Model of Care
Redesign for Nunavut:
a report in brief

Comprehensive model of care review and recommendations by:

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Commissioned by:

Department of Health
Government of Nunavut

Building Nunavut Together
Nunavu liuqatigiingniq
Bâtir le Nunavut ensemble

Nunavut

April 2018

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Context

Healthcare delivery in community health centres across Nunavut reflects their history as isolated nursing stations, each very much shaped by local history and the nurses who have worked there, largely independently. These nursing stations were established in the 1950s by the Canadian government, and then transferred to the Northwest Territories, and transferred again 19 years ago to the new Government of Nunavut. While there has been considerable development and expansion in the range of services provided, the model of care has not evolved to support those changes – including the number of healthcare staff working in the system, the overall infrastructure and system configuration. Variation across the system has also been shaped by regional differences in alignment to southern healthcare systems (i.e. Kitikmeot to Yellowknife and Edmonton, Kivalliq to Churchill and Winnipeg, and Qikiqtaaluk to Ottawa).

In 2017, the Office of the Auditor General recommended that the Department of Health improve how it delivers services to Nunavummiut and regularly assess the extent to which it is meeting community needs. The Department of Health responded with a commitment to develop a model of care, with a focus on identifying the "basket of services" needed in Nunavut communities, the number of staff and types of roles most appropriate to delivering those services, and approaches to greater patient and community engagement within the healthcare system.

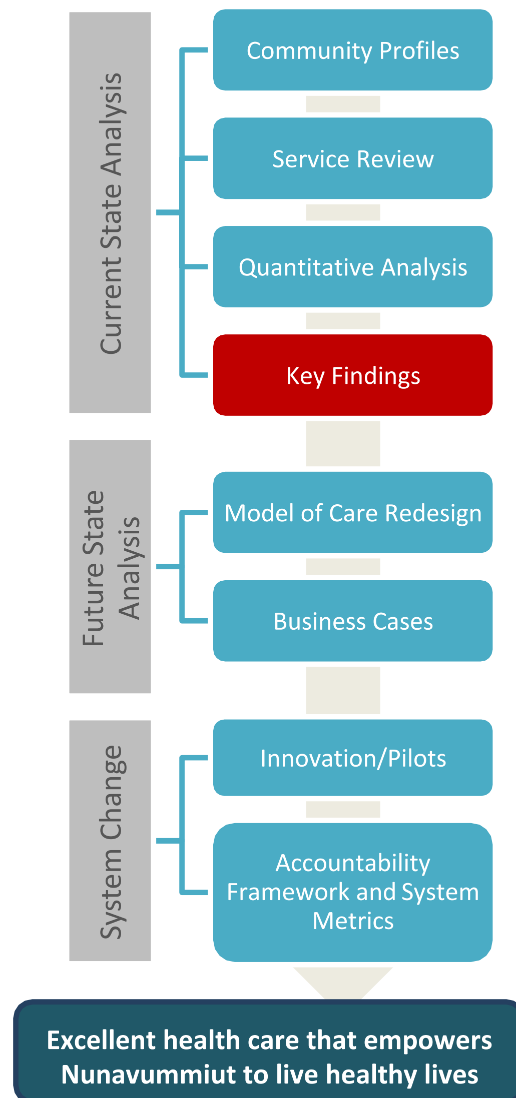
Given the current lack of consistency in how healthcare is organized and delivered, this model of care is intended to provide a coherent framework which can be used to guide fulsome dialogue and planning with patients, families, communities, Inuit organizations, healthcare providers and other stakeholders regarding healthcare service design and delivery. Resulting system change and development will take place over the coming years.

Methodology

An experienced and independent consultancy, Health Intelligence Inc., was contracted by the Department of Health through the GN procurement process to undertake development of a new model of care. Health Intelligence drew upon a variety of sources to understand the current state and identify opportunities for improving service delivery:

- 25 comprehensive community profiles were developed based on:
  - Community demographics
  - Indicators of social determinants of health service utilization
  - Availability of health human resources
- 132 in-depth interviews were conducted, the majority of which were face-to-face, with:
  - Supervisors of Health Programs from all 25 communities
  - Additional nursing and other health care professionals in 16 communities
  - Elders and community members from 4 communities
- Health data analysis
  - Review and analysis of available population and health system data, including data related to: medical travel, population health, human resources, population demographics, Canadian Institute for Health Information health indicators, Health Canada and Statistics Canada reports
- Additional System-Level Inputs:
  - Orientation in the Department of Health's Strategic Plan
  - Review of peer-reviewed and grey literature

- 63 executive interviews, including:
  - Territorial leaders of mental health and addictions, pharmacy, population health and home and community care services
  - Nurse and staff leaders
  - Medical leaders
- Analysis of medical travel and staffing costs
- Review of role descriptions



Health Intelligence also undertook a review of best and promising practices in other Arctic jurisdictions, as well as internationally, to inform recommendations regarding an appropriate model of care for the Nunavut healthcare system.

It is to be noted that Iqaluit Health Services and the referral centres in southern Canada were outside the scope of this review. This was based on a pragmatic decision that, for planning and modeling purposes, health centre redesign is distinct from care provided in Iqaluit and referral centres both in terms of their geographical isolation, relatively small size, and nurse-led healthcare delivery model. This decision is not intended to imply that alignment between the community health centres, Iqaluit and referral centres is anything less than essential. The strength of the territorial healthcare system is ultimately a reflection of the nature and intensity of care provided in the community health centres and supported further by external resources. It is believed that focusing on the transformation of the community health centre will lead to a stronger overall transformation of the health system.

The model of care redesign will be used to inform future business cases, innovation and pilot projects, the development of an accountability framework and associated system metrics. Throughout the process of implementing the model of care patients, families, communities, Inuit organizations, healthcare providers and other stakeholders will be engaged to inform and guide development of the Nunavut healthcare system in achieving its mission to provide excellent healthcare services that empower Nunavummiut to lead healthy lives.

Current State

System Strengths

- Strong staff commitment to their communities and quality healthcare outcomes
- Good working relationship between nurses and physicians
- Community Health Representatives provide a strong link between the community and the health centre
- Clerk Interpreters provide substantial assistance to patients and play a key role in culturally safe clinical care
- System experience with the provision of regional, territorial and out-of-territory supports for the delivery of local primary health care
- Strong readiness for change and system improvement

System Weaknesses

- Dual reporting structures and unclear lines of accountability cause confusion across the system and do not optimize team collaboration in the delivery of primary health care services
- Current human and financial resources in the present model barely keep up with (and most often lag behind) current service demand
- Clinical and administrative processes are not standardized across the territory
- Supports for health centre staff are inconsistent across the territory
- Mental health and addiction service needs far exceeds local capacity, and is not formally integrated into primary care
- Regional and territorial systems for planning, monitoring, and quality improvement are not adequately developed

System Opportunities

- Greater patient, family and community engagement to inform and drive system improvements
- Use of non-clinical staff to carry out administrative functions and paraprofessional staff (e.g. TB DOT Workers) to support professionals to work at the top of their license
- Developing territorial response capacity for emergencies, epidemics, critical events
- Diversification of clinical workforce (e.g. Nurse Practitioners, Licensed Practical Nurses) in some settings
- Improved nurse retention through better orientation, training, clinical support
- System efficiencies through the use of technology and improved case management

System Threats

- High staff turnover throughout the healthcare system will make change difficult to sustain
- Continual nursing shortages and lack of appropriate workforce resources impede the capacity to deliver the range of healthcare services needed.
- Many health determinants are outside the Department's control (e.g. overcrowded housing, food insecurity, multiple forms of ongoing trauma)
- While growth in the healthcare system is required, escalating healthcare expenditures will likely become an issue
- Healthcare staff are at risk of vicarious trauma
- Political priorities may displace priorities and plans developed by healthcare leadership

The Department of Health's ability to deliver coordinated, integrated, and efficient quality health care services is hampered by (1) changes in patient, family and community demands and expectations; (2) ongoing fiscal and resource constraints; (3) changes in societal demographics, particularly in the aging population; (4) increases in the burden of chronic disease and suicides; (5) inefficiencies in internal processes; and (6) vast geographical coverage. There is a readiness for change within the department and thus an impetus to modernize the current model of care to improve health service delivery in the territory and the patient, client and family health care service experience.

Principles

The Nunavut healthcare system will be:

Patient, family and community centred – Patients and their families will be engaged, as partners, in planning and decision making regarding their personal healthcare. The healthcare system will have multiple patient access points and support a seamless journey of the patient through different care providers throughout the system in order to meet the patient's individual needs. Cultural practices and traditional knowledge will also be sought out, respected, and integrated into the design and delivery of healthcare programming and services.

Responsive to individual, family and community needs – The design of healthcare services and the model of care needs to be flexible in order to evolve over time in response to individual, family and community needs. Communities will be provided with multiple ways of involvement in the design and delivery of healthcare services delivery. Such engagement will be undertaken with the objective of increasing cultural safety and empowerment for patients throughout their healthcare experience. This will include the transparent collection and analysis of data to inform planning and decision making.

Primary health care focused – Healthcare delivery will be viewed as a continuous relationship, rather than episodic visits. A holistic approach will be taken to assessment, treatment, care and programming, with a focus on prevention, health promotion and addressing the social determinants of health.

Integrated and collaborative – Each patient's healthcare delivery will be guided by a single plan of care and will be supported, as necessary, by strong case management to ensure continuity and effective communication. Healthcare delivery at the community, region and territorial levels, including interface with external providers, will be organized and managed as an integrated system.

Innovative, cost-effective and efficient – The Nunavut healthcare system will seek out innovation and efficiencies in healthcare delivery to support appropriate utilization of resources.
Technology will be utilized, where appropriate, to improve healthcare access and deliver cost-effective solutions. Data will be used to inform decision making and planning, and to measure outcomes / progress.

Equitable across the territory and in relation to the rest of Canada – Healthcare will be provided as close to home as possible. A standard basket of primary care services will be provided in all communities. Patients will have access to additional, more specialized services through regional hubs and out-of-territory referral.

Safe, of high quality and continually being improved – The Nunavut healthcare system will create a culture of patient safety and quality improvement, with an emphasis on reducing blame and improving learning. This is based on the recognition that there is an opportunity for improvement in every process and on every occasion. Patients and their families will be actively engaged in this work.

Delivered by a well-supported and engaged healthcare workforce – Healthcare will be delivered by local interdisciplinary teams working together to meet the needs of their patients and the community. All healthcare staff will be provided with clinical supervision / consultation to support their day to day work, as well as ongoing opportunities for training, competency development, mentoring and other means to support professional development. Managers will work together with their teams to nurture a positive work environment. Maximizing opportunities for the development of the Nunavut Inuit health care workforce across Nunavut will be a priority.

New Model of Care

Clinical Services Plan

The Department of Health supports the vision of "Care Closer to Home". As such, the new model of care reflects the system enhancements needed to increase the services and supports available to the setting in which majority of healthcare is delivered – the ***Community Health Centre***. The new model wraps essential programming and clinical expert support around the community health centre such that each community health care team has access to standardized, evidence-informed program standards, policies, training, and special clinical support.

Basket of Services at community, regional and territorial levels

This is a generic model, which will be informed and modified for each Nunavut community based on local population needs, demographics, and health service utilization demands.

The basket of services described in this section reflects standard models involving primary care, secondary care, and tertiary care (Figure 1). How this translates for the current structure of the Department of Health is as follows:

> Primary Care is a basic level of care and is usually the first contact with a healthcare professional. For the purposes of the Nunavut Model of Care, Primary Care services are integrated with a more fulsome suite of primary healthcare programs and services. These are identified as the minimum basket of services required in each community and described herein as "Core Clinical Services". These services are delivered at home or in community health centres.
>
> Secondary Care occurs in larger communities (typically in the regional hubs - Cambridge Bay, Rankin Inlet and Iqaluit) and includes services delivered by physicians, specialists, and other specialty health professions. These services are also administered in smaller communities through the use of visiting specialty clinics, specialist programs, and telehealth clinics programs.
>
> Tertiary Care refers to specialized diagnostic and treatment services provided by referral from other physicians or nurse practitioners. These services are delivered in larger southern urban centres, because they cannot be efficiently or safely provided in territory.

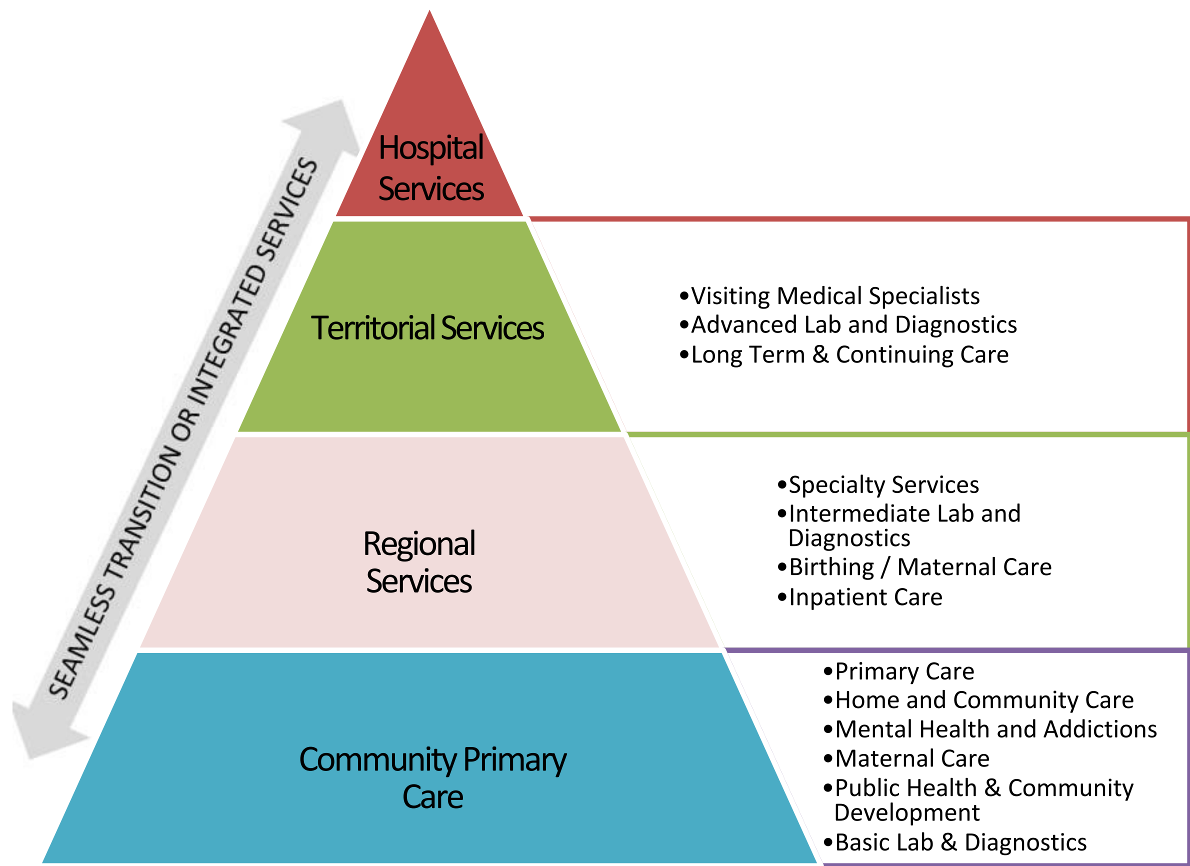


Figure 1

Clinical Services

<table>
<tr><td rowspan="7">COMMUNITY LEVEL SERVICES</td><td colspan="2">CORE CLINICAL SERVICES</td></tr>
<tr><td colspan="2">The core clinical services are a baseline suite of primary health care services available in each community health centre.</td></tr>
<tr><td rowspan="2">Public Health
Health Promotion, Disease and Injury Prevention
● Activities aimed at reducing specific risks, and delivered in the community, schools, workplace and health centre
● Tobacco prevention, reduction and cessation services
● Oral health services
● Health Protection
● Communicable disease prevention and control
● Immunization program
● Environmental Health services
● Community wellness
● Community wellness events
● Public health education</td><td>Wellness Program Services
● Well Infant and Child Health services
● School Health services
● Well Adult Health services</td></tr>
<tr><td>Community Development Services and Patient Engagement
● Community health committees
● Community and patient engagement activities</td></tr>
<tr><td>Home and Community Care and Continuing Care Services
● Nursing home visiting program
● Personal care support program
● Palliative Care Services</td><td>Mental Health Services
● Assessment, early intervention and treatment
● Individual and family support
● Intensive case management
● Substance abuse / addictions support</td></tr>
<tr><td>Treatment, Urgent / Emergent Care Services
● Treatment services - acute and episodic
● Chronic disease management services
● Pre-hospital emergency care services
● Minor procedures (e.g. cryotherapy, electrocautery, curettage, therapeutic injections, aspirations, excisions, incision and drainage, endometrial biopsy)</td><td>Maternal Care Services
● Prenatal Care Services
● Postpartum Care Services
● Sexual Health and Reproductive Care Services</td></tr>
<tr><td>Laboratory and Diagnostic Services
● Basic Radiology
● Point of care testing (POCT)
● Phlebotomy</td><td>Misc. Services
● Pre-operative Assessment Services
● Employment Assessment Services
● Interpreter Services</td></tr>
</table>

REGIONAL LEVEL SERVICES

REGIONAL VISITING CLINICAL SERVICES

Specialty services are offered in addition to the suite of core clinical services. These services are administered through a visiting services program and are offered virtually, locally, regionally and/or territorially.

It is not feasible to offer all specialty services in every community, thus allocation of resources requires consideration of several factors, including the community demographics and identified population needs. If a specialty service is not available locally in a community, mechanisms are in place to help patients and families access the required service from a regional, territorial or virtual (e.g. telehealth) site, as appropriate.

Acute Care, Urgent / Emergent Services

- 24/7 on-call physician consultation
- Inpatient services in Rankin Inlet and Iqaluit and in referral sites (Yellowknife, Edmonton, Winnipeg and Ottawa).
- Emergency medical evacuation services

Allied Health Services

- Rehabilitation Support Services (Physiotherapy, Occupational Therapy, Speech Language Pathology)
- Clinical Nutrition Services
- Audiology
- Eye Team
- Respite Services
- On Call Clinical Clerk Interpreter Services

Physician Services

- Family Physician
- Pediatrics
- Orthopedic Surgeon
- Obstetrics/gynecology
- Otolaryngology
- Psychiatry
- Internal medicine
- Dental

<table>
<tr><td rowspan="7">TERRITORIAL LEVEL SERVICES</td><td colspan="2">TERRITORIAL CLINICAL SERVICES</td></tr>
<tr><td colspan="2">The Territorial Clinical Services support patient and family access to required clinical services not available in their community.</td></tr>
<tr><td>Medical Travel
Supports provisions for scheduled (non-emergency) and emergency medical evacuation</td><td rowspan="5">Acute Care, Urgent / Emergent Services
● 24/7 on-call physician consultation
● Specialist consultation services in referral sites – Ottawa, Winnipeg, Yellowknife and Edmonton (usually physician to physician)
● eConsultation services
● Inpatient services in Rankin Inlet and Iqaluit and in referral sites (Yellowknife, Edmonton, Winnipeg and Ottawa).</td></tr>
<tr><td>Telehealth
Supports clinical consultation and treatment with physician and specialty services in and out of the territory</td></tr>
<tr><td>Advanced Imaging and Advanced Diagnostics
Available by referral in Iqaluit and in southern referral sites (Ottawa, Edmonton, Winnipeg, Yellowknife)</td></tr>
<tr><td>Patient Engagement
● Patient Relations Office
● Patient Advisory Committees
● Patient involvement in quality improvement</td></tr>
<tr><td>Long Term / Continuing Care
Supports patient care needs through access to long term care, continuing care, and respite care services within the territory and in southern partner facilities</td></tr>
</table>

Staffing Allocation Model

It has been determined that the current staffing model is struggling to meet service demands consistently across the territory. There is an opportunity in developing the new model of care to reconfigure the healthcare staffing model to deliver the basket of services described on Pages 8-10. Introducing new health care professional positions into the Community Health Centre environment (e.g. Nurse Practitioners, Licensed Practical Nurses and Public Health Nurses) has the potential to alleviate nursing workload pressure points, improve timely access, and improve health promotion and disease prevention efforts. Without significant enhancements to current human resources, the delivery of required healthcare services will not be achievable or sustainable. As well, recruitment and retention efforts will not succeed in the absence of a sustainable and realistic staffing model. It is recognized that the proposed staffing model will involve additional costs to the healthcare system but will deliver many efficiencies.

One size does not fit all

Staffing Allocation Model at community, regional and territorial levels

This is a generic model, which will be informed and modified for each Nunavut community based on local population needs, demographics, and health service utilization demands. The proposed staffing model provides flexibility and responsiveness in the HR process by allowing the Nurse in Charge and their Director of Health Programs to re-profile and/or combine allocated positions, such as partial PYs (e.g. 0.25), to meet the identified and evolving needs of the community, and to capitalize on specialized resources which may become available to the community. In particular, paraprofessional roles might be combined to create full-time employment opportunities for Nunavut Inuit in their home community. As well, staffing configuration in an individual health centre / community will be dependent on space availability and prioritization.

The following staffing model represents multidisciplinary teams providing primary healthcare services in the community health centres, as well as coordinating a range of other clinical services from healthcare providers in the territory and southern referral sites. It should be noted that reception, medical travel and other administrative staffing are not detailed in the charts which follow, as this will be dependent on the final re-design of other programs, such as extending hours of operations and expanding telehealth programming.

Community (Population 50 – 249)	Population 2016 / 2026	Core Clinical Services (as described on page 8)
Grise Fiord	164 / 173	***Community Services***: ▪ Home and Community Care Services ▪ Laboratory and Diagnostic Services ▪ Maternal Care Services ▪ Mental Health Services ▪ Palliative Care Services ▪ Public Health Services ▪ Rehabilitation Support Services ▪ Treatment, Urgent / Emergent Treatment ▪ Wellness Health Services ***Visiting Services***: as described in section below
Visiting Specialty, Allied Health and Physician Services	Family Physician, Pediatrician, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer. *The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.*	
Regional Level Services	The roles and functions of the Regional Clinical and Supportive Services available are described on Page 9.	
Territorial Level Services	The roles and functions of the Territorial Clinical and Supportive Services available are described on Page 10. These services will be offered in and out of the territory, as appropriate.	

Community (Population 250 – 999)	Population 2016 / 2026	Core Clinical Services
Arctic Bay **Chesterfield Inlet** **Kimmirut** **Qikiqtarjuaq** **Resolute Bay** **Whale Cove**	895 / 989 398 / 447 489 / 531 535 / 578 254 / 272 468 / 538	***Community Services***: ▪ Home and Community Care Services ▪ Laboratory and Diagnostic Services ▪ Maternal Care Services ▪ Mental Health Services ▪ Palliative Care Services ▪ Public Health Services ▪ Rehabilitation Support Services ▪ Treatment, Urgent / Emergent Treatment ▪ Wellness Health Services ***Visiting Services***: as described in section below
Visiting Specialty, Allied Health and Physician Services	Family Physician, Pediatrician, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer. *The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.*	
Regional Level Services	The roles and functions of the Regional Clinical and Supportive Services available are described on Page 9.	
Territorial Level Services	The roles and functions of the Territorial Clinical and Supportive Services available are described on Page 10 . These services will be offered in and out of the territory, as appropriate.	

Community (Population 1000 –1,499)	Population 2016 / 2026	Core Clinical Services
Clyde River **Coral Harbour** **Gjoa Haven** **Hall Beach** **Kugaaruk** **Naujaat** **Sanikiluaq** **Taloyoak**	1,077 / 1,247 998 / 1,197 1,404 / 1,578 936 / 1,140 979 / 1,111 1,118 / 1,396 962 / 1,130 1,030 / 1,171	***Community Services***: ▪ Home and Community Care Services ▪ Laboratory and Diagnostic Services ▪ Maternal Care Services ▪ Mental Health Services ▪ Palliative Care Services ▪ Public Health Services ▪ Rehabilitation Support Services ▪ Treatment, Urgent / Emergent Treatment ▪ Wellness Health Services ***Visiting Services***: as described in section below
Visiting Specialty, Allied Health and Physician Services	Family Physician, Pediatrician, Ophthalmology, ENT, Psychiatry, Midwifery, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer. *The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.*	
Regional Level Services	The roles and functions of the Regional Clinical and Supportive Services available are described on Page 9.	
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<table>
<tr><th>Community (Population 1,500 –3,000)</th><th>Population 2016 / 2026</th><th>Core Clinical Services</th></tr>
<tr><td>Baker Lake
Cape Dorset
Igloolik
Kugluktuk
Pangnirtung
Pond Inlet</td><td>2,229 / 2,565
1,555 / 1,752
2,075 / 2,049
1,623 / 1,743
1,664 / 1,885
1,727 / 2,006</td><td>Community Services:
▪ Home and Community Care Services
▪ Laboratory and Diagnostic Services (includes intermediate Radiological imaging)
▪ Maternal Care Services
▪ Mental Health and Wellness Services
▪ Palliative Care Services
▪ Public Health Services
▪ Rehabilitation Support Services
▪ Treatment, Urgent / Emergent Treatment
Services transferred from visiting services to in- community services:
▪ Family physician (Baker Lake)
▪ Physio and Occupational Therapy (Baker Lake, Igloolik, with outlying community visits)
Visiting Services: as described in section below</td></tr>
<tr><td>Visiting Specialty, Allied Health and Physician Services</td><td colspan="2">Family Physician, Pediatrician, Ophthalmology, ENT, Obs/gyne, Psychiatry, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer.

The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.</td></tr>
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Community (Population 1,500 – 3,000)	Population 2016 / 2026	Core Clinical Services
Cambridge Bay	1,718 / 1,895	***Community Services:*** ▪ Home and Community Care Services ▪ Laboratory and Diagnostic Services (includes intermediate Radiological imaging) ▪ Maternal Care Services ▪ Mental Health and Wellness Services ▪ Palliative Care Services ▪ Public Health Services ▪ Rehabilitation Support Services ▪ Treatment, Urgent / Emergent Treatment ***Services transferred from visiting services to in- community services:*** ▪ Family physician ▪ Midwifery services ▪ Nutritionist and Speech Language Pathology ▪ Physio and Occupational Therapy ***Visiting Services***: as described in section below
Visiting Specialty, Allied Health and Physician Services	Family Physician, Pediatrician, Ophthalmology, ENT, Obs/gyne, Psychiatry, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer. *The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.*	
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Community (Population 3,000 –4,999)	Population 2016 / 2026	Core Clinical Services
Arviat	2,908 / 3,365	***Community Services:*** ▪ Home and Community Care Services ▪ Laboratory and Diagnostic Services (also includes intermediate Radiological imaging) ▪ Maternal Care Services ▪ Mental Health and Wellness Services ▪ Palliative Care Services ▪ Public Health Services ▪ Rehabilitation Support Services ▪ Treatment, Urgent / Emergent Treatment ***Services transferred from visiting services to in- community services:*** ▪ Family physician ▪ Midwifery (with outlying community visits) ***Visiting Services***: as described in section below
Visiting Specialty, Allied Health and Physician Services	Family Physician, Pediatrician, Ophthalmology, ENT, Obs/gyne, Psychiatry, Orthopedic surgery, Internal Medicine, Dental, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer. *The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.*	
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<table>
<tr><th>Community (Population 3,000 –4,999)</th><th>Population 2016 / 2026</th><th>Core Clinical Services</th></tr>
<tr><td>Rankin Inlet</td><td>2,908 / 3,365</td><td>Community Services:
▪ Home and Community Care Services
▪ Laboratory and Diagnostic Services (also includes intermediate Radiological imaging)
▪ Maternal Care Services
▪ Mental Health and Wellness Services
▪ Palliative Care Services
▪ Public Health Services
▪ Rehabilitation Support Services
▪ Treatment, Urgent / Emergent Treatment
Services transferred from visiting services to in- community services:
▪ Family physician
▪ Inpatient services
▪ Midwifery
▪ Clinical nutritionist, Speech Language Pathology, Physiotherapy and Occupational Therapy
Visiting Services: as described in section below</td></tr>
<tr><td>Visiting Specialty, Allied Health and Physician Services</td><td colspan="2">Family Physician, Pediatrician, Ophthalmology, ENT, Obs/gyne, Psychiatry, Orthopedic surgery, Internal Medicine, Dental, Community Nutritionist, Occupational Therapy, Physiotherapy, Speech Language Pathologist, Audiology, Eye Team, Environmental Health Officer.

The frequency of visits will be influenced by the visiting discipline, population and needs assessments and under the direction of the NIC. Clinical telehealth visits are available to supplement scheduled community specialty visits.</td></tr>
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</table>

Empower a Team: Supporting community primary healthcare

Transforming health centres is the route to system transformation; however, a health centre does not exist in isolation. Each health centre is linked to a region and to the territory, as a whole; therefore, these interdependencies must be strongly established as part of the new model of care.

Through the reorganization process at the territorial level, it will be critical to have clear distinctions drawn between the ministry functions of government and the operational healthcare delivery functions. In all other Canadian jurisdictions this is accomplished through the establishment of delegated health authorities at arm's length from government. In Nunavut, until such capacity is developed, it is imperative that this be accomplished through an organizational design which effectively supports these distinct functions and purposely allocates positions which clearly delineates the distinct functions.

<u>Organizational Design</u>

Central to the model of care is the re-design and streamlining of the current reporting structures with a clear focus on strengthening and supporting community primary healthcare delivery. These changes are essential to addressing organizational factors which currently impede community healthcare teams by creating: clear lines of authority and accountability, ready flow of information, clarity regarding how decisions are made, team structures which communicate and reinforce workplace values and standards, and promote both accountability and quality improvement. These changes to organizational design must clearly differentiate the respective roles and responsibilities of the Health Headquarters (ministry functions) and Healthcare Operations (healthcare delivery functions). These distinctions are summarized in the chart which follows.

It is also important to note that the current organizational structure provides significant management and staff infrastructure to support the Health Headquarters functions and very little capacity within the Operations Division at the territorial or regional levels to carry out the considerable functions which are necessary to support effective healthcare delivery. This must be addressed as a first step in implementation of the model of care in order for the Operations Division to have sufficient bench strength to lead and sustain systems change.

Respective Roles and Responsibilities

	Health Headquarters	Healthcare Operations
Mandate	Health system design, planning, monitoring and reporting	Delivery, administration and assessment of health services
Responsible Division	● Corporate Services ● Programs and Standards ● Population Health	Operations
Core functions	● Secure system funding ● Provide system governance and oversight ● Administers the Nunavut Health Care Plan, Non-Insured Health Benefits, and Extended Health Benefits programs ● Advise government on health policy ● Monitor policy implementation and compliance ● Establish health program and service delivery standards ● Monitor implementation of and compliance with program and service delivery standards ● Engage Health Operations in developing / updating the Nunavut Health Plan and the Public Health Plan, including setting long and short-term objectives ● Monitor the performance of Health Operations against the Nunavut Health Plan and the Public Health Plan, and the established budget	Subject to the direction of and the resources provided by the Ministry: ● Promote and protect the health of Nunavummiut, and work toward the prevention of disease and injury ● Assess on an ongoing basis the health needs of Nunavummiut ● Determine priorities in the provision of health services within the context of the Nunavut Health Plan ● Ensure reasonable access to quality health services ● Deliver health services in a manner that is responsive to the needs of individuals, families and communities
Business lines	Public health policy, planning, program development related to: o Health protection o Health promotion o Disease prevention o Emergency preparedness / response o Population health assessment o Population health surveillance o Policy, planning, program development o Health policy o Healthcare planning, including Nunavut Health Plan development and updating o Health program and service standards o Consultation services regarding program and service standard implementation	Public health service delivery -- programs and services o Health protection o Health promotion o Disease prevention o Emergency preparedness / response (local) o Population health assessment o Population health surveillance (e.g. data collection) Primary care delivery o Wellness programming o School health services o Maternal care o Infant and child health care o Mental health and addictions o Home and community care o Oral health o Laboratory / diagnostic services

	Health Headquarters	Healthcare Operations
Business lines (cont'd)	Monitoring and reporting o In relation to program and service standards / policy compliance o Delivery of territorial services o Medical travel o Boarding homes o Patient relations o Emergency response o Nursing surge capacity o Telehealth equipment and scheduling eHealth innovation planning	Acute care, emergency services Physician services o Family physician o Pediatrics o Orthopedic surgeon o Obstetrics / gynecology o Otolaryngology o Psychiatry o Internal medicine o Dentist o Other specialists by referral Allied health services o Rehabilitation (PT, OT, SLP) o Nutrition o Audiology o Vision o Respite Continuing care (residential) Midwifery Clinical supports o Clinical supervision (e.g. MH&A) o Case consultation – urgent, by request and regularly scheduled Case management o Service transitions o Service coordination o Information sharing Community engagement / development o Community health committees o Patient advisory committees Telehealth program o Use of telehealth for service delivery (per above) eHealth innovation implementation

	Health Headquarters	Healthcare Operations
Other responsibilities	Health data o Data standards o Information systems – hardware and software o Population data aggregation, reporting and analysis Human resource management o Organization design o HR policy compliance and audits o Establish staff competencies and evaluation tools o Develop staff orientation curriculum o Design and coordinate staff training Health and safety o Establish safe work practices o Provide training Identify and address workplace hazards	Quality improvement Risk management Accreditation Program monitoring and evaluation Health data o Medical records o Data collection o Data analysis Human resource management o Staff orientation o Staff coaching / training o Performance management and professional development o Leave and attendance Health and safety o Workplace H&S committees o Familiarize staff with workplace hazard mitigation WSCC responsibilities

Structure of Supports to Local Healthcare Teams

A second recommended strategy to support care delivery at the health centre level and connect health centres with the system as a whole, is through the deployment of supportive services. These services should be delivered from the regional and territorial levels and are designed to provide the primary health care team in each community with ready access to clinical and program expertise, clinical consultation, resources, standards and training. These are described in detail in the charts which follow.

<table>
<tr><td rowspan="5">REGIONAL LEVEL SUPPORTIVE SERVICES</td><td colspan="2">REGIONAL SUPPORTIVE SERVICES</td></tr>
<tr><td colspan="2">The Regional Support Services are available to the community health centre staff for the purpose of supporting effective primary care and public health clinical practice.</td></tr>
<tr><td>Primary Care
▪ Support onboarding and orientation of new staff to their respective programming;
▪ Support the operationalization of the programs and standards
▪ Provide clinical expertise and leadership for primary care and public health programming in the communities
▪ Resource and support complex case management</td><td>Regional Public Health (PH)
▪ Support onboarding of new staff to PH programming;
▪ Facilitate ongoing staff professional development training related to PH competencies;
▪ Provide leadership for population health programming and activities in the region
▪ Provide expertise and leadership for health protection and communicable disease prevention and control programs in the region
▪ Provide expertise and leadership for complex case management</td></tr>
<tr><td>Mental Health and Addictions (MHA)
▪ Support onboarding and orientation of new staff to MHA programming;
▪ Support ongoing professional development training related to MHA competencies for community staff;
▪ Provide clinical expertise and leadership for MHA programming in the communities and complex case management.</td><td>Home and Community Care (HCC)
▪ Support onboarding of new staff to HCC programming;
▪ Facilitate ongoing staff professional development training related to HCC competencies;
▪ Provide leadership for HCC programming and activities in the region</td></tr>
<tr><td>Maternal Health
▪ Provide clinical expertise and leadership for complex case management</td><td>Intermediate Laboratory and Diagnostics
▪ Provide services for the region from Cambridge Bay, Rankin Inlet and Iqaluit</td></tr>
</table>

TERRITORIAL LEVEL SUPPORTIVE SERVICES	**TERRITORIAL SUPPORTIVE SERVICES**
	The Territorial Supportive Services provide foundational programming support for standardized evidence-informed practice at the community and regional level. These services include: program planning, program evaluation, and delivery of professional development activities, and the development of program standards, policies and guidelines.
	Maternal Health ▪ Facilitate ongoing staff professional development training related to maternal health and midwifery services; ▪ Provide expertise, leadership and additional resources (when needed) for maternal health and midwifery planning, programming and evaluation in the territory; ▪ Develop and disseminate policies, standards and guidelines related to Maternal Health and Midwifery programming in the territory; ▪ Develop and disseminate clinical and programming resources related to maternal health and midwifery programming in the territory.
	Territorial HCC and Continuing Care ▪ OOT long term care, respite and continuing care assessment and placement support; ▪ Provide expertise, leadership and additional resources (when needed) for HCC and CCC planning, programming and evaluation in the territory; ▪ Develop and disseminate policies, standards and guidelines related to HCC and CCC programming; ▪ Develop (and deliver) orientation curriculum and ongoing professional development activities related to HCC and CCC programming in the territory; ▪ Develop and disseminate clinical and programming resources related to HCC and CCC programming in the territory.
	Dental ▪ Support onboarding and orientation of new staff to Oral Health programming; ▪ Facilitate ongoing staff professional development training related to Oral Health competencies; ▪ Provide clinical expertise and leadership for Oral Health planning, programming and evaluation in the communities and case management; ▪ Develop and disseminate policies, standards and guidelines related to Oral Health programming; ▪ Provide support to the NIC for the evaluation of community Oral Health staff competency; ▪ Develop and disseminate clinical and programming resources for effective Oral health programming in the territory.
	Mental Health and Addictions (MHA) ▪ OOT assessment and placement support; ▪ Provide expertise, leadership and additional resources (when needed) for MHA planning, programming and evaluation in the territory; ▪ Develop and disseminate policies, standards and guidelines related to MHA programming; ▪ Develop (and deliver) orientation curriculum and ongoing professional development activities related to MHA programming in the territory; ▪ Develop and disseminate clinical and programming resources related to MHA programming in the territory; ▪ Provide leadership and resources for Mobile crisis intervention services and Critical incident stress management.

	Public Health ▪ Provide data related to the management, prevention and control of vaccine preventable and non-vaccine preventable communicable diseases; ▪ Epidemiological support, territorial surveillance, and evaluation of territorial performance in the management, control and prevention of communicable disease; ▪ Provide expertise, leadership and additional resources (when needed) for Population Health planning, programming and evaluation in the territory; ▪ Provide expertise, leadership and additional resources (when needed) for outbreak management, control and prevention; ▪ Develop and disseminate policies, standards and guidelines related to Population Health programming; ▪ Develop (and deliver) orientation curriculum and ongoing professional development activities related to Population Health programming in the territory; ▪ Develop and disseminate clinical and programming resources for effective Population Health programming in the territory.
	Pharmacy ▪ Develop and disseminate policies, standards and guidelines related to Pharmacy Services in the community setting; ▪ Provide expertise, leadership and additional resources (when needed) for Pharmacy Services planning and programming in the territory; ▪ Develop (and deliver) orientation curriculum and ongoing professional development activities related to Pharmacy Services in the territory; ▪ Develop and disseminate clinical and programming resources for effective Pharmacy Services programming in the territory.
	Advanced Laboratory and Diagnostics ▪ Provide advanced services for the territory from Iqaluit

Foundational Supports

Human Resource Management

In order to function to its full capacity, the healthcare system requires appropriate and carefully managed human resources. This extends well beyond recruitment of healthcare professionals and staff. It involves all of the elements of personnel management: selection, onboarding, appraisal and performance review, training and development, supervision, mentoring, reward management, and working conditions. A fully staffed and well supported healthcare workforce is absolutely the foundation for the healthcare system development anticipated in this report.

Effective human resource management is a core function at every level of the healthcare delivery system. The Nurse in Charge, who manages a community healthcare team, as well as regional and territorial management, need to be provided with human resource training and ongoing technical assistance / consultation in order to ensure that best practices in human resource management become the norm and are maintained across the healthcare system.

It should be noted the entire human resource recruitment and retention process would be significantly easier, as well as more effective, if it were managed through a health authority rather than through the Government of Nunavut bureaucracy.

Workforce Development

All staff working within the healthcare system need to be provided with ongoing competency- based training, education and mentorship opportunities. While the needs of individual staff will vary, ready access to pre-vetted training is essential (e.g. post graduate certificate in remote nursing, supervisory training, basic radiological technician training, mental health paraprofessional training, etc.). These courses and programs can be delivered through a variety of distance education and face-to-face formats / technologies. Structured educational opportunities can also be strategically integrated into clinical practice to support successful implementation of clinical standards, best practices, and programming (e.g. Project ECHO, clinical communities of practice, formal mentorships, etc.).

In order to leverage the full benefit of these investments, a formal Workforce Development Program should be organized which strategically supports all managers in:

- human resource planning for their team
- conducting performance reviews
- creating individual development plans
- staff coaching
- supporting their staff in career planning

There is also a critical need to develop an employment model which encourages nurses to be employed by the GN on a long-term basis, but which allows for and supports flexibility regarding the number of weeks worked per year and the duration of work rotations. Without establishing such an employment model, investments in the professional development of nurses will not be fully leveraged. A deliberate focus on the retention and development of nursing staff is key to building capacity and the delivery of quality healthcare in the territory.

Development of the Nunavut Inuit health care workforce is important. This will require Health to work with Nunavut Arctic College and other partners to provide opportunities for educational upgrading, as well as laddered professional development. This should be supported by a well-organized skills and competency evaluation and tracking system which supports Nunavut Inuit in charting progress toward their employment goals.

Housing

Implementation of the model of care outlined in this document requires the Department of Health to strategically move forward to fully staff local healthcare teams, as well as the regional and territorial positions which support them. It was noted through the analysis phase that there is a historical trend of positions remaining vacant for extended periods of time due to the lack of available housing in the community. Adequate staff housing is essential to achieving the full implementation of the new model of care. This will require community by community planning, as well as collaboration with the Nunavut Housing Corporation and, perhaps, public sector developers. Future business cases for health system capacity development should include the costs related to staff housing.

Healthcare Delivery Space

Adequate and appropriate physical space is essential for the delivery of quality healthcare services and programs. The Government of Nunavut currently is building one new health centre annually, with planning for future builds taking place to support continual new builds at that rate. The health centre design must be able to accommodate the current service delivery demands, as well as forecasted service delivery expansions over the life of the health centre facility.

Sustained funding for this physical infrastructure development is critical. The availability of suitable clinic and programming space is critical to implementation of the staffing levels which have been established as required in each community.

As well, capital improvements to existing health centres and healthcare facilities is often required to keep this infrastructure in good repair, to address infection, prevention and control standards and workplace safety issues. These capital improvements are not adequately meeting the demands associated with expanded service delivery. Appropriate planning and funding for such capital improvements is an important aspect of healthcare service capacity development, as anticipated in this report.

Expanding the hours of operation of community health centres has been identified as an opportunity to maximize facility utilization. This would also open up options regarding staff scheduling which could address some aspects of current overtime costs and increase accessibility of primary care services.

To alleviate some of the capital spending pressures in the short-term, considerations should be given to the establishment of a satellite office in one of the referral centres (Ottawa, Winnipeg, Edmonton) to house a variety of new professional practice consultants in the territory. The lack of available office space and housing in the regional and territorial hubs will likely impede the Department of Health’s ability to recruit qualified staff into the new positions being proposed under the new model of care. These clinical experts are critical to developing robust programs, monitoring effectiveness and supporting clinical competencies of front line staff.

Going forward, there may be opportunities for collaboration with other GN departments in infrastructure development projects – particularly in creating multi-use space appropriate for community programming, small group activities, team training, etc.

Healthcare Delivery to Special Populations

Health programming and service delivery to some groups can best be facilitated through partnerships with other service providers. For example, evidence-based mental wellness programming for children and youth is often delivered in the school setting. Best practice in coordinated crisis response, criminal investigation, healthcare intervention and counselling supports for child victims of abuse is delivered by a team of professionals drawn from Health, RCMP and Family Services. Psychiatric services for incarcerated adults can be delivered in the correctional setting. Screening and service planning for children with hearing, mobility and developmental deficits has been demonstrated to be most effective when coordinated across the health, education and child welfare systems. Establishing such programming in the Nunavut context requires cross-departmental planning, as well as dedicated management oversight to sustain the associated partnerships. In order to leverage these opportunities, this capacity needs to be developed within the healthcare system.

Digital Health and Informatics

Digital health is regarded as the future of health-care delivery, enabling patients, their caregivers and healthcare professionals to connect to information and data and improve quality and outcomes of health and social care. The commitment of the federal government to bandwidth as an essential service for Canadians will open the door to deploying digital health solutions across Nunavut. It is expected that these "real-time health systems" will create exponential growth of options for more efficient, safe and accessible health care programming which will lead to an improved healthcare experience for patients, families and communities. It must be noted, however, that these opportunities are totally dependent on this bandwidth availability.

Examples of opportunities for leveraging digital health for the improvements in health service delivery include:

- Electronic health records fully implemented in each community. It is noted that the health centres require a simple, easy to use electronic medical record system which will be functional in the context of limited bandwidth. A more robust EHR is needed in the regional hubs to accommodate the specialty services delivered in those sites. Despite the different needs of the local community health centre and the regional hubs, the electronic health record systems must be tightly integrated.

- Expanding telehealth program such that there are dedicated clinical staff assigned to the program to facilitate and coordinate the delivery of full specialty clinics in the community health centre setting. Throughout the analysis of current state, it was apparent the current telehealth system is under-utilized for clinical service delivery and requires a program framework and dedicated program staff. It is clear that investments in this area would provide a good return on investment and improve service delivery capacity.

- Real-time telehealth will be an important aspect of the telehealth expansion project to support improved patient outcomes and increased patient access to specialist services. A pilot project proposal was developed which would allow the emergency room physicians at QGH to connect immediately to the nurse and patient located in the emergency room in a remote health centre. This type of real time telehealth will provide significant support to the physician on call, the nurse and ultimately the patient, especially true in complex case management.

- Leveraging e-Consult services for improved timely access to specialist services and thus timely access to advanced diagnostic and treatment services. This service is currently utilized in the Qikiqtaaluk region; however, is not it its full capacity. There is an opportunity, through the eConsult service, to access additional specialty services to support chronic disease management such as diabetes educators.

- Development of flexible, user-friendly data systems. These will support the development quality improvement process, as well as provide tools for monitoring, evaluation and reporting service and program activities/outcomes. Such tools are essential for effective healthcare delivery management and planning.

As such, planning and capacity development in the area of digital health is critical both to take advantage of current technology capacity, as well as begin the process of fundamental change to clinical services and their delivery within the healthcare system. A territorial digital health strategy is required to provide direction and to establish a footprint that enables new capabilities for digital health through partnerships, collaboration, and an improved understanding of the investment. Digital health can be expected to make shifts in the system which will improve capacity, optimize workflows and timely access to information, contribute to quality of care, and deliver cost efficiencies.

Data, which is central to digital healthcare delivery, needs to be supported by a robust health informatics program. This involves the definition, measurement, capture, transmission, reporting, and analysis of inputs, processes, outputs, and outcomes as they relate to population need, human resource supply, and program services delivered. Enhancing health informatics capacity is not a complex undertaking, but does require additional dedicated resources, expertise and leadership.

Healthcare Policy, Strategic Planning, Program Planning and Evaluation, and Performance Management Capacity

In other Canadian jurisdictions, the provincial government is responsible for healthcare policy, strategic planning, program planning and evaluation, and performance management. Public health is often included within this provincial structure. Healthcare delivery (and, in some jurisdictions, public healthcare delivery) are delegated to regional or local health authorities.

These semi-independent bodies are responsible for public and patient engagement, as well as the management of internal quality improvement functions. Nunavut currently lacks this differentiation of roles and responsibilities.

As the Department of Health plans for the implementation of the model of care outlined in this report, there is an opportunity to realign regional and territorial functions in a way that provides clearer distinction between “health care policy” and “health care delivery”. Doing so will address a key weakness in the current system, as well as facilitate role clarity. Corresponding capacity development in the areas of planning, evaluation and performance management are important to strengthen accountability across the healthcare system.

It is also to be noted that the current configuration of the Health Operations Division at the territorial and regional levels lacks the staffing infrastructure typical of health authorities in other jurisdictions. (The exception is the Qikiqtani General Hospital in Iqaluit which, in comparison, has a staffing infrastructure much like other small rural hospitals in southern jurisdictions.) Adequate territorial and regional staffing infrastructure is critical to the delivery of effective, efficient, quality healthcare services. Without addressing this system deficit, implementation of the new model of care will not be possible and gains in healthcare delivery will not be sustainable.

A consideration for the Government of Nunavut is the establishment of a regional health authority in order to effectively to address the existing role confusion and to provide improved healthcare delivery supports. Through this model, the Department of Health would assume the administrative and operational functions for the healthcare system, suchas:

1. Directly managing and delivering territorial health programs such as (but not limited to) the Nunavut health insurance plan, medical travel program, physician services, and some public health services.
2. Provide coordination, direction and support to the regional health authority and Iqaluit Health Services, such as (but not limited to) strategic planning, monitoring the quality and effectiveness of healthcare services,
3. Allocate financial resources and set territorial targets and priorities
4. Support the operation of governance structures and administration of various health related acts and regulations.

The regional health authority team, in turn, would focus on the planning, organization, administration and delivery of healthcare services across the three regions. This would involve:

1. Identifying population health needs through community consultation activities and review of regional system performancereports
2. Develop and report on annual regional business plans
3. Setting and reporting on regional targets, as well as reporting on territorial targets.
4. Providing the basket of services established by the Department of Health (as described earlier in this report) and acquiring the appropriate regional and community-level staffing to fulfill this mandate

Recommendations

Primary Health Care Focus

1. Recognize that while Community Health Centers have the lead role in providing for both treatment of illness and wellness care in Nunavut, total investment in Community Health Centers and their personnel is considerably less than what is spent on hospital services in Nunavut and out-of-territory and similar expenditures for medical travel. There is the potential for internal reallocation of investment over time to permit a relatively greater investment in health services in the communities and for proactive initiatives in health promotion.
2. Integrate health services and programs to support individual patient and family needs.
3. Focus services on *prevention*, *education*, and *community involvement* in wellness. This recommendation includes dedicating staff roles in supporting and strengthening the Community Health Committees.
4. Provide uniformity of, and equitable access to, quality healthcare services to communities of similar demographics.
5. Establish greater integration of pan-government services to improve healthcare service impact and effectiveness. Specifically, Housing, Education, Economic Development and Transportation, and Culture and Heritage should be required to collaborate more intentionally and frequently to address the social determinants of health and wellness.
6. Develop a territorial palliative care program which is delivered in each community. This will require a territorially designated clinician who specializes in palliative care and can provide direction to community healthcare providers. This role could be arranged through a partnership agreement with one of Health's referral sites.
7. Establish links and ensure continuity between the Iqaluit Health Services primary care program and primary care services delivered in community health centres.

Community Engagement and Ownership

1. Develop processes which reinforce patient, family and community centred care, such that Nunavummiut are partners in the design and delivery of culturally safe health care services.
2. Strengthen processes and programming which support community development and empowerment.
3. Establish hours of operation for the health centres which reflect community utilization patterns to increase timely access to care and reduce overtime burden on staff.

Organizational Structure, Authority and Decision Making

1. Improve accountability and effectiveness across the healthcare delivery system through establishing clear roles and responsibilities. The regional leadership teams should be directly accountable for service delivery and thus must also have the appropriate delegated authority for decision making regarding healthcare delivery in the regions. This includes priority setting, planning and decision making which impacts healthcare delivery in their community health centres.
2. Restructure the Department at the territorial (headquarters) level to support effective healthcare delivery, as outlined in this report. The final organizational plan should reflect the separate, yet supporting, 'ministry' roles and direct service delivery roles, as well as sufficient staffing capacity to be effective. This reorganization should take place early in implementation process.
3. Create administrative positions in each health centre and regional office to reduce the administrative burden on management and increase the focus on supporting effective healthcare delivery. Consideration should be given, as well, to increasing administrative staffing at the territorial (headquarters) level as part of their restructuring.
4. Consider development and transition of regional health authorities with responsibility for the delivery of community healthcare delivery.

Quality of Care and Patient Safety

1. Provide additional administrative resources at the community, regional and territorial levels to allow those accountable for program delivery to monitor and evaluate compliance to program standards.
2. Provide additional human resources to support the development, implementation and monitoring of evidence-informed program standards and additional human resources to support the development and maintenance of clinician competency.
3. Develop and implement a robust continuous quality improvement program.
4. Design the Nurse Practitioner roles and responsibilities to include clinical leadership in the Elder facilities and Continuing Care facilities.
5. Involve patients and their families in patient safety and quality improvement processes.

Skilled and Stable Workforce

1. Strengthen all the elements of personnel management: selection, onboarding, appraisal, performance review, training and development, supervision, mentoring, reward management, and working conditions -- with a focus on developing a fully staffed and well support healthcare workforce.
2. Provide all Nurses in Charge, as well as regional and territorial management, with human resource training and ongoing technical assistance / consultation to ensure that best practices in human resource management become the norm and are maintained across the healthcare system.
3. Modify the staffing model of the health centres such that each health care provider is working to full scope of license. This should include the introduction of new regulated and non-regulated health care workers, such as Nurse Practitioners, Basic Radiological Technicians and Licensed Practical Nurses.
4. Consider advancing midwifery practice outside of Rankin Inlet and Cambridge Bay.
5. Monitor and adjust the standard community health centre staffing configurations to ensure the capacity to meet current health care services demands and the evolving needs of communities.
6. Maximize opportunities for increasing Inuit employment within the health workforce. This should include cross-training, laddered skill and knowledge development, as well as creating entry level positions within the healthcare delivery system (e.g. Public Health Assistants, Community Outreach Workers).

Digital Healthcare Services

1. Develop a territorial digital health strategy to provide direction and to establish a footprint that enables new capabilities for digital health through partnerships, collaboration, and an improved understanding of the investment.
2. Identify and act on opportunities that will begin to shift how clinical services and their delivery within the healthcare system are delivered.
3. Optimize usage of Telehealth for clinical consultation, communication, continuing education and problem solving.
4. Optimize user-friendly electronic health records.
5. Enhance the Department's health informatics capacity to collect and utilize reliable data to support all aspects of effective healthcare delivery and management.
6. Explore other eHealth innovations which are appropriate in community healthcare settings in Nunavut.

Medical Travel

1. Consider repatriation of follow up clinical visits through the use of Nurse Practitioners and telehealth services.
2. Develop a comprehensive plan to establish "Specialized Clinics":
    a. Purchase, where feasible and cost-effective, usually routine medical devices such as stress testing equipment, ultrasound scanners, and gastroscopes and deploy them in Regional Health Centers for Specialized Clinics.
    b. Contract, as appropriate, trained personnel to circuit-visit communities to provide Specialized Clinic services or provide these services at Regional Health Centers.
3. Establish training programs for community primary health team personnel to enable them to perform routine medical tasks that would reduce the need for out-of-territory medical travel.
4. Monitor medical travel utilization to identify and prioritize opportunities for in-territory service capacity development.