium in 2009 and 2012. There have been on-going discussions at the Aboriginal Health Circle. The First Nation Health Directors met in October 2012 to table health concerns from a First Nation perspective.

The following is a list of health priorities as identified by the Aboriginal community in our region:

Child and Youth Mental Health

- Need for treatment services specific to children and youth mental health needs
- Need for screening & assessment tools that are culturally appropriate
- Housing/Support for Transitional Age Youth
- Strengthening positive cultural identity for children and youth

Diabetes / Chronic Disease Management

- To increase the capacity of the Aboriginal community / service providers to support family and community members to manage chronic disease
- Increase prevention efforts through education
- Increase opportunities to improve the physical health of community members
- Increase knowledge and use of traditional medicines

Mental Health and Addictions

- There is a need for an Aboriginal-specific addictions treatment facility in our region
- Increase capacity of the community to support family members to recover/manage addiction
- Address prevention/education needs within the community, especially maternal health.
- More availability of traditional healing practices to support recovery

The Aboriginal community has expressed a concern with the (seemingly) unregulated growth and expansion of methadone clinics. Other methods of providing support and help to people addicted to opiates, including withdrawal, should be supported.

Seniors Health

- Limited supports available at home, especially in the First Nation communities
- Few culturally appropriate supports and services available in the urban areas of our region

Health System Priorities

Recognition of Traditional Healing Practices

- Traditional healing practices need to be recognized as legitimate treatment by health service providers, with the necessary funds available to support it.
- The Aboriginal community in North Simcoe Muskoka needs to meet and collectively decide on the policies and practices to ensure the continued integrity of traditional healing practices

System Navigation

- There are health services which can never be fully delivered by the Aboriginal community. In those instances, we rely on the primary care system to help keep us healthy, i.e., hospitals, CHC's, etc. These systems are not well understood beyond the ER. We need to establish a method to increase/transfer knowledge on how to navigate this system.

Transportation

- Due to the size of our region, transportation remains an outstanding issue.

Challenges in System Change

- Decisions are being made without adequate input from the Aboriginal community. Capacity to respond to health system change/development is limited. It is hoped that the LHIN will accommodate this reality and have some courageous conversations in how to engage the Aboriginal community. There is a need for a protocol to engage communities, especially when funding announcements or system changes are occurring.

- Best practices for serving the Aboriginal population is to build capacity in the community to design and deliver services that are meaningful and effective.

- Cultural competency training can lead to better opportunities for Aboriginal communities to access services they need. However, this only scratches the surface. HSP's need to go deeper. Policies in service delivery, program planning, human resource planning and facilities development should be examined from a health equity lens.

- The Aboriginal Health Circle is acutely aware of the changes that are occurring within our health care system. It has been challenging to get full participation from the Aboriginal communities in the implementation of the Care Connections model. It has been difficult to get Aboriginal representation to take seats on the coordinating councils. As key decisions are being made here, it is important to somehow address this capacity issue.

Current Initiatives Underway within the Aboriginal System

Through BANAC and a community partnership with a number of agencies, the Aboriginal Capacity Building Circle (ACBC) has been meeting since 2008 to strengthen the system of care for Aboriginal children and youth. This has produced some positive results and initiatives currently underway such as:

- ✓ A Common Tool developed to manage initial contacts and referral – The first phase of this project was to develop a common form to be used by all Aboriginal agencies in our region, so that family members would only have to tell their story once. The form was developed in 2011. The second phase involves meeting with the governing bodies of all Aboriginal agencies and First Nation communities to develop a protocol for use, followed by training of staff in all agencies.

- ✓ CANS Tool Adaptation – This project is currently in process, supported by CAMH. Aboriginal agencies and HSP's are meeting to adapt the Children and Adolescents Needs and Strengths Tool to a tool that is culturally appropriate, meaningful and effective for Aboriginal families. This work is in collaboration with the designer of the tool, Dr. John Lyons, with support and involvement of the Children's Coalition of Simcoe County.

The First Nation health directors met in October to discuss health issues of common concern. A common concern was the expansion of the use of methadone as a treatment option in the management of opiate addictions. The First Nation health directors will be making a presentation to the mental health and addictions coordinating council in February to detail and share these concerns.

The Aboriginal Health Circle (AHC) continues to meet. The AHC assisted the LHIN with hosting a provincial meeting of the Aboriginal LHIN Leads in May of 2012. The AHC had an initial meeting with representatives of senior management, and governance of WayPoint to discuss community relationships. This is an on-going discussion.

The AHC is planning to address the issue of traditional healing practices through community discussion and/or a forum in this fiscal year.

Thank you for the opportunity to address the Leadership Council. The information contained herein is a summary of on-going community discussions with regard to Aboriginal health issues in our region.

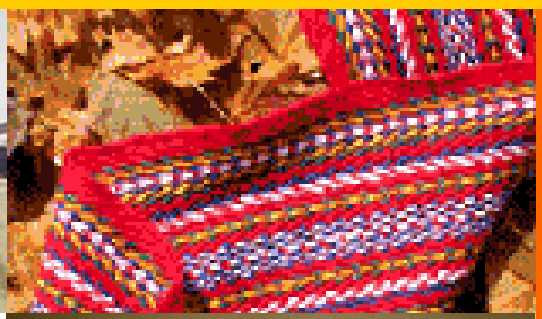
Germaine Elliott

Chair,

Aboriginal Health Circle

August 2012

A Snapshot of the Aboriginal Population in Simcoe County and Muskoka District



By: Susan Lalonde Rankin,
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ABORIGINAL IDENTITY POPULATION

Population

According to the 2006 Census Data there are 14,450 people who identify as Aboriginal identity* in Simcoe County and Muskoka Districts. This comprises about 3% of the total population of Simcoe and Muskoka, which is higher than the provincial percentage of 2%. However, it is important to note that the population numbers for Aboriginal people in the Census is likely an under-representation because census counts do not include persons living in institutions, those living outside Canada on census day, individuals who may be missed and non-participating individuals.

Aboriginal identity	Simcoe County	Muskoka Districts	Total population
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Inuit	45	10	55
Multiple response	85	0	85
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Total	**13,035**	**1,410**	**14,450**

**note categories for aboriginal identity are from Census Canada 2006*

This report will examine the data available from Statistics Canada for the Aboriginal Population as a whole, then look specifically at data for the First Nations people living on reserve in the region and Métis population.

Age Characteristics

The Aboriginal population of Simcoe County and Muskoka district is younger when compared with the rest of the region. The median age of the Aboriginal identity population in Simcoe and Muskoka is 32.3 which is lower than the region as a whole (42.6 median age). The percentage of the population under 15 is higher for the Aboriginal population when compared with the population of Simcoe and Muskoka as a whole. In addition the percentage of people over 65 is much smaller (less than half) when compared with the population of the area as a whole.

Region	2006 Population	Population change (01-06)	Median Age	Population under 15	Population over 65
Simcoe County	422,204	12%	39.8	19%	14%
Simcoe Aboriginal identity population	13,035	-	31.4	23.2%	4.7%
Muskoka District	57,563	8.4%	45.3	15.3%	20%
Muskoka District Aboriginal identity population	1,415	-	33.2	21.6%	6.7%

There are approximately 2,465 Transition Age youth (aged 15 to 24) in Simcoe and Muskoka who identify as Aboriginal. Transition Age youth make up 43% of the youth population in Aboriginal communities.

Aboriginal Population 0 to 24 years old, by 5 year age group					
Region	**Under 5 years**	**5 to 9**	**10 to 14**	**15 to 19**	**20 to 24**
Muskoka District	110	105	95	140	100
Simcoe County	915	985	1115	1330	895
TOTAL	**1025**	**1090**	**1210**	**1470**	**995**

Source: Statistics Canada, 2006 Aboriginal Census

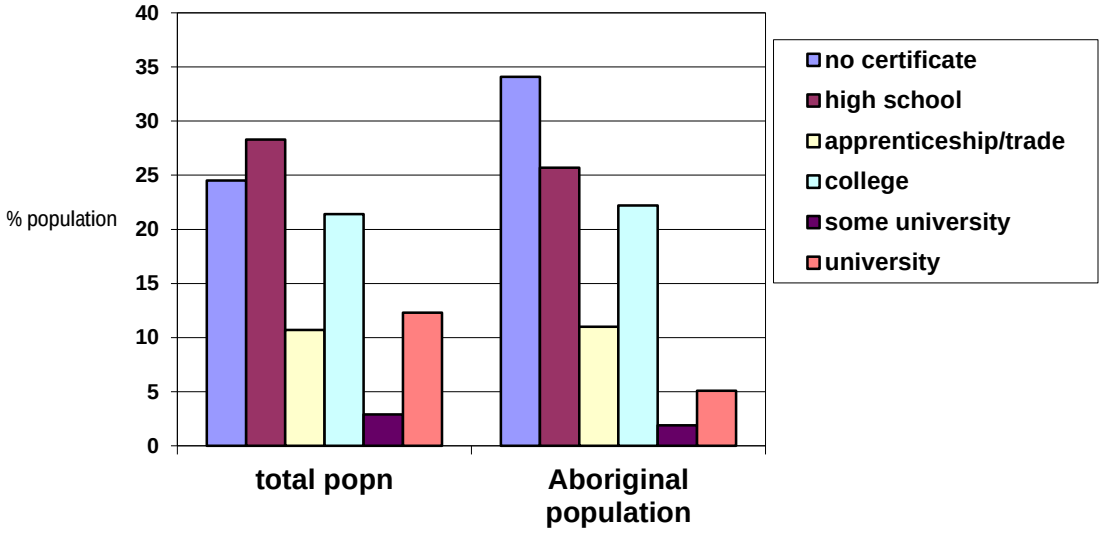
DETERMINANTS OF HEALTH

Education

Completing high school is an important indicator of life chances related to employment, income and health status. Statistics from the Census indicate that the Aboriginal population has a much higher proportion not completing high school and a smaller percentage completing university.

**Aboriginal identity refers to those persons reported identifying with at least one Aboriginal group: North Amerian Indian, Métis or Inuit*

Education attained Simcoe and Muskoka



Economic factors

Economic security is critical to good health. There is strong and convincing evidence that adequate stable income leads to safe housing, nutritious food and access to recreational opportunities.

- Median earnings for Aboriginal people in Simcoe Muskoka is $24,579 which is lower than the median for the total of the population of the area($27,986)
- Unemployment rate is 9.6% in the Aboriginal community- almost double the rate for Simcoe and Muskoka (5.6%)
- Main occupations are similar to the rest of the population with Sales and services being the main occupation, followed by trades/transport and equipment operators. There is a lower percentage in the education sector than in the rest of Simcoe and Muskoka

	Aboriginal population	**Total population**
Health care and social services	10%	9.2%
Education	4.6%	6.2%
Manufacturing	16%	14%

Family structure

Living in a lone parent family can be a barrier to achieving good health, principally because lone parent families in general have lower than average family incomes. Unfortunately given the data available from Stats Canada (below) we are unable to provide information on the average number of children per Aboriginal family or the % of lone parent families.

	Total number of census families	**Number persons in census families**	**Children in census families**		**Lone Parent families**	
			#	%	#	%
Simcoe	122,655	367,965	----		17,560	14%
Muskoka	17,315	48,482	-----		2,035	12%
Aboriginal pop'n	-------	14,395	5,620	39%	945	----

Housing

Rates of home ownership and rental can help to identify basic issues and needs in the community. When compared with the population of Simcoe and Muskoka, a larger percentage of the Aboriginal identity population rents and a larger percentage of the dwellings they live in require major repair.

	Rent*	**Own***	**Dwellings requiring repair ***	**Ave # rooms per dwelling***	**Dwellings with more than one person per room***
Simcoe	19%	81%	6.0%	7.1	0.5%
Muskoka	17%	82%	8.25%	6.9	0.7%
Aboriginal identity popn	31%	68%	11%	6.8	0.9%

*(as % of total dwellings occupied)

Health Status

Numerous studies have concluded that Aboriginal populations have poorer health than the population of Ontario as a whole. Aboriginal people have a lower life expectancy, higher mortality rate from injury and suicide, higher rates of cancer and cardiovascular disease, higher rates of chronic disease like diabetes, mental illness and addiction. (see for example NAHO 2009 Health inequalities and social determinants of Aboriginal Peoples Health) Indicators of health status are available for the Aboriginal population at the level of the province. However, data is not available at the county and district level on the health of FNMI populations.

FIRST NATIONS COMMUNITIES

Population

A small percentage of Aboriginal People (around 1 674 or 12%) live on First Nations reserves. There are four First Nations reserves in Simcoe and Muskoka:

- Moose Deer Point
- Wahta Mohawk First Nation
- Beausoleil First Nation
- Chippewas of Rama First Nation

Each of the four communities is unique in terms of history, geography and culture. Some are affiliated with the Haudenosaunee people and others with Anishnaabe people.

The community's geography - its proximity to urban centres and accessibility – are strong determinants of access to education, employment and health services. For example the Beausoleil First Nation lives mainly on Christian Island which is accessed by boat only. At certain times of the year (freeze and thaw) the ferry does not run. Community members who work off the island or attend high school must live "in town" at those times of the year. The remoteness of the island creates barriers to accessing specialized health services off reserve as well as delays for emergency services.

The economy of each community is unique. Rama First Nation is the site of Casino Rama which is a source of employment. Many from the community work there and many Aboriginal people from other communities move to the area to work at the Casino. The fact that there is a large employer on the reserve may in part explain why the community of Rama has a higher median income when compared with other First Nations communities in the area.

Photo: Casino Rama

Age Characteristics

The age characteristics of on reserve First Nations populations differs quite a bit from surrounding communities in two ways: 1) they are younger in that the median age is lower and there is a greater proportion of people under age 15 and 2) they are growing much more quickly.

Region	2006 Population	Population change (01-06)	Median Age	Population under 15	Population over 65
Simcoe County	422,204	12%	39.8	19%	14%
District of Muskoka	57,563	8.4%	45.3	15.3%	20%
Christian Island Beausoleil First Nation	620	12.7%	28.7	30.8%	3%
Moose Deer Point	210	13.5%	30.7	31%	5%
Rama Mnjikaning First Nation	846	41.7%	30.8	32.2%	6%

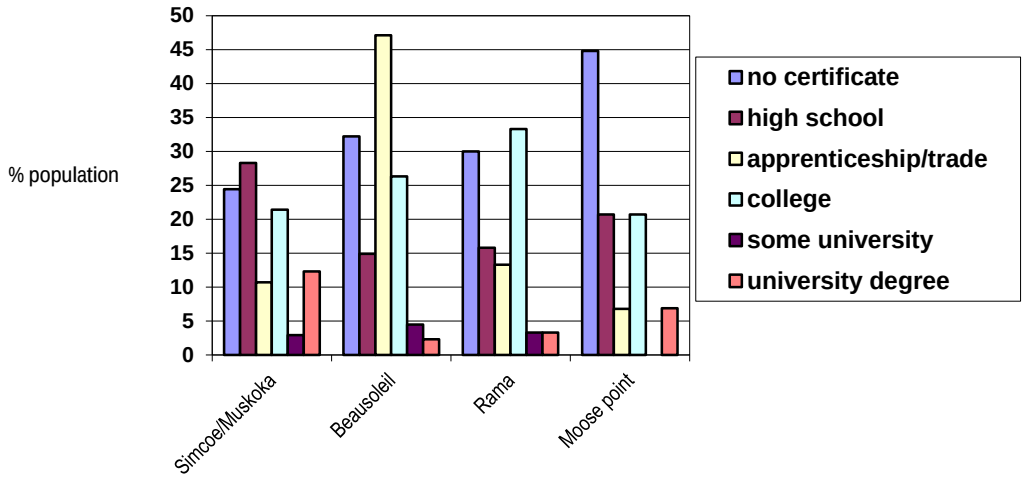
note data from Wahta Mohawk Territory not available from Stats Can.

DETERMINANTS OF HEALTH

Education

Education levels for on-reserve First Nations populations differ from those of the population of the area as a whole. The percentage of the population without a high school certificate is much higher in the three communities of Beausoleil, Rama and Moose Point that for Simcoe / Muskoka as a whole. However, the percentage of the population in Beausoleil and Rama who have a college certificate is higher than the population as a whole. This may reflect in part efforts by the local college (Georgian College) to put in place supports and programs geared specifically to the Aboriginal communities in the area (see page 12). Note that a similar pattern is not reflected in the percent of the population with a university degree, which are a lot lower in First Nations communities than Simcoe Muskoka regions.

Education age 15 and over



Economic factors

Economic security is a critical determinant of health. Individuals and families need a source of income that provides them with the resources and benefits necessary to participate fully in their communities. There is strong evidence that higher income is associated with better health. Income determines whether a family has access to safe housing and nutritious food which can greatly impact health.

The median earnings in the community of Rama are on par with the earnings of the population of Simcoe and higher than the median earnings in Muskoka. However, median earnings in Beausoleil are significant lower than Rama, Simcoe and Muskoka. Unemployment rates among First Nations communities are much higher than in surrounding communities.

Community	Median earnings	Unemployent rate
Simcoe	$27,838	5.8%
Muskoka	$22,985	4.6%
Beausoleil	$13,280	23.1%
Rama	$27,712	13.33%
Moose point	-------	10.5%

Family Structure

The County of Simcoe has analyzed data in Simcoe County on Family Structure for the Child, Family and Youth Coalition. Results for on-reserve populations are below. The percentage of female lone parent families is double among on-reserve populations when compared to Simcoe County as a whole.

	Total census families	Couple families with children	Couple families without children	Female lone parent families	Male lone parent families
Simcoe County	122,655	47%	39%	11%	3%
Beausoleil	150	50%	10%	27%	7%
Rama	230	50%	22%	22%	7%
Moose deer point	----	----	----	----	----

Housing

The proportion of dwelling requiring major repair is a significant risk to health as there may be risks of fire or mould damage which can be harmful to health. In terms of housing, there seems to be a much high proportion of dwellings requiring major repair at the Beausoleil First Nation when compared with Rama.

	Rent*	**Own***	**Dwellings requiring repair ***	**Ave # rooms per dwelling***	**Dwellings with more than one person per room***
Beausoleil	28%	65%	40%	6.4	0
Rama	22%	75%	19%	6.1	0
Moose deer point	---	---	---	---	---

*(as % of total dwellings occupied)

MÉTIS POPULATION

Population

Simcoe County has the highest concentration of self identified Métis people in all of Ontario. The Métis are a unique culture blended from European (mainly French and Scottish) and First Nations cultures (Cree, Ojibwa, Saulteaux and Assiniboine). Historically the Métis population settled in the Penetanguishene area in the mid 19th century, relocating to the area from Drummond Island after the war of 1812 when the island was turned over to the United States. Many were civilian employees of the British army or fur traders who moved to the area along with the British soldiers who were re-locating from Drummond Island to the military post at Penetanguishene. The civilians, known as voyageurs, brought with them their First Nation wives and children and were granted lands around the Penetanguishene area. Many stayed in the area where the Métis culture continues to thrive.

Scott Carpenter talks about the significance of the sash at Mocassin camp

Health

An overview of the Health of the Métis population in Canada is provided in a Stats Canada report http://www.statcan.gc.ca/pub/89-637-x/89-637-x2009004-eng.pdf . The report does not provide specific data for the Simcoe county Métis population but rather provides an overview of the health of the Métis population in all of Canada.

Results indicate that:

- Arthritis is the most commonly reported chronic condition – and reported at a higher rate (21%) than the rest of the Canadian population (13%)
- The rate of diabetes (7%) is higher in the Métis population than in the rest of Canada (4%)

- Young adult Métis (15-19 years of age) report better health than the rest of Canada, however the percentage of the Métis population rating their health as good or very good is lower than the Canadian population for groups older than 35 (see table below)
- The most common chronic condition among young adult Métis (15-19) is asthma with almost double (20%) the percentage found among the same age group in Canada

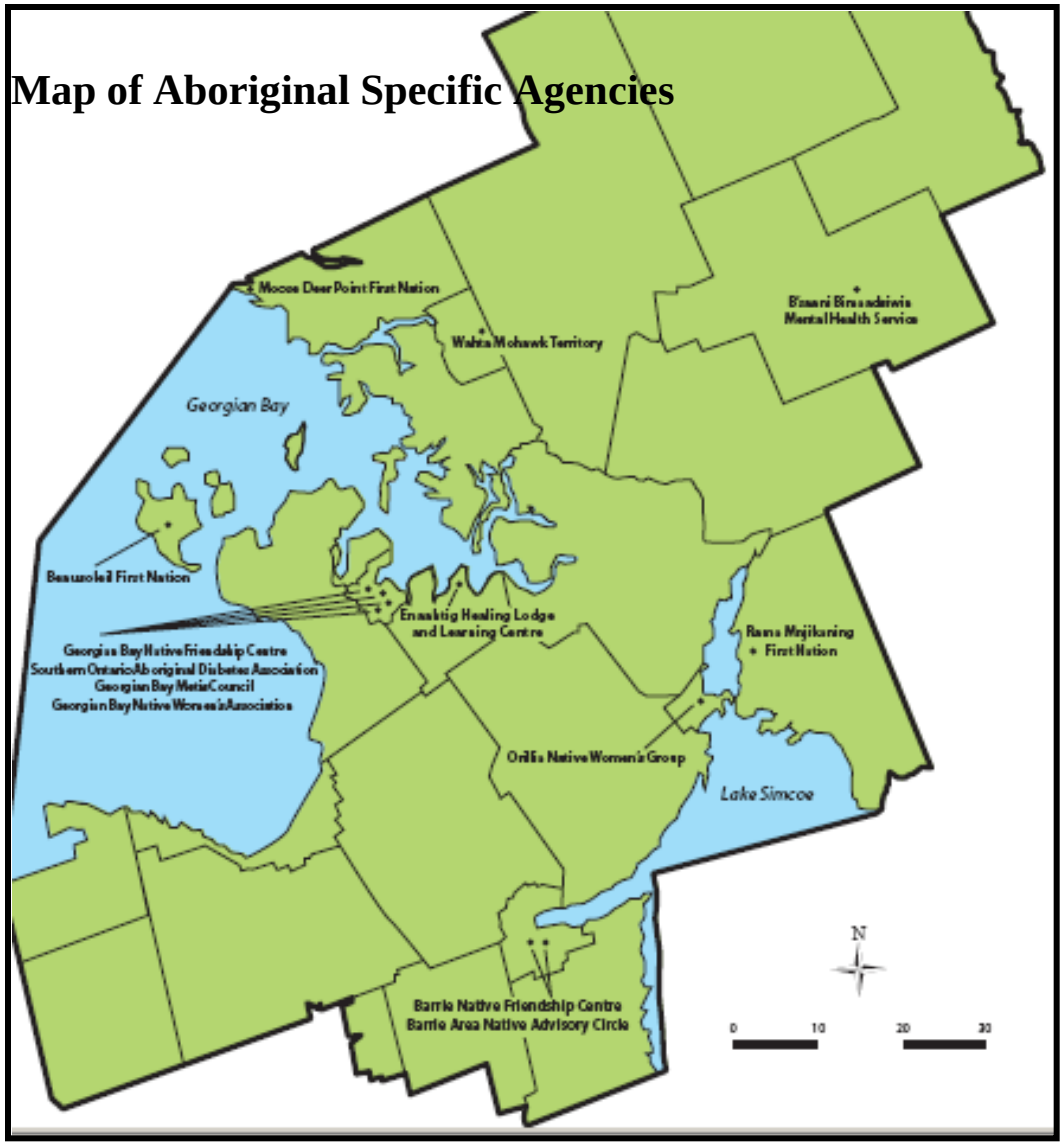
AGENCIES WITH SPECIALIZED SERVICES FOR ABORIGINAL POPULATIONS

Agency	Programs	Location
B"saaniBimaadsiwin Mental Health Service (Muskoka-Parry Sound Community Mental Health Service)	- mental health assessment and referral - crisis services - counseling - community development - consultation to non-aboriginal service providers	Bracebridge
Barrie Native Friendship Centre	- Health Outreach workers - Healing and Wellness Coordinator - Healthy babies/healthy children - Lifelong Care Coordinator - Ak:wego program provides children 7-12 supports and tools to make healthy lifestyle choices	Barrie
Barrie and Area Native Advisory Circle - Aboriginal Health Circle	- regional planning and coordination for Simcoe and Muskoka and northern York regions – brings Aborgianl and mainstream agencies together - supports the Aboriginal Health Circle which plans health services - also provides some programming like Family Wellness programming, long-term care/aging at home and child care centres in Barrie, Midland and Orillia	Barrie
Beausoleil Health Centre	- Addictions and mental health program provides intake, min assessment, referrals and support - telemedicine consultation medical specialists -traditional healing - Community Health Representatives – health advocacy, development and referral coordinates access to various services (massage therapy, foot care, acupuncture, healthy food boxes etc.)	Christian Island
Biminaawzogin Regional Aboriginal Women's Circle	- regional body composed of women's organizations and individual women from Simcoe county and northern York region - provides eight week groups sessions as part of Aboriginal Women's Education, Training and Employment Bridging project that builds bridges between education, employers and Aboriginal women	Barrie

Agency	Programs	Location
Centre de Santé Communautaire Chigamik Community Health Centre	- primary care via a team of NP, physicians, mental health and addiction workers and others - health promotion - community development - traditional healing	Midland
Enaahtig Healing Lodge and learning Centre	- mental health case management - case management concurrent disorders - counseling and referral - trauma and recovery program -residential programs - traditional teachings and ceremonies - wellness workshops	Vasey (main centre) and satellite in Orillia
Georgian Bay Native Friendship centre	- Healing and Wellness Coordinator - Healthy babies/healthy children - Lifelong Care Coordinator	Midland
Georgian Bay Native Womens' association	- Aboriginal seniors program - Childrens programs (CAP-C_ - health outreach support for women - prenatal nutrition program	Midland
Métis Nation of Ontario (Georgian Bay Métis Council)	- Healthy babies / healthy children - Healing and Wellness coordinator - Lifelong care coordinator - pilot telemental health services	Midland
Georgian College	Aboriginal student support services that include a visiting Elder program, peer mentoring, resource centre/study area and much more. In addition to offering courses with an Aboriginal focus, a range of college and university	Barrie

Agency	Programs	Location
	courses are also available.	
Huronia family housing co-op	Non-profit housing for Aboriginal people	Midland
Moose Deer Point First Nations Health Clinic	- Primary care - Community Health Promotion worker - Youth support Worker - NNADAP worker - Community Health Rep.	Mactier
Orillia Native Women's group	- prenatal - community action program for children - nutrition information - traditional parenting - health related workshops - parent and tot's programs - sharing circles for men and women	Orillia
Rama Health Centre	- foot care clinic - diabetes clinic - counseling for mental health and addictions - home care and home support	
Southern Ontario Aboriginal Diabetes Association	- education, prevention and management of diabetes	Coordinator in Central East
Simcoe Urban Native Housing	Provides rent geared to income housing for native people.	Barrie
Wahta Nursing Station	- primary care	

Map of Aboriginal Specific Agencies



August 2012

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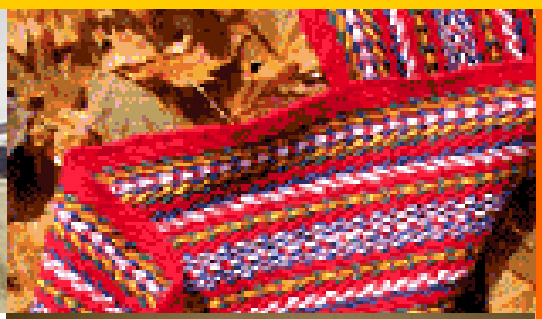

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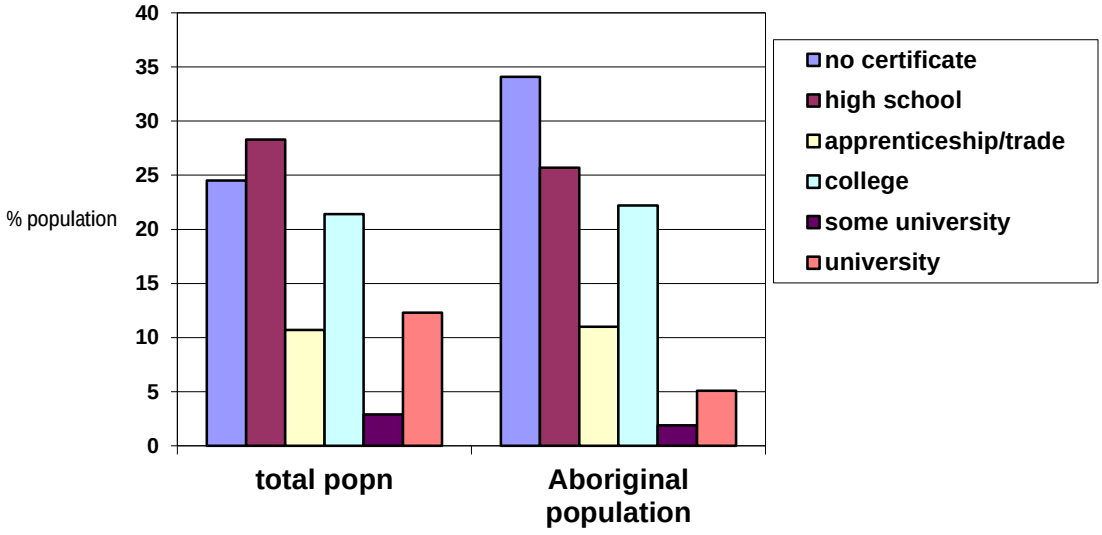

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Photo: Casino Rama

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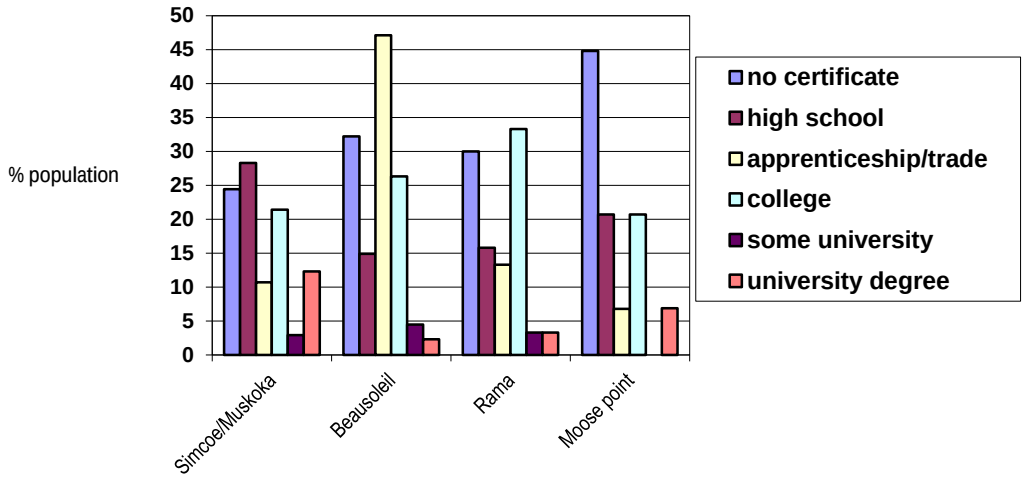
Education levels for on-reserve First Nations populations differ from those of the population of the area as a whole. The percentage of the population without a high school certificate is much higher in the three communities of Beausoleil, Rama and Moose Point that for Simcoe / Muskoka as a whole. However, the percentage of the population in Beausoleil and Rama who have a college certificate is higher than the population as a whole. This may reflect in part efforts by the local college (Georgian College) to put in place supports and programs geared specifically to the Aboriginal communities in the area (see page 12). Note that a similar pattern is not reflected in the percent of the population with a university degree, which are a lot lower in First Nations communities than Simcoe Muskoka regions.

Education age 15 and over



Economic factors

Economic security is a critical determinant of health. Individuals and families need a source of income that provides them with the resources and benefits necessary to participate fully in their communities. There is strong evidence that higher income is associated with better health. Income determines whether a family has access to safe housing and nutritious food which can greatly impact health.

The median earnings in the community of Rama are on par with the earnings of the population of Simcoe and higher than the median earnings in Muskoka. However, median earnings in Beausoleil are significant lower than Rama, Simcoe and Muskoka. Unemployment rates among First Nations communities are much higher than in surrounding communities.

Community	Median earnings	Unemployent rate
Simcoe	$27,838	5.8%
Muskoka	$22,985	4.6%
Beausoleil	$13,280	23.1%
Rama	$27,712	13.33%
Moose point	-------	10.5%

Family Structure

The County of Simcoe has analyzed data in Simcoe County on Family Structure for the Child, Family and Youth Coalition. Results for on-reserve populations are below. The percentage of female lone parent families is double among on-reserve populations when compared to Simcoe County as a whole.

	Total census families	Couple families with children	Couple families without children	Female lone parent families	Male lone parent families
Simcoe County	122,655	47%	39%	11%	3%
Beausoleil	150	50%	10%	27%	7%
Rama	230	50%	22%	22%	7%
Moose deer point	----	----	----	----	----

Housing

The proportion of dwelling requiring major repair is a significant risk to health as there may be risks of fire or mould damage which can be harmful to health. In terms of housing, there seems to be a much high proportion of dwellings requiring major repair at the Beausoleil First Nation when compared with Rama.

	Rent*	**Own***	**Dwellings requiring repair ***	**Ave # rooms per dwelling***	**Dwellings with more than one person per room***
Beausoleil	28%	65%	40%	6.4	0
Rama	22%	75%	19%	6.1	0
Moose deer point	---	---	---	---	---

*(as % of total dwellings occupied)

MÉTIS POPULATION

Population

Simcoe County has the highest concentration of self identified Métis people in all of Ontario. The Métis are a unique culture blended from European (mainly French and Scottish) and First Nations cultures (Cree, Ojibwa, Saulteaux and Assiniboine). Historically the Métis population settled in the Penetanguishene area in the mid 19th century, relocating to the area from Drummond Island after the war of 1812 when the island was turned over to the United States. Many were civilian employees of the British army or fur traders who moved to the area along with the British soldiers who were re-locating from Drummond Island to the military post at Penetanguishene. The civilians, known as voyageurs, brought with them their First Nation wives and children and were granted lands around the Penetanguishene area. Many stayed in the area where the Métis culture continues to thrive.

Scott Carpenter talks about the significance of the sash at Mocassin camp

Health

An overview of the Health of the Métis population in Canada is provided in a Stats Canada report http://www.statcan.gc.ca/pub/89-637-x/89-637-x2009004-eng.pdf . The report does not provide specific data for the Simcoe county Métis population but rather provides an overview of the health of the Métis population in all of Canada.

Results indicate that:

- Arthritis is the most commonly reported chronic condition – and reported at a higher rate (21%) than the rest of the Canadian population (13%)
- The rate of diabetes (7%) is higher in the Métis population than in the rest of Canada (4%)

- Young adult Métis (15-19 years of age) report better health than the rest of Canada, however the percentage of the Métis population rating their health as good or very good is lower than the Canadian population for groups older than 35 (see table below)
- The most common chronic condition among young adult Métis (15-19) is asthma with almost double (20%) the percentage found among the same age group in Canada

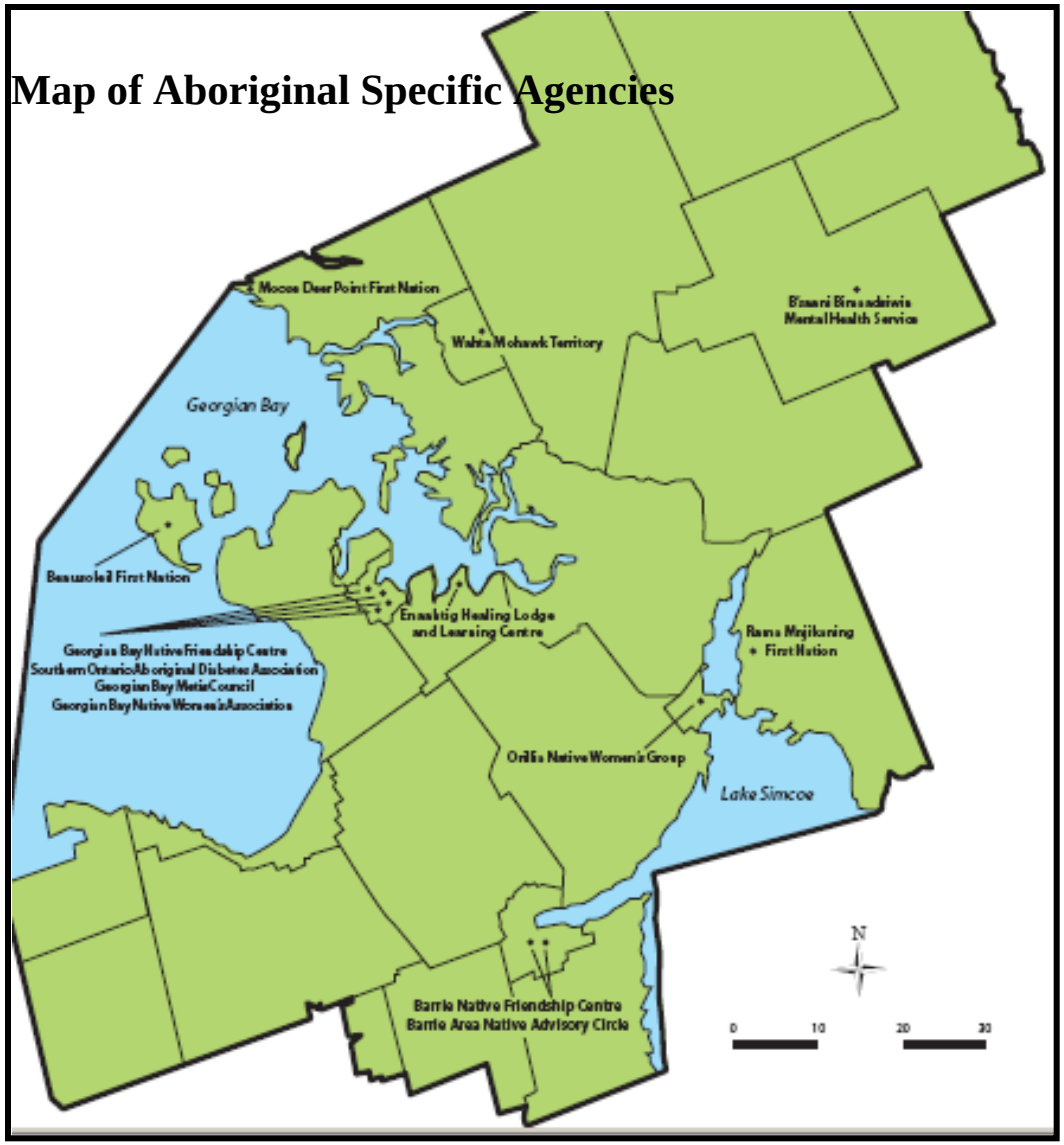
AGENCIES WITH SPECIALIZED SERVICES FOR ABORIGINAL POPULATIONS

Agency	Programs	Location
B"saaniBimaadsiwin Mental Health Service (Muskoka-Parry Sound Community Mental Health Service)	- mental health assessment and referral - crisis services - counseling - community development - consultation to non-aboriginal service providers	Bracebridge
Barrie Native Friendship Centre	- Health Outreach workers - Healing and Wellness Coordinator - Healthy babies/healthy children - Lifelong Care Coordinator - Ak:wego program provides children 7-12 supports and tools to make healthy lifestyle choices	Barrie
Barrie and Area Native Advisory Circle - Aboriginal Health Circle	- regional planning and coordination for Simcoe and Muskoka and northern York regions – brings Aborgianl and mainstream agencies together - supports the Aboriginal Health Circle which plans health services - also provides some programming like Family Wellness programming, long-term care/aging at home and child care centres in Barrie, Midland and Orillia	Barrie
Beausoleil Health Centre	- Addictions and mental health program provides intake, min assessment, referrals and support - telemedicine consultation medical specialists -traditional healing - Community Health Representatives – health advocacy, development and referral coordinates access to various services (massage therapy, foot care, acupuncture, healthy food boxes etc.)	Christian Island
Biminaawzogin Regional Aboriginal Women's Circle	- regional body composed of women's organizations and individual women from Simcoe county and northern York region - provides eight week groups sessions as part of Aboriginal Women's Education, Training and Employment Bridging project that builds bridges between education, employers and Aboriginal women	Barrie

Agency	Programs	Location
Centre de Santé Communautaire Chigamik Community Health Centre	- primary care via a team of NP, physicians, mental health and addiction workers and others - health promotion - community development - traditional healing	Midland
Enaahtig Healing Lodge and learning Centre	- mental health case management - case management concurrent disorders - counseling and referral - trauma and recovery program -residential programs - traditional teachings and ceremonies - wellness workshops	Vasey (main centre) and satellite in Orillia
Georgian Bay Native Friendship centre	- Healing and Wellness Coordinator - Healthy babies/healthy children - Lifelong Care Coordinator	Midland
Georgian Bay Native Womens' association	- Aboriginal seniors program - Childrens programs (CAP-C_ - health outreach support for women - prenatal nutrition program	Midland
Métis Nation of Ontario (Georgian Bay Métis Council)	- Healthy babies / healthy children - Healing and Wellness coordinator - Lifelong care coordinator - pilot telemental health services	Midland
Georgian College	Aboriginal student support services that include a visiting Elder program, peer mentoring, resource centre/study area and much more. In addition to offering courses with an Aboriginal focus, a range of college and university	Barrie

Agency	Programs	Location
	courses are also available.	
Huronia family housing co-op	Non-profit housing for Aboriginal people	Midland
Moose Deer Point First Nations Health Clinic	- Primary care - Community Health Promotion worker - Youth support Worker - NNADAP worker - Community Health Rep.	Mactier
Orillia Native Women's group	- prenatal - community action program for children - nutrition information - traditional parenting - health related workshops - parent and tot's programs - sharing circles for men and women	Orillia
Rama Health Centre	- foot care clinic - diabetes clinic - counseling for mental health and addictions - home care and home support	
Southern Ontario Aboriginal Diabetes Association	- education, prevention and management of diabetes	Coordinator in Central East
Simcoe Urban Native Housing	Provides rent geared to income housing for native people.	Barrie
Wahta Nursing Station	- primary care	

Map of Aboriginal Specific Agencies



Understanding Supportive Housing Services

November 14, 2012

There is a proud history behind the development of Supportive Housing in Canada. This program evolved in the early 1970's based on the Independent Living philosophy which emerged from California following the Vietnam war. This philosophy was based on developing options for living in the community for adults with ongoing support needs, which served as alternatives to LTC, Chronic Care facilities, and locked institutions. The original "Living" or "Aging at Home"

In Ontario, the different program components that were emerging were centralized in a Supportive Housing Policy in 1994 for 4 target groups: Adults with Physical Disabilities, ABI, living with HIV/AIDS, and the frail elderly. This was an attempt to formalize the structure of these government funded programs, while allowing room for their continued evolution.

These programs were identified as a non-medical model of service which offered support in the areas of Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). These programs were available to support adults to do the things that they would do for themselves if they were physically or cognitively able. There was a requirement that adults in the program be able to direct their own care, or learn how to do this. If individuals required clinical services, these services should be available through either community health care (primary care, mental health, etc.) or the CCAC. Service maximums were based on an average level of care of the client group in the program, not to exceed an average of 180 hours/month. The preference to delink housing services from support services was emphasized.

When compared to other support services available in the community, the type of support available to clients in Supportive Housing is the same as the In Home services available through the CCAC, subsidized seniors programs through Helping Hands and Red Cross, or Attendant Care Outreach services available through The Friends in Muskoka, and Independent Living Services (ILS previously S.C.A.P.D.) in Simcoe County.

These services include (for eligibility, clients must require Personal Care Services):

- Personal grooming and hygiene
- Bathing and washing
- Rising and retiring
- Assistance with breathing*
- Bowel and Bladder procedures*
- Assistance with eating
- Assistance with essential communication
- Positioning and transferring
- Assistance with exercises
- Meal preparations
- Light housekeeping, shopping and banking.

Within the programs delivered to frail seniors under this policy, the target group, and their family members, have demanded different types of service models be available. The target group for these services has emerged as low to moderate needs seniors, who require assistance with basic ADL and IADL to remain safe in their homes, and opportunities for social interaction within a group atmosphere. Although the Supportive Housing Policy discourages joining housing services and support services, many Supportive Housing programs for seniors have incorporated both housing sand services into their models.

There are longitudinal studies that show the positive impact of these programs on the use of hospital and LTC facilities over a number of years, when targeting low to moderate risk seniors.

The new Assisted Living Services for High Risk Seniors Policy refocuses the Supportive Housing Policy on those seniors who are currently using Alternative Level of Care beds in the hospital, or are high users of health care services in the community and Emergency Departments.

So what is different between Supportive Housing and Community Visiting Programs (CCAC/seniors supports/Attendant Care Outreach)?

1. Level of Services – the number of available support hours in a Supportive Housing program are 180/month – twice the amount of the other In Home supports.
2. Supportive Housing programs offer access to unscheduled services for urgent personal care needs – 24 hours a day, 365 days per year. In Home services require the client to have backup supports in place to deal with support needs outside of regular scheduled visits.
3. Care Coordination – the Supportive Housing model builds in support to the client to stay on top of medical appointments, regular assessment of needs, and support the maintenance or development of family and social networks.

Supportive Housing Program Models available in North Simcoe Muskoka

There are no Supportive Housing programs available in North Simcoe Muskoka for adults with ABI or living with HIV/AIDS.

Supportive Housing programs for Adults with Physical Disabilities have been developed in Barrie, Orillia, Midland, Collingwood and Bracebridge through The Friends and Independent Living Services of Simcoe County. A variety of service delivery models have been developed since 1994, as supported by the 1994 policy, most programs delink housing and support services.

Supportive Housing programs have emerged for frail seniors in most communities across the region, through a variety of service providers (municipal, and non-profit).

In Summary:

Both "Supportive Housing" and "Assisted Living Services" offer the same combination of personal support services and homemaking services to people living in their homes, on a 24 hour basis. The terms relate to the services and supports available to the client on a 24/365 basis in their home. These services are non-medical in nature, but professional/clinical services, as required, can be accessed through the CCAC.

The differences come from the overriding legislation which establish the parameters of each program:

Supportive Housing Policy 1994, which targets adults with physical disabilities, ABI, HIV/AIDS, and frail senior already living in Supportive Housing programs and:

Assisted Living Services for HRS 2011 targeting high risk seniors. Low to medium risk seniors are no longer eligible for this type of service model.

Different Models have Emerged Over Time

The target groups for these various programs have supported the development of parallel delivery systems based on emerging client group needs. There were other policy developments that influenced these programs, such as the Attendant Care Outreach guidelines for adults with physical disabilities.

Each service provider has adopted their own level of Risk Tolerance over time, based on the target group they have offered service to, which leads to some variation in service models available. Some models have develop a community focused program (geographic hubs), while others offer these services in combination with housing in a defined building.

Prepared by: Dan McGale, Independent Living Services of Simcoe County

Notes* (example – assistance with breathing)

*The Regulated Health Professions Act (RHPA) allows for exceptions under which a person performing a controlled act would not be in breach of the legislation (sections 29(1)). Section 29 .1 (e) states that "assisting a person with his or her routine activities of living, and the act is a controlled act set out in paragraph 5 or 6 of subsections 27 (2)", is an exception to the RHPA. In this case delegation of responsibility under the RHPA is not required.

Employers of PSW or Attendant Care staff (AC) who permit their staff to perform controlled acts under 29.1 (e) manage risk by having policies/procedures or guidelines that speak to:

- The agency's definition of a routine activity of daily living;
- The training that staff would normally undergo to ensure they are competent, current and comfortable with the performance of the skill (may include consumer direction as part of the training);
- The agency's process for on-going support, refreshing training and monitoring of the performance of the act.

These conditions have allowed for the divergence of various Supportive Housing/Outreach models over time, based on the client group supported, and the risk tolerance of the agency. This has influenced the level of care available in different Supportive Housing programs, offered by various service providers across NSM, and the province.

For example, from working with a target group of adults with significant physical disabilities over 32 years, agencies that support adults with physical disabilities (members of Ont. Assoc. of Independent Living Service Providers) have grown into offering a variety of personal support services that other groups would not see as within their expertise. This provincial network has learned together, and shared expertise and joint training over the years.

At Independent Living Services of Simcoe County, we see the Attendant Care Worker as the only health provider occupational group whose scope of practice encompasses solely activities that the client would do for him, or herself, if physically or cognitively able.

- The agency determines the acts performed within the boundaries of legislation
- ACWs can provide routine activities of living if:
    1. The need for the specific procedure has been identified;
    2. The frequency of performing the procedure has been established;
    3. The individual responds, or reacts, to the procedure in a consistent predictable way;

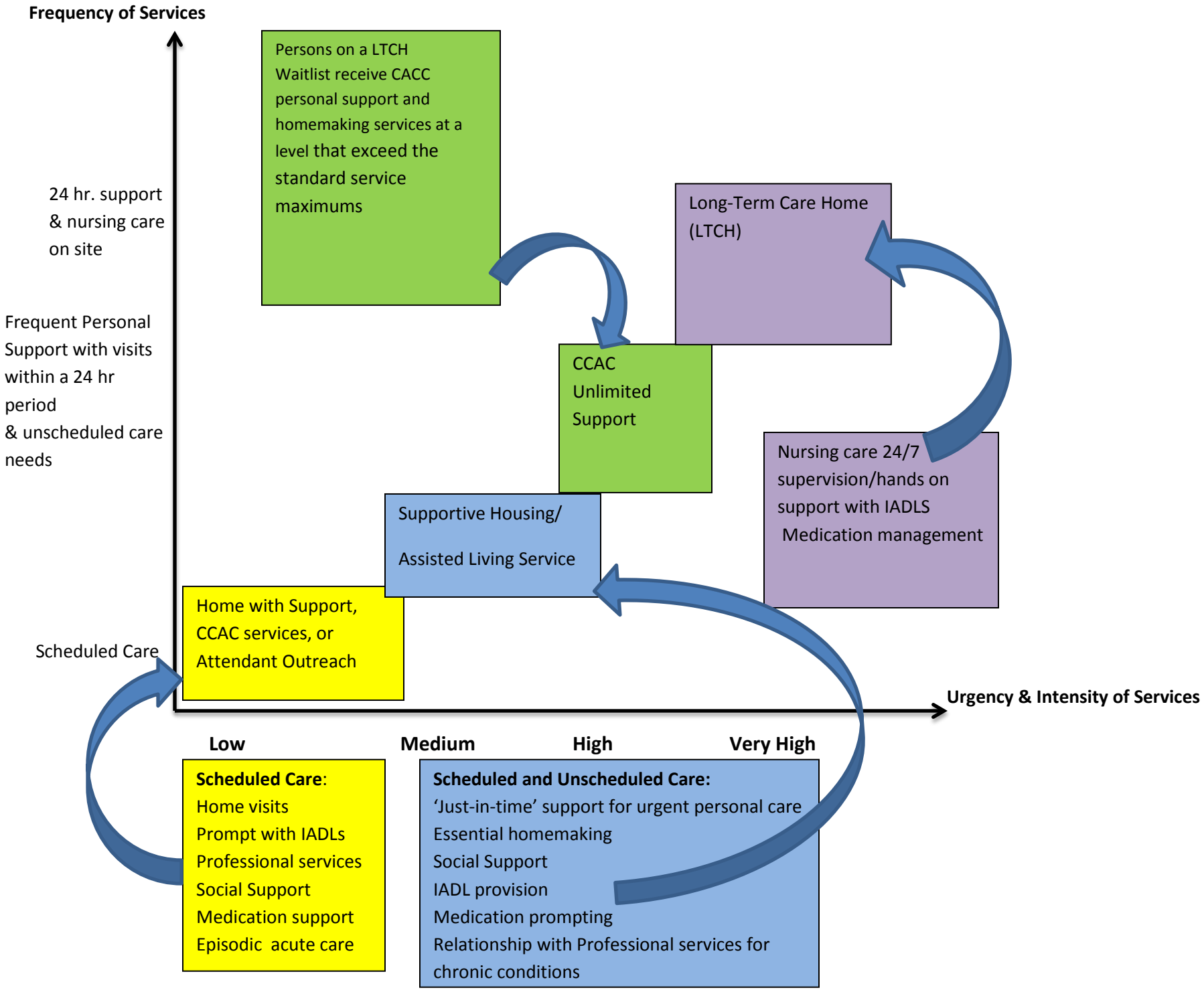
4. The outcome of performing the procedure is always the same; and
5. The specific procedure is required indefinitely.

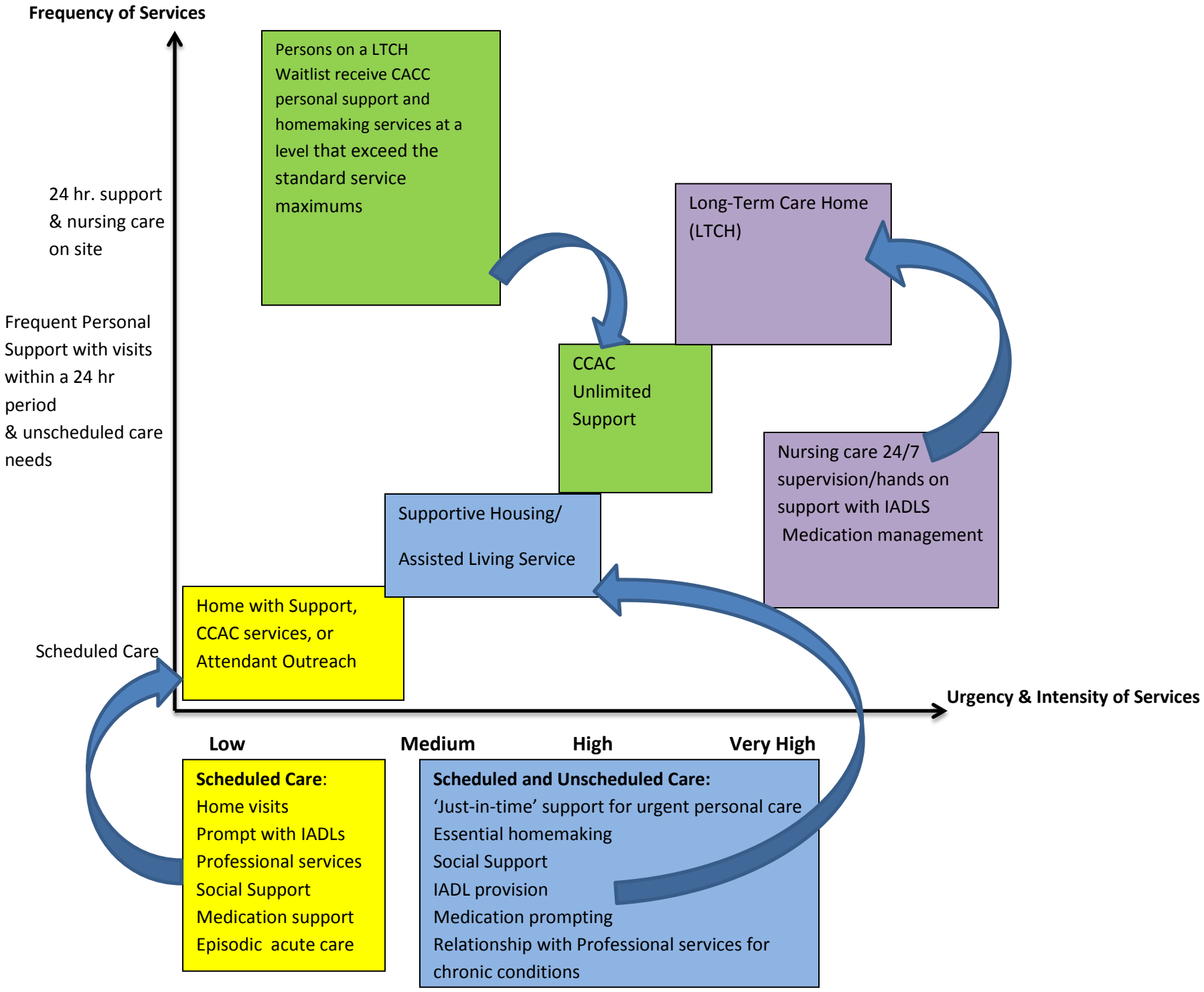
- No act is appropriate if the individual staff member has not been trained.

Scenario

Suctioning is required to regularly clear the airway of an individual who has a permanent tracheotomy. The need for the procedure, the response of the individual, and the outcome of performing the procedure has been well established. The procedure has become a predictable part of the individual's routine.

However, the same procedure for an individual who has developed pneumonia is no longer a routine activity of living since the need, response, and outcome have become unpredictable during the illness.


Frequency of Services
Persons on a LTCH Waitlist receive CACC personal support and homemaking services at a level that exceed the standard service maximums
Long-Term Care Home (LTCH)
24 hr. support & nursing care on site
Frequent Personal Support with visits within a 24 hr period & unscheduled care needs
CCAC Unlimited Support
Nursing care 24/7 supervision/hands on support with IADLS Medication management
Supportive Housing/ Assisted Living Service
Home with Support, CCAC services, or Attendant Outreach
Scheduled Care
Urgency & Intensity of Services
Low
Medium
High
Very High
Scheduled Care:
Home visits
Prompt with IADLs
Professional services
Social Support
Medication support
Episodic acute care
Scheduled and Unscheduled Care:
'Just-in-time' support for urgent personal care
Essential homemaking
Social Support
IADL provision
Medication prompting
Relationship with Professional services for chronic conditions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