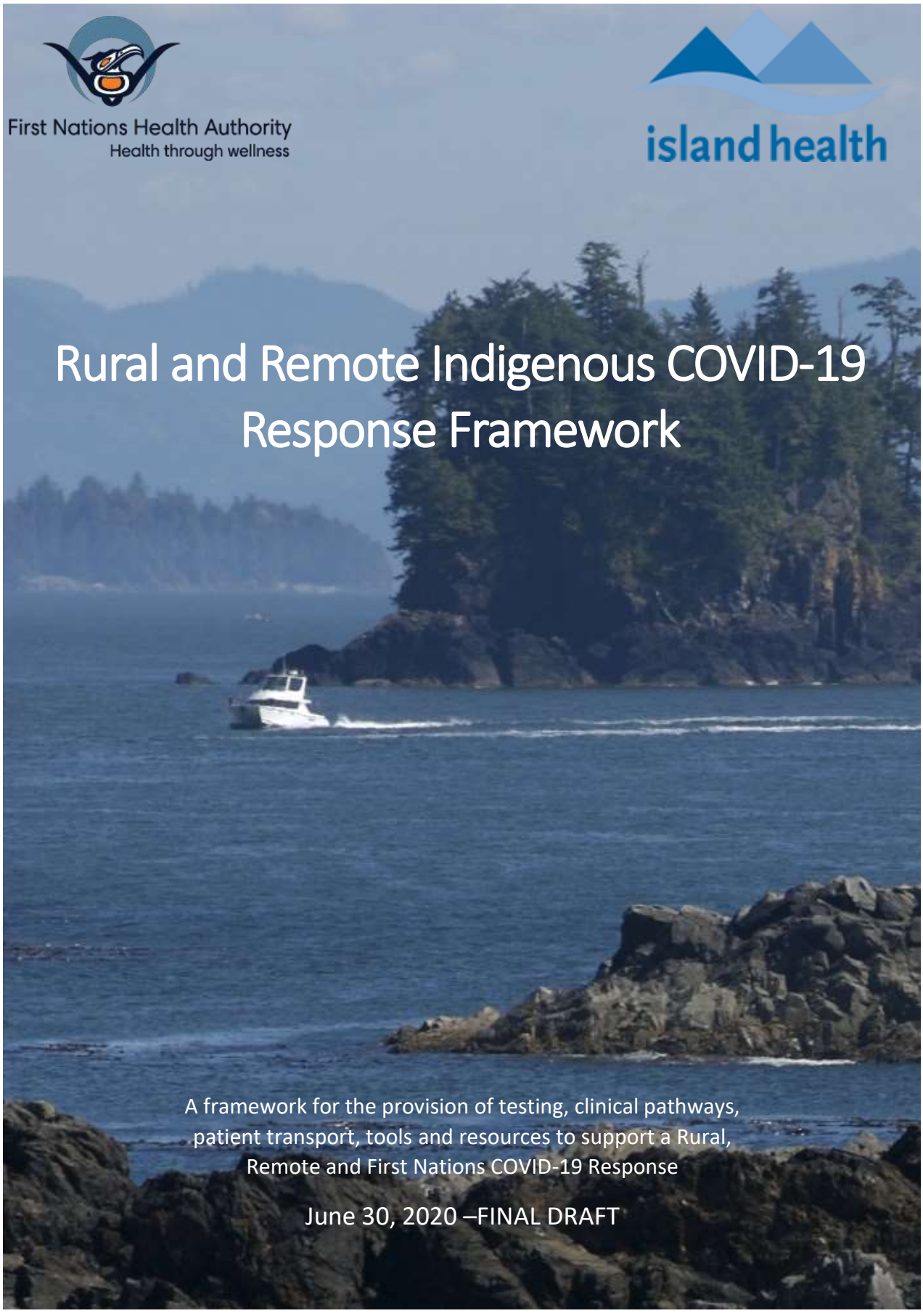

First Nations Health Authority
Health through wellness
island health
Rural and Remote Indigenous COVID-19 Response Framework
A framework for the provision of testing, clinical pathways, patient transport, tools and resources to support a Rural, Remote and First Nations COVID-19 Response
June 30, 2020 –FINAL DRAFT

Contents

ACKNOWLEDGMENTS

We raise our hands in acknowledgement and appreciation to all of you caring for your communities during the COVID–19 pandemic response. This framework was made possible through the relationships developed here in the Vancouver Island Region between Island Health, the First Nations Health Authority (FNHA), and First Nations communities. Thank you to the many community health directors and leads, healthcare workers, Island Health staff, and FNHA team members who worked to create a document that will help to guide a collaborative, coordinated, and culturally safe COVID-19 response if the need arises.

We know that to respond effectively to this pandemic, we must first recognize and name the impacts of colonization, oppression, and systemic racism that First Nations communities still face. Historic trauma, marginalization, and negative health care experiences have led many Indigenous peoples to mistrust the contemporary health system. By walking with Nations and communities through the development of this framework, we are taking organizational responsibility to ensure that Indigenous voices are actively included in pandemic response planning, and First Nations self-determination and leadership is respected.

Our commitment is to strengthen relationships across organizations and communities to create an environment that is supportive, responsive, and appropriate to the unique and varied needs of each community.

We also acknowledge that this framework is one of many steps to improving the quality and accessibility of services for those living in rural, remote, and Indigenous communities. This framework is evergreen, and will be updated as needed over the course of the COVID-19 pandemic response.

PURPOSE

In British Columbia, Dr. Henry, Provincial Health Officer declared a public health emergency related to the COVID-19 pandemic on March 17, 2020 and the next day the Government of British Columbia declared a provincial state of emergency.[1]

In response to the pandemic, the FNHA and Island Health established the Rural and Remote Indigenous Work Stream (the RRI Work Stream) to provide a coordinated, collaborative, and culturally safe approach to support rural and remote communities in addressing COVID-19. The RRI Work Stream developed this rural and remote COVID-19 framework.

The overarching goal is to address the inherent challenges for remote and Indigenous communities when responding to COVID-19 through the establishment of tools and processes to align health and wellness service delivery professional and organizational actions, and also enhance community response capacity.

This framework serves as a guide for testing, clinical pathways, patient transport, and provides other tools to support a rural, remote, and Indigenous COVID-19 response and to achieve the key deliverables outlined by the

[1] Rural and Remote COVID Response Framework V3.0

Ministry of Health. The framework also acts as the building blocks towards a permanent foundation capable of addressing the urgent and emergent health needs of rural, remote and indigenous communities across BC.

It is acknowledged that barriers to accessing care and transport are not specific to rural and remote and that in our work, we will leave no one behind. While this framework has been developed for a rural and remote COVID-19 response, the solutions and pathways are available for all of Vancouver Island's 50 First Nations communities.

GUIDING PRINCIPLES

The overarching principles underpinning this work are consistent with the pandemic response public health measures and take into account the unique realities and context of rural and remote communities. These principles influence both the public health and care management response to COVID-19 and include:

- **Evidence-informed decision making** – guides decision making based on the best available evidence
- **Flexibility** – ensures timeliness and relevance to the community context
- **Collaboration** – promotes all levels of government and organizations to work together to support the health and well-being of communities and their membership
- **Geography** – influences decisions critical to clinical and transportation pathways
- **Community networks** – recognizes the interconnectedness of rural and remote communities amongst themselves and with other communities
- **Local contexts** – influence the relevance and effectiveness of specific public health measures
- **First Nations rights and entitlement** – are recognized and supported
- **Culturally safe and respectful** – implementation of policies, programs and services
- **Collaborative dialogue** – occurs between partners in order to maintain clarity of action and sustained relationships

Vancouver Island Regional Approach

The RRI Working Stream seeks to uphold the Vancouver Island Partnership Accord agreement and the joint commitment to improve health and wellness outcomes, strengthen partnerships, and share decision-making across partners. The RRI Working Stream acknowledges the Vancouver Island Region is home to a wide range of diverse First Nations communities and remote communities with varying needs reflective of community health service availability, size, and accessibility. The planning approach includes:

1. Recognition of the autonomy and self-determination of rural and remote communities;
2. Linkages to community-led Communicable Disease Emergency Response plans and community-based resources and strategies;
3. Considerations for lasting impacts of bringing resources, services, and amenities closer to communities; and
4. Organizational capacity across partners to move work forward in a good way.

INDIGENOUS PAST EXPERIENCE WITH PANDEMICS AND RACISM WITHIN HEALTH CARE AND CURRENT MEASURES TO ADDRESS COVID-19 PANDEMIC

This is not the first pandemic Indigenous Peoples have lived through. In past pandemics, some First Nations suffered a loss of 90% of their population. Some Indigenous peoples living through this current pandemic have also experienced the segregation and isolation of the Indian Hospital system. Responding to this pandemic can trigger past traumas, and can create additional fears – especially around being transported away from community for treatment.

We also know that current experiences of racism within the health system in British Columbia, both at the individual and system level, impact care seeking behaviour for Indigenous peoples.[2] The design and delivery of this framework is grounded in the understanding of the historical traumas experienced by many Indigenous communities.

CULTURAL SAFETY

Indigenous Cultural Safety is about what is felt or experienced by an Indigenous person; it is an approach that considers how social, historical and present-day contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences.

It is both a process and an outcome based on respectful engagement that results in an environment free of racism and discrimination, where Indigenous people feel safe when accessing and receiving health care.

Cultural Safety is determined by the client. The following outcomes determine Cultural Safety:

- Feeling respected
- Feeling understood
- Feeling honoured
- Feeling cared for
- Feeling who you are is important
- Feeling included in your own care
- Feeling safe to share

TRAUMA AND VIOLENCE INFORMED PRACTICE

Trauma-Informed Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al., 2010). A trauma-informed practice acknowledges and understands how trauma affects individuals, families, and communities. Being trauma aware means recognizing signs of trauma, and how trauma informs behaviours and responses.

During the COVID -19 pandemic, it is important to recognize that a trauma and violence informed approach can be used to address the systemic violence that Indigenous people face today. Lived experiences can trigger a memory recall stress and a trauma response without a person even being aware of these triggers or feelings. It is also important to understand how historical and intergenerational trauma could be brought forward during this

[2] https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf

crisis. Considering these possibilities, we must work together to create a culturally safe experience. The lived experience and memory recall can revert individuals back to the use of their Traditional Language and safety mechanisms to protect themselves, such as not responding to questions because of fear and no trust of the system. When providing supports, there needs to be a consideration to these challenges.

RURAL AND REMOTE COMMUNITIES

It is acknowledged that defining rural and remote is complex and there is not a single definition or list of rural and remote communities for Vancouver Island. For the purpose of this document, considerations were given to the accessibility of timely medical transportation, the distance to an Island Health designated COVID-19 care facility, existing health services within a community for regular monitoring and symptom tracking or probable or positive individuals, and community capacity for self-isolation.

FIRST NATIONS REGIONAL CONTEXT

Vancouver Island is home to 50 First Nations communities that make up three distinct families on the Island: Coast Salish, Nuu-chah-nulth and Kwakwaka'wakw. Vancouver Island's First Nations are diverse, with distinct culture and traditions, cultural knowledge and practice, and languages across the region. Self-determination is a key determinant of health, and the framework acts as a guide to enable First Nations to make their own decisions about their health and well-being and ensuring communities are informed on the process and services available in responding to COVID-19.

COAST SALISH

Of the 50 First Nations on Vancouver Island, 20 are within the Coast Salish Family. Geographically, the majority of Coast Salish communities are located between the southern tip of Vancouver Island and Qualicum Beach facing eastward towards the Salish Sea. Two communities are located further north; these being Homalco and Klahoose First Nations, which have their traditional territories off the coast of Campbell River, BC and Bute Inlet. While Coast Salish communities may be considered relatively close physically and have similar cultural traditions they are also have differences in their size, remoteness and language.

Each Nation varies in size from less than one hundred members to over one-thousand members. Some communities are located in rural areas and remote areas while others are located in or border urban settings. Three communities are located on islands, namely Penelekut, located on Penelakut Island; Klahoose, located on Cortes Island; and Lyakson, located on Valdes Island. Other communities are land locked and do not have direct access to the Salish Sea (Cowichan Tribes and Ts'uubaa-asatx).

NUU-CHAH-NULTH

The *Nuučaaʔuł* (Nuu-chah-nulth) also formerly referred to as the Nootka or *Nuu-chah-nulth*, are one of the Indigenous peoples of the Pacific Northwest Coast of Canada. The term *Nuučaaʔuł* is used to describe sixteen separate but related Nations and translates as "all along the mountains and sea"[3]. *Nuučaaʔuł* is a distinct language on the West Coast of Vancouver Island that is similar to the spoken dialects.
The *Nuučaaʔuł* people formed an alliance in 1958 known as the West Coast Allied Tribes. In 1973, this alliance became incorporated as a non-profit society called the West Coast District Society of Indian Chiefs *Ḥa`wiiḥ* and

[3] Nuu-chah-nulth Tribal Council Website

six years later the Society changed its name to the Nuu-chah-nulth Tribal Council (NTC). The NTC offers a wide range of programs and services to registered members of 14 *Nuučaaʔuł* First Nations. Today, some Nuuč*aaʔuł* First Nations include several *Ḥaʕwiiḥ* (chief) families, and most include what were once considered several separate local groups.

KWAKWAKA'WAKW

The Kwakwaka'wakw people, also referred to as the Kwak'wala speaking people live on the Northern coastal area of Vancouver Island and on the coast of the mainland of British Columbia. The Kwakwaka'wakw people have lived on this land as long as the waves have crashed against the beach and the wind has blown through the cedars. Today there are 15 Nations within the Kwakwaka'wakw Family.

Each Kwakwaka'wakw Nation is governed through a hereditary system that is grounded in the laws set forth by ancestors. Modern governance respects both the hereditary and democratically elected systems. Working toward self-determination, Kwakwaka'wakw leaders recognize the diversity of each community. Relationships, connection to traditional, spiritual and cultural practices, as well as connection to the physical landscapes of the traditional territories are inherent to Kwakwaka'wakw ways of being.

Rural and Remote First Nations Communities	Less remote/Urban First Nations Communities	A & B RSA Non-Indigenous Communities	Metis Associations
Kwakwaka'wakw 1. Da'naxdaw'xw (New Vancouver) 2. Dzawada'enuxw (Kingcome) 3. Kwikwasut'inuxw Haxwa'mis (Gilford Island) 4. Gwatsinuxw (Quatsino) 5. Gwawaenuk 6. Namgis **Nuu-chah-nulth** 7. Ahousaht 8. Hesquiaht 9. K:yu:'k't'h/Che:k'tles7et'h' (Kyuquot) 10. Ditidaht 11. Ehattesaht/Chinehkint 12. Huu-ay-aht 13. Mowachaht/Muchalaht 14. Nuchatlaht 15. Tla-o-qui-aht (Opitisaht community) 16. Toquaht 17. Pacheedaht **Coast Salish** 18. Klahoose 19. Penelakut	**Kwakwaka'wakw** 1. Gwa'Sala-Nakwaxda'xw 2. K'omoks First Nation 3. Kwakiutl 4. Kwiakah 5. Mamalilikulla-Qwe'Qwa'Sot'Em 6. Tlatlasikwala 7. Tlowitsis 8. Wei Wai Kum 9. Wei Wai Kai **Nuu-chah-nulth** 10. Hupacasath First Nation 11. Tla-o-qui-aht 12. Tseshaht 13. Uchucklesaht 14. Ucluelet **Coast Salish** 15. Cowichan Tribes 16. Esquimalt 17. Halalt 18. Homalco 19. Pauquachin 20. Qualicum First Nation 21. Scia'new (Beecher Bay) 22. Snaw-Naw-As (Nanoose) 23. Snuneymuxw First Nation 24. Songhees First Nation 25. Stz'uminus First Nation 26. Ts'uubaa-asatx (Lake Cowichan First Nation) 27. Lyackson 28. Malahat First Nation 29. T'Sou-ke First Nation 30. Tsartlip 31. Tsawout First Nation 32. Tseycum	1. Alert Bay 2. Cortes Bay 3. Gold River 4. Holberg 5. Denman Island 6. Hornby Island 7. Woss 8. Port Alice 9. Quadra 10. Port Hardy 11. Port McNeill 12. Sayward 13. Sointula 14. Tahsis 15. Texada Island 16. Zeballos 17. Bamfield 18. Lasqueti Island 19. Tofino 20. Ucluelet 21. Mayne Island 22. Galiano Island 23. Pender Island 24. Saturna 25. Port Renfrew	1. North Island Metis Nation 2. MIKI'SIW Metis Association 3. Mid-Island Metis Nation 4. Alberni Clayoquot Metis Association 5. Cowichan Valley Metis Association 6. Metis Nation of Greater Victoria

ROLES AND RESPONSIBILITIES

In the event of a positive lab result, or outbreak COVID-19 in community, the MHO becomes Order-in-Chief and has legal authority and responsibility for receiving CD lab reports, making case determinations, and directing the appropriate CD management. Please see Appendix F (COVID-19 Adapted Regional Health Authority- First

Nations Health Authority Communicable Disease Protocol- April 2020) regarding the roles and responsibilities of Island Health, FNHA and Health Service organizations.

You may also want to refer to Appendix E (Notice and follow-up of a confirmed case). To understand who is notified to support a positive case and/or outbreak.

Community Services

Nurse/Community Health Nurse Working in First Nations Health Service Organization

1. Collaborate with Regional Health Authority Communicable Disease units/Medical Health Officers for case and contact management when case or contacts reside in First Nations Community.
2. Share clear and consistent prevention messaging with whole community, reputable sources of information FNHA website, BCCDC, PHAC etc. – provide consistent messaging
3. Support Communicable Disease Emergency planning (pandemic) in community

Health Director Responsibilities in conjunction with community

1. Support connection to a health care provider to determine need for testing
2. Safe housing for self-isolation
3. Education for social distancing, self isolation, handwashing with soap, absence of social gathering.
4. Coordination of food security
5. Education and support for community members
6. Transportation for testing as needed
7. Mental Health & Wellness of Community

Primary Care Team

Clinical Responsibilities Primary Care Team in Community

Primary care provided in community by a visiting GP/NP, a community health nurse, primary care outside of community or FNHA Doctor of the Day. This team varies by community.

1. Provision of primary care locally, who is providing this, where, and how often
2. Recognition of symptoms that could be COVID 19
3. Testing as appropriate – at a testing site (NH owned and operated), in community with appropriate supplies, PPE; and cleaning protocols in place; requisition completed with appropriate ordering and primary care provider noted on requisition; transport of laboratory specimen to receiving site
4. Provides clinical support and guidance on clinical decision-making and for isolation and transportation
5. The development of health care plans, as needed for those receiving care and treatment in the community setting.

FNHA

Office of the Chief Medical Officer

1. Primary and initial contact for confirmation of a positive result in a First Nations Community
2. Provides highest level medical leadership and guidance to FNHA response alongside RHA CMHO Peers

Regional Executive Director

1. Overall operational oversight, support and coordination for regional partnered response from FNHA

2. Lead discussions within partnership between community and Island Health and escalate, as required, to resolve any issues and barriers
3. Performing functions related to notification of a confirmed case as outlined in Appendix E: COVID-19 – Notice and Follow-up Process for a Confirmed Case in a First Nations Community

Regional Nurse Manager

1. Support CHPC and RED with coordinating response
2. Support Coordination with RHA partner and CD team
3. Support clinical follow up coordination when there is no clinical provider in community

Community Health Practice Consultant

1. Working with all partners including Health directors, communities, FNHA and NH Communicable Disease units and community primary care providers
2. Clinical Support to health care team in community, 1:1 support and identification of training and other identified needs
3. Collaborating with partners to support PPE, testing, equipment, supplies, education, training and support
4. Share clear and consistent prevention messaging with whole community, reputable sources of information NH website, FNHA website, BCCDC, Public Health Agency of Canada etc.
5. Collaborate with FNHA Provincial Nursing Practice Consultants and Clinical Nurse Specialists to obtain additional community support as needed; develop resources, provide training and specialized practice support

Community Engagement Coordinator

1. Validating information from this partnership table and to and from community back to regional teams
2. Assist with community plan in conjunction with the Health director
3. Coordinate resources

Regional Services

1. Supporting requests and coordinating resources, where appropriate, in the areas including but not limited to: primary care services, nursing, mental health and wellness, community engagement, planning and development, maternity care, supporting self-isolation in-community
2. Delivery of First Nations Health Benefits

Island Health

Island Health's public health communicable disease team are responsible for overseeing the screening, testing, identification of positive COVID-19 cases, notification/reporting, contact tracing, follow up and monitoring processes.

Laboratory Services

Where testing is provided on an Island Health device, Island Health is responsible for testing and interpreting results and for commencing the COVID-19 notification process, where required

Communicable Disease Team

1. Medical Health Officers have the legal authority and responsibility for receiving Communicable Disease lab reports, making case determinations, and directing the appropriate Communicable Disease management
2. Leading capacity management in collaboration with community and FNHA
3. The Communicable Disease unit/Medical Health Officer automatically receive notification of reportable communicable disease by positive lab reports. May learn of probable or suspect cases from a care provider
4. They will confirm case definition is met

Case Management

1. Will notify the individual of the positive lab, will do a case interview to complete the BCCDC Case Report Form, will deliver any needed education/resources about diagnosis and prevention of spread, will commence contact tracing by asking who the individual has been in contact with during the period of communicability and where they have been
    a. As much as possible this will be done in collaboration with Primary Care Team in community by the individual who has the relationship with the patient

Contact Management

1. For contacts of confirmed cases (will notify contacts that have been in contact with a confirmed case, will assess for any symptoms and provide any needed education/resources of what to do if symptoms develop and how to prevent spread). If the contact was in a public place, a public notice will be drafted and released
2. Follow-up and reporting completed as per BCCDC guidelines and Regional Health Authority processes
3. Surveillance within their region to monitor disease transmission, trends and identify clusters
4. Collaboration with Nurse/Community Health Nurse Working in First Nations Health Service Organization for case and contact management when client resides in a First Nations Community in accordance with staffing levels, education and training

INFORMED COMMUNITY AND INDIVIDUAL CHOICES

Processes that support informed community and individual choices enables the care team to work in partnership with the individual and their family in the context of their community and transportation network(s). Understanding the community and clinical pathways available to an individual diagnosed with COVID-19 symptoms in a First Nations community enables partners initiate infrastructure and supportive processes to for an individual's informed choice about their care and subsequent care journey whether they choose to remain in-community or go nearer to acute care facilities.

The decision that an individual with symptoms of COVID-19 may make regarding their care pathway is, by necessity, guided by a conversation between the clinical care team and the individual. This conversation is guided by cultural safety and humility and enables the individual to make an informed choice based on their understanding of their care needs within the context of their community.

Transparency regarding the choices that an individual and their family make ensures that appropriate assets at the appropriate level are mobilized to support choices and that the risks associated with choices are understood an individual, their family and the care team. Advance planning and establishing the infrastructure and processes associated with the choices that individuals and their families make enables:

- Transportation services to be arranged efficiently depending on the choices an individual may make with the clinical care team about the next steps in their plan of care.
- Community supports to be mobilized such as access to healthy food, social supports, mental wellness, and cultural traditions.

CIRCLE OF CARE AND CIRCLE OF SUPPORT

Partnership is a key to success, innovation and access to excellence in care. In 2012, FNHA and Island Health have developed a Partnership Accord Steering Committee, which provides a foundation for a shared commitment to improved access to care on Vancouver Island. This collaboration is driven and led by the guidance, knowledge and advice of Vancouver Island's 50 First Nations Communities. Vancouver Island recognizes the principles of the Circle of Care and Circle of Support developed by Northern Health and Norther Region FNHA. We acknowledge the work at community level that health leadership support through the "circle of support" that helps to care for the entire community so that the "circle of care" can wrap care around an individual in need.

Should community members choose to self-isolate away from home, partners want to ensure that a "Circle of Support" similar to that which is provided by the community Health Directors, is made available for community members isolating away from home or at cohort facility.

The clinical care team or circle of care, whether virtual or physically present, may consist of a primary care physician, nurse practitioner, community health nurse, a community health representative, additional Indigenous specific supports, community paramedic, or other first responders present in some First Nations communities.

In relation to the COVID-19 response, these local clinical care teams are supported by a public health team including the Medical Health Officer and nurses with expertise in communicable disease control, the BC Emergency Health Services patient transfer team, and the acute care specialized services team.

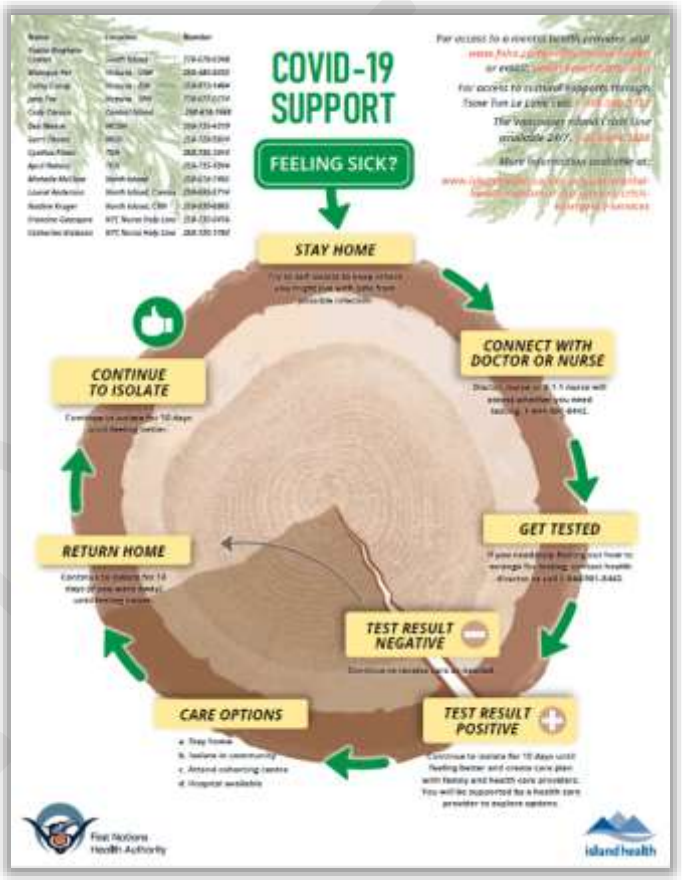
A further consideration in supporting people living in First Nations communities, is the role of the broader community support team (circle of community support) that can be mobilized to support an individual and community. The focus of these services include supporting mental health and wellness, mobilizing social and cultural traditions supports, enabling safe housing, transportation and food security. These supports may be available within the community or from the broader system of services provided by the First Nations Health Authority. The communication pathways between the public health communicable disease team, the clinical care team, and the community support team are important to describe and work out in advance.

GUIDING DOCUMENTS AND PLANNING TOOLS

The guiding documents and planning tools within this framework are intended to be adapted to meet the needs of regions/communities. When reviewing the framework with a health director or other community healthcare leader, a community's available assets to support service delivery and care should be considered.

The pathways that Island Health and First Nations Health Authority have developed provide guidance for the circle of care and circle of support to care for an individual with COVID-19 symptoms or a positive result. These pathways mark an individuals' journey that starts at home and ends at home.

For full size see Appendix E.



COMMUNITY TEMPLATE

This community planning template has the following purpose:

- Support the ability of the medical system to respond to a positive case of COVID-19 in an efficient and organized manner.
- Prepare critical information in one location that can be added to your pandemic plan (if relevant to your community).
- Validate community information to ensure accuracy.
- Facilitate secure information sharing to prevent duplication.

The confidentiality of your community information is critical. This information is for clinical use only to support planning and response efforts. It is NOT intended for public release. We expect that there will be errors in this information and invite you to join us in ensuring that they information is as accurate as possible. We are committed to work with you as true partners in health and wellness.

COMMUNITY: (03.06.20)	
1. Family Group:	
2. Health Director/Health Lead:	
3. Contact Info:	
4. Population:	
5. Community EOC (Y/N):	
6. If yes, primary contact:	
7. Essential Services Status: (Band Office, Health Services Contacts):	Band Office: ☐Open ☐Closed Health Services: ☐Open ☐Closed Visitors Permitted? ☐ Yes ☐No
8. FNHA Community Engagement Coordinator:	
9. FNHA Nurse Practice Consultant:	
10. Health Service Organization (Y/N): If yes, include HSO name	
11. Pandemic/CD Plan (Y/N):	
12. Does your Pandemic/CD Plan for frail or vulnerable community members? (Y/N):	
13. Current Health Care staff: ☐ Nurse ☐ Nurse Practitioner ☐ Physician ☐ Other	Name: Frequency (Days & Times): Name: Frequency (Days & Times): Name: Frequency (Days & Times):
14. First responders/paramedics (on reserve) (Y/N):	
15. Virtual Care in Community ☐ Yes ☐ No	Type: Frequency (Days & Times):
16. Clinical equipment for monitoring related to COVID care currently in community:	☐ Automatic blood pressure machine ☐ Digital thermometer/temporal ☐ O2 SAT machine/pulse oximeter ☐ Stethoscope
17. Medical supplier:	
18. Travel considerations:	Remote Isolated (no flights, no road access)
19. Nearest Hospital 1. Distance 2. Time 3. Travel Requirements	Hospital: 1. Distance: 2. Time: 3. Travel Requirements:

20. Nearest COVID-19 Designated Hospital 1. Distance 2. Time 3. Travel Requirements	Hospital: 1. Distance: 2. Time: 3. Travel Requirements:
21. Transportation Plan? (Y/N):	
22. Do you have facilities or options in community that could be used for self-isolation if a community member cannot stay in their own home? (Y/N): (separate location for COVID-19 Patients)	
23. If yes, list facilities and how many people it can accommodate:	
24. Closest Testing Facility (Building/Lab/Hospital):	Site: Hours: Is mobile testing possible from this site? ☐Yes ☐No

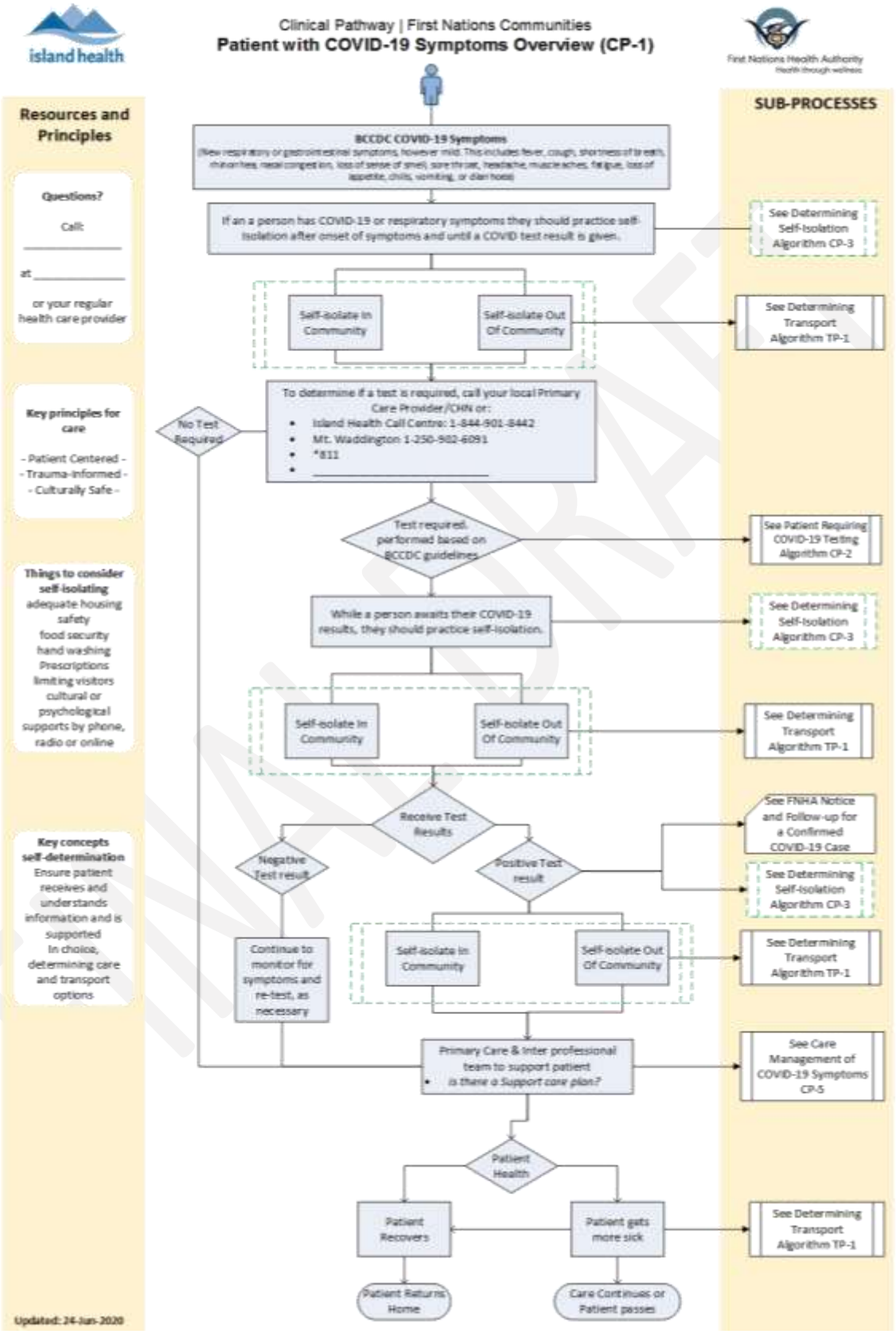
NON INDIGENOUS COMMUNITY: (17.06.20)	
25. Rural Site Director:	
26. Contact Info:	
27. Population:	
28. Community EOC (Y/N):	
29. If yes, primary contact:	
30. Essential Services Status:	Municipal Office: ☐Open ☐Closed Health Services: ☐Open ☐Closed Visitors Permitted? ☐ Yes ☐No
31. Pandemic/CD Plan (Y/N):	
32. Current Health Care staff: ☐ Nurse ☐ Nurse Practitioner ☐ Physician ☐ Other	Name: Frequency (Days & Times): Name: Frequency (Days & Times): Name: Frequency (Days & Times):
33. First responders/paramedics (on reserve) (Y/N):	
34. Virtual Care in Community ☐ Yes ☐ No	Type: Frequency (Days & Times):
35. Phone / Internet access:	☐ Phone ☐Internet

36. Clinical equipment for monitoring related to COVID care currently in community:	☐ Automatic blood pressure machine ☐ Digital thermometer/temporal ☐ O2 SAT machine/pulse oximeter ☐ Stethoscope
37. Medical supplier:	
38. Travel considerations:	Remote Isolated (no flights, no road access)
39. Nearest Hospital 1. Distance 2. Time 3. Travel Requirements	Hospital: 1. Distance: 2. Time: 3. Travel Requirements:
40. Nearest COVID-19 Designated Hospital 1. Distance 2. Time 3. Travel Requirements	Hospital: 1. Distance: 2. Time: 3. Travel Requirements:
41. Transportation Plan? (Y/N):	
42. Do you have facilities or options in community that could be used for self-isolation if a community member cannot stay in their own home? (Y/N): (separate location for COVID-19 Patients)	
43. If yes, list facilities and how many people it can accommodate:	
44. Closest Testing Facility (Building/Lab/Hospital):	Site: Hours: Is mobile testing possible from this site? ☐Yes ☐No

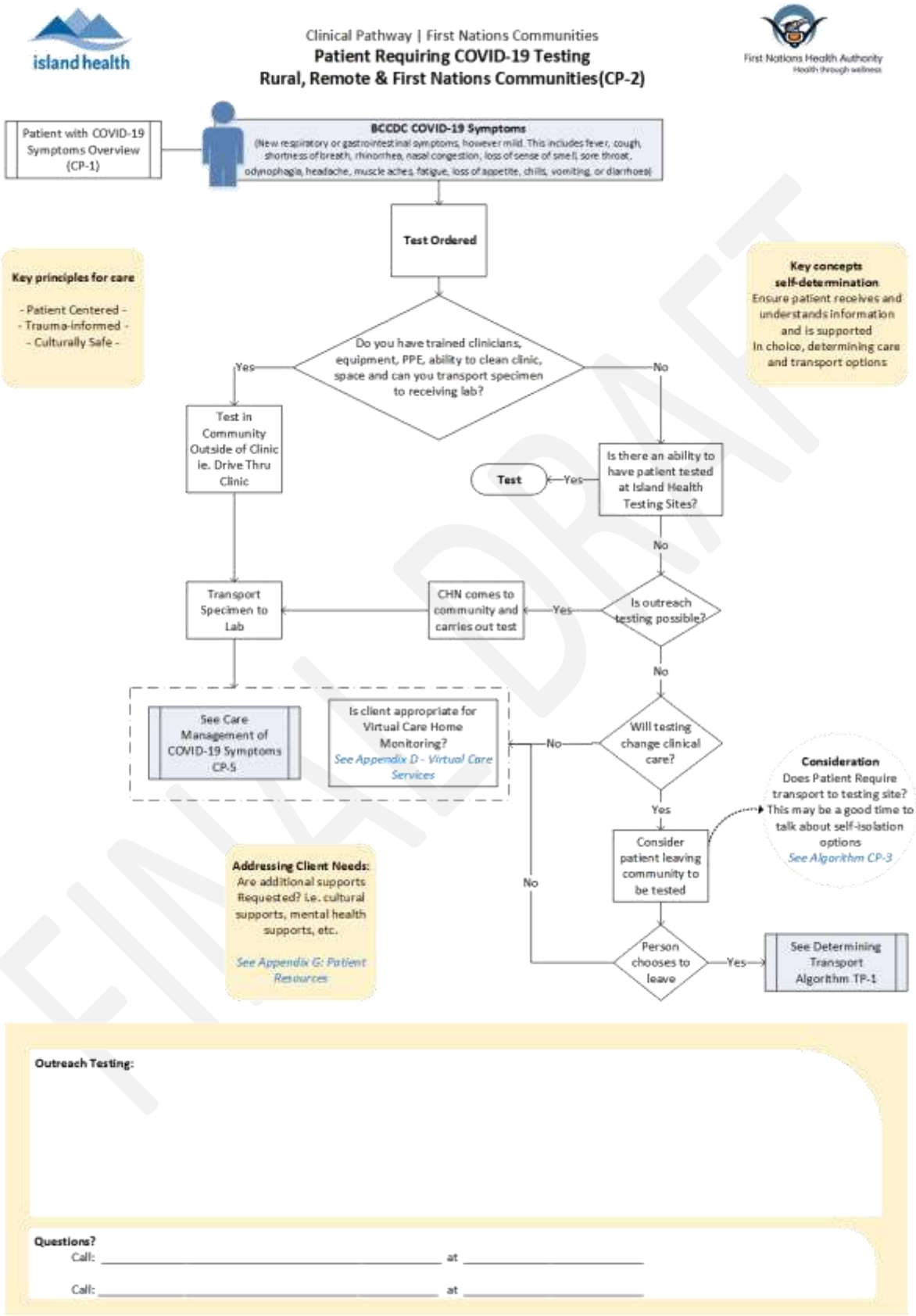
CLINICAL PATHWAYS

Describing clinical pathways provides decision-making guidance to care teams and health directors where an individual in community experiences symptoms consistent with COVID-19. The following pathways inform, at a high-level, the accessing of testing, management of symptoms, determination for self-isolation, transport options and referral to Community cohort centres, where an individual chooses to leave community for care.

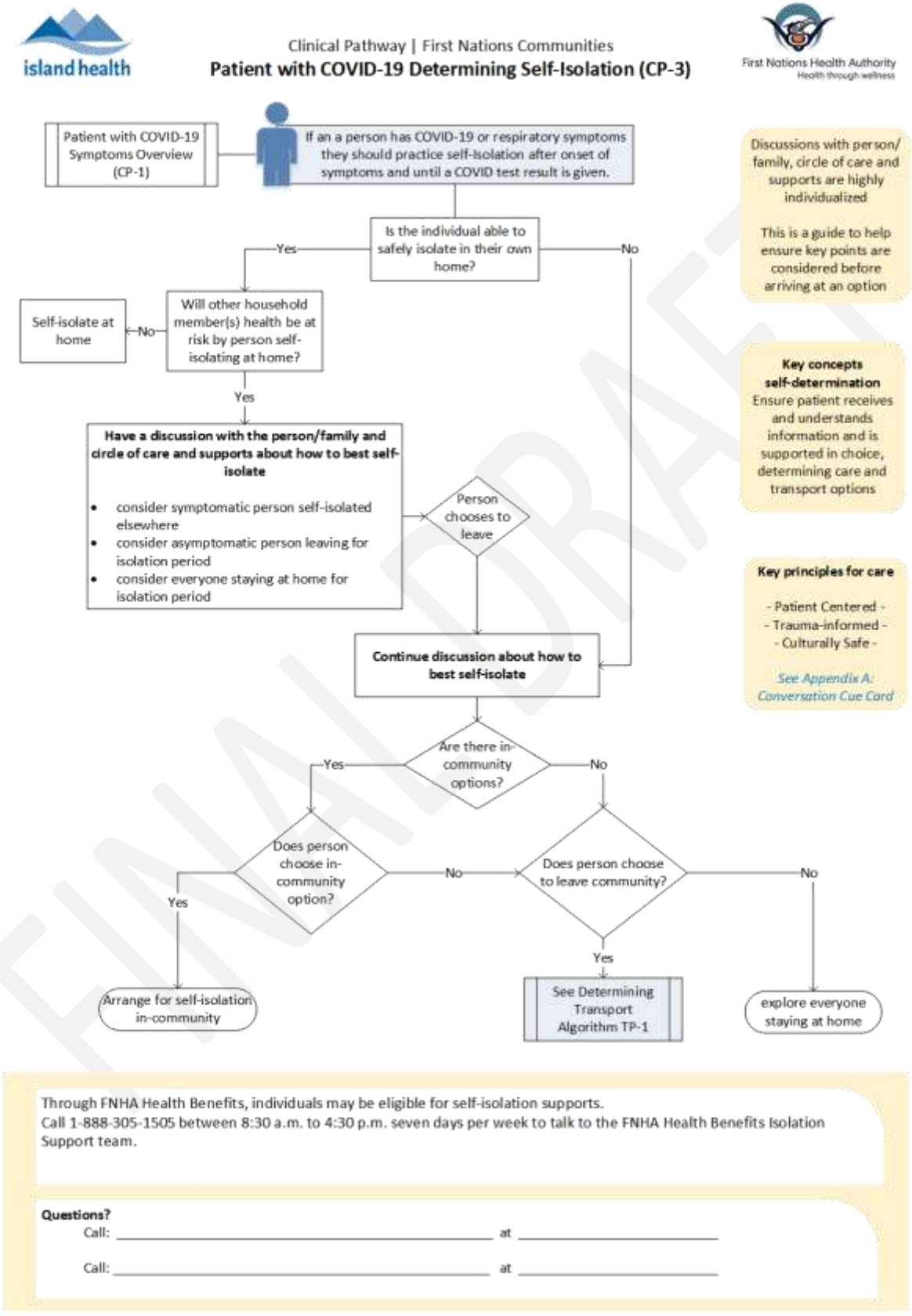
Symptoms Overview



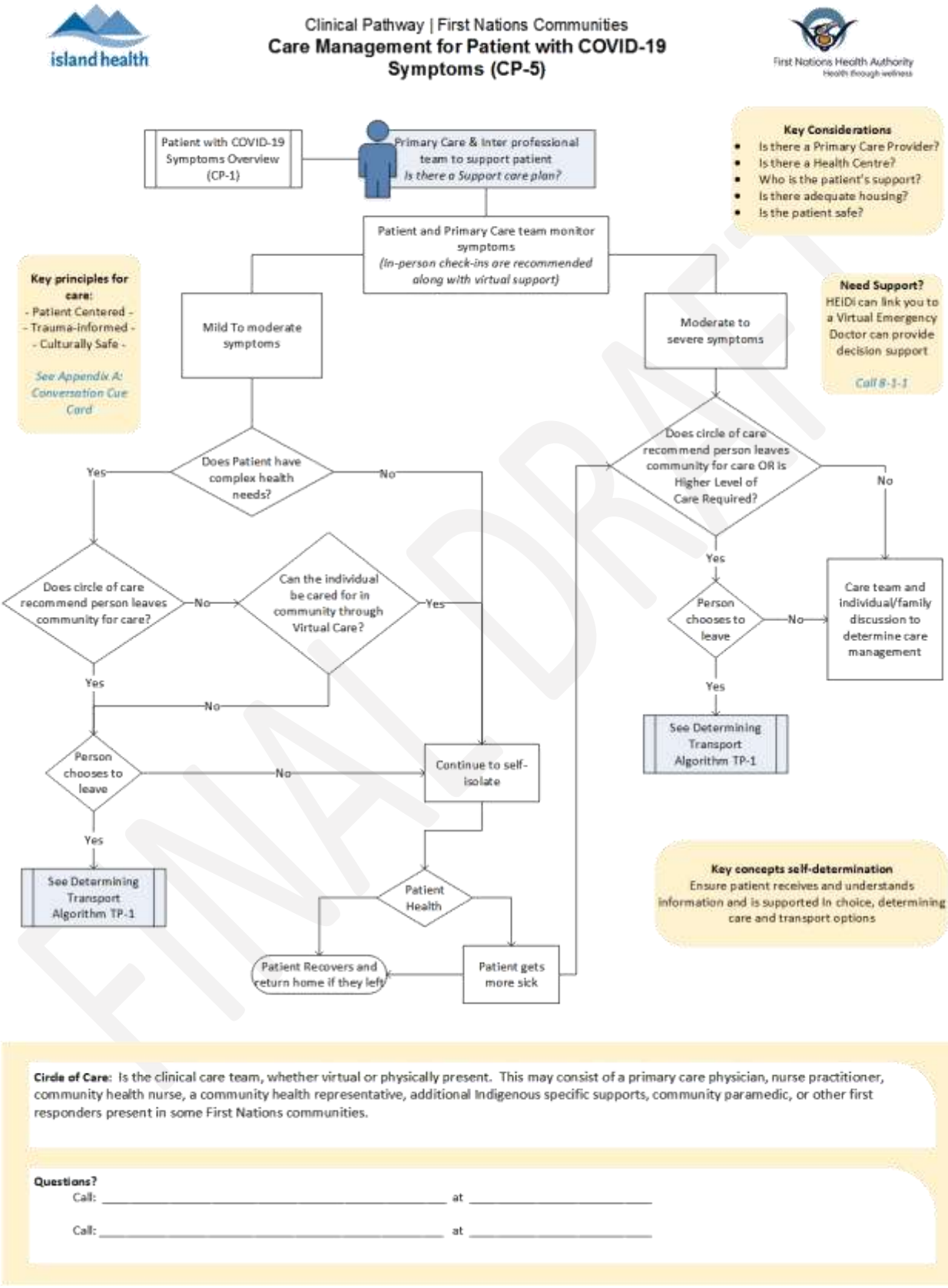
Testing


island health
Clinical Pathway | First Nations Communities
Patient Requiring COVID-19 Testing
Rural, Remote & First Nations Communities(CP-2)
First Nations Health Authority
Health through wellness
Patient with COVID-19 Symptoms Overview (CP-1)
BCCDC COVID-19 Symptoms
(New respiratory or gastrointestinal symptoms, however mild. This includes fever, cough, shortness of breath, rhinorrhea, nasal congestion, loss of sense of smell, sore throat, odynophagia, headache, muscle aches, fatigue, loss of appetite, chills, vomiting, or diarrhoea)
Test Ordered
Key principles for care
- Patient Centered -
- Trauma-informed -
- Culturally Safe -
Do you have trained clinicians, equipment, PPE, ability to clean clinic, space and can you transport specimen to receiving lab?
Yes
No
Key concepts
self-determination
Ensure patient receives and understands information and is supported
In choice, determining care and transport options
Test in Community Outside of Clinic ie. Drive Thru Clinic
Test
Yes
Is there an ability to have patient tested at Island Health Testing Sites?
No
Transport Specimen to Lab
CHN comes to community and carries out test
Yes
Is outreach testing possible?
No
See Care Management of COVID-19 Symptoms CP-5
Is client appropriate for Virtual Care Home Monitoring?
See Appendix D - Virtual Care Services
No
Will testing change clinical care?
No
Consideration
Does Patient Require transport to testing site? This may be a good time to talk about self-isolation options
See Algorithm CP-3
Yes
Consider patient leaving community to be tested
Addressing Client Needs:
Are additional supports requested? i.e. cultural supports, mental health supports, etc.
See Appendix G: Patient Resources
No
Person chooses to leave
Yes
See Determining Transport Algorithm TP-1
Outreach Testing:
Questions?
Call: _____ at _____
Call: _____ at _____

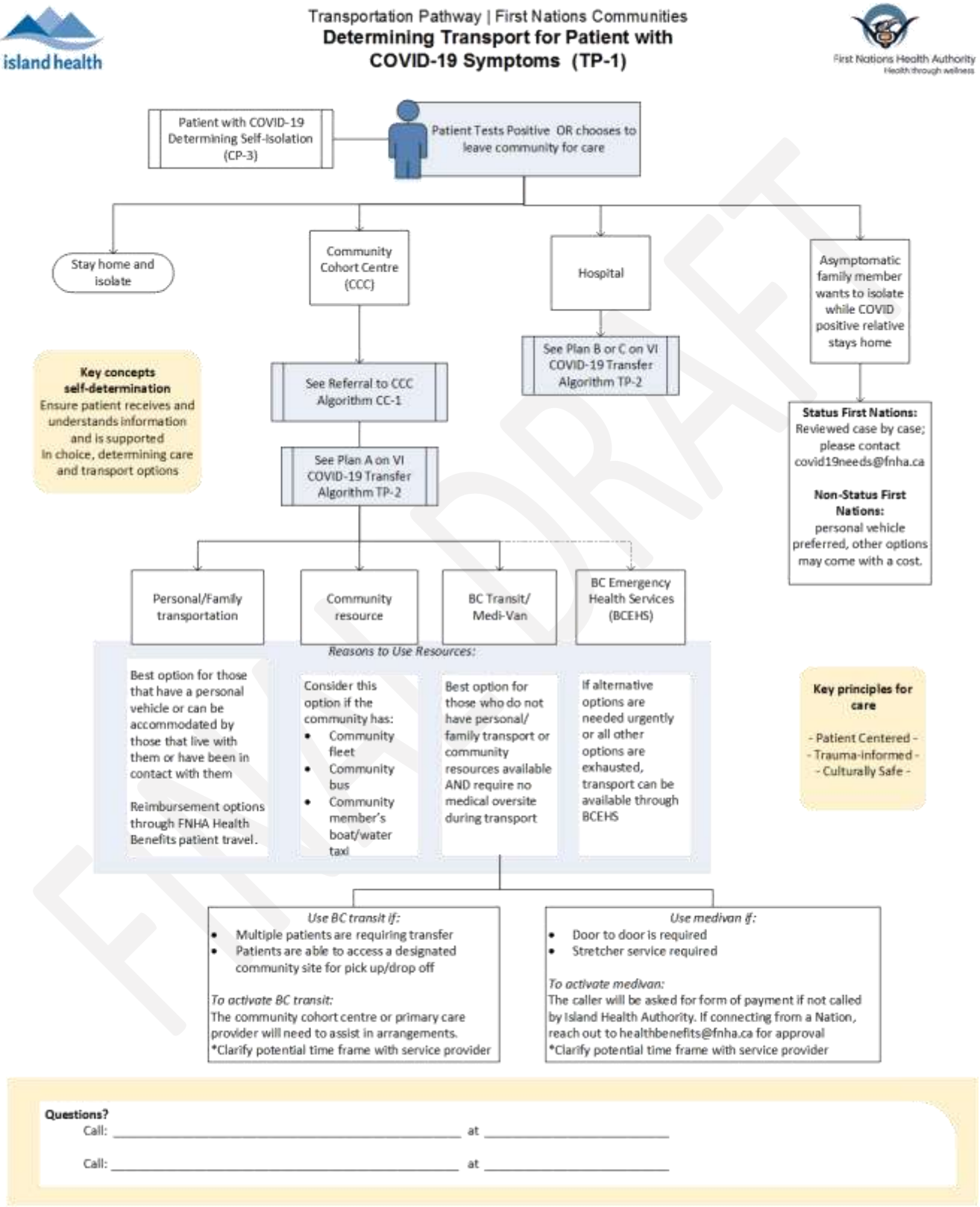
Determining Self-Isolation



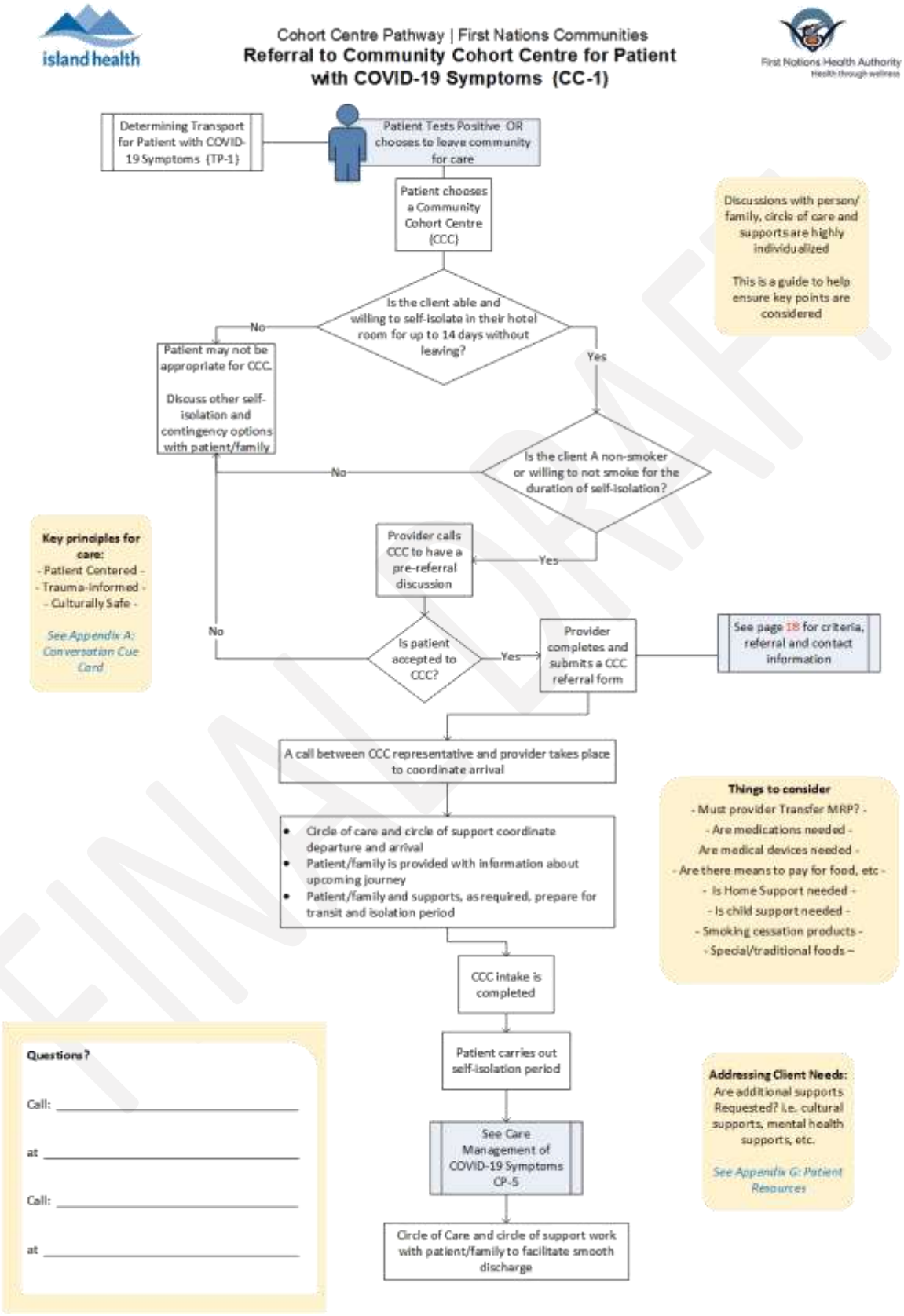
Care Management



Determining Transport



Community Cohort Referral



PATIENT TRANSPORTATION

Describing the patient transport pathways provides opportunity for advance planning and decision-making guidance to individuals (and their care team) where symptoms consistent with COVID-19 are experienced and an individual chooses to leave community to self-isolate and/or receive care.

Temporary Medical Transportation Changes in Response to COVID-19 for Health Benefits

- https://www.fnha.ca/about/news-and-events/news/temporary-medical-transportation-changes-in-response-to-COVID-19

Rural and Remote COVID-19 Transport Options

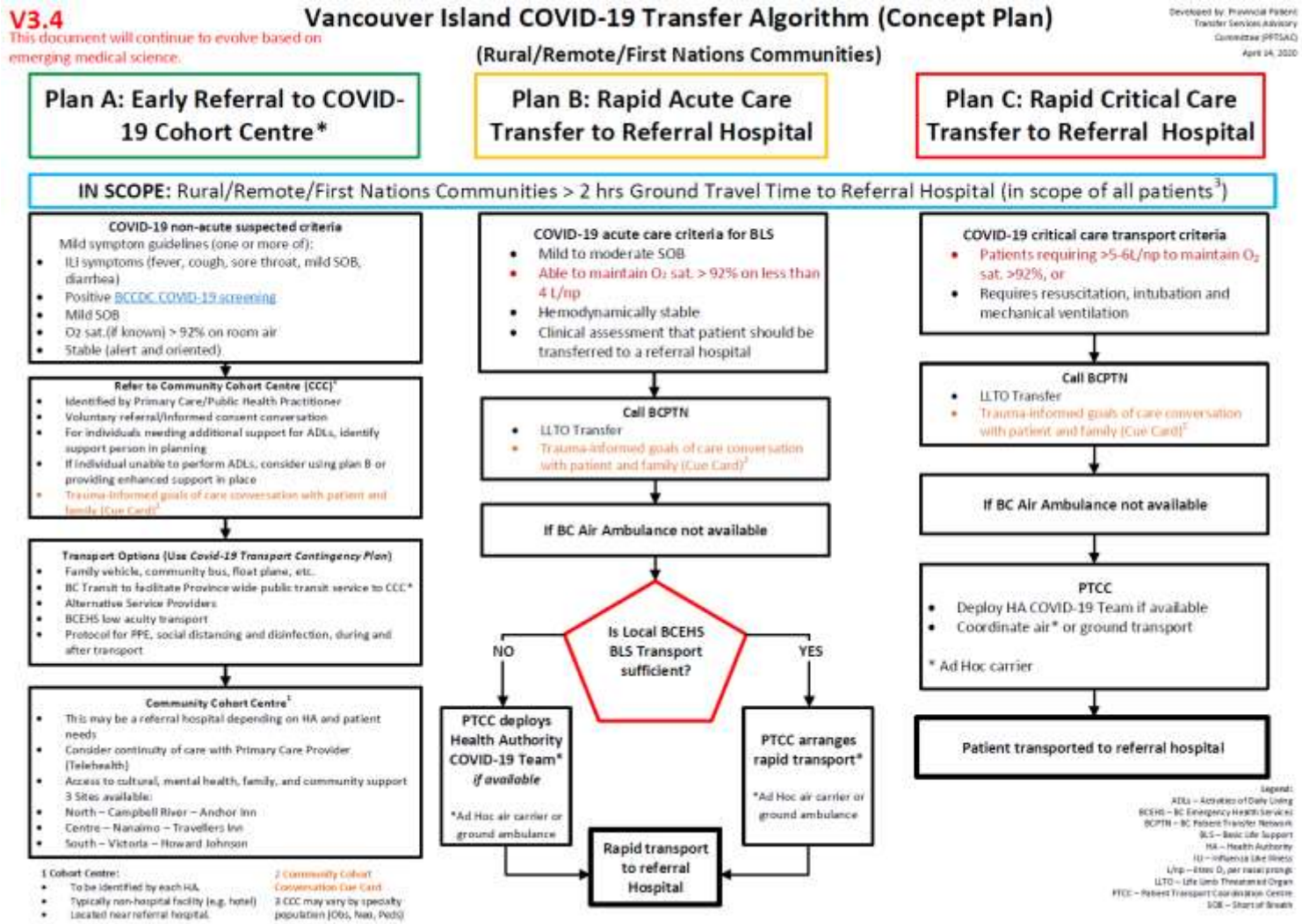
Community Transport Options	Transport Requirements			
	Critically Unwell	**Medical Support Required**	**No Medical Needs**	**Repatriation Home**
Paved Road (+/- BC Ferries) **Gravel Road (+/- BC Ferries)**	BCEHS Air/ Ground as per usual transport process	BCEHS as per usual process May use sending site RN or CERT Team as needed	Options: • Medi-van (Cost to Island Health) • BC Transit Handy Dart (Cost to Island Health) • Personal vehicle	Options: • Personal vehicle/family • Medi-van (cost to Island Health) • BC Transit (cost to Island Health)
Water/Air only (no BC Ferries) *6 communities		BCEHS with their water taxi contracts May use CERT Team as needed	Local contracts, not yet determined For patients with high risk comorbidities, consider transfer using Yellow or Red options in this table	Not yet determined FNHA HB may have eligible costs for individuals with families who can support repatriation Option to remain in another location on a case-by-case scenario based on individuals' choice

Cultural Safety principles should be applied to transportation and cohort discussions:

Supporting self-isolation: identifying and creating appropriate spaces and opportunities to self-isolate. De-stigmatizing the practice of self-isolating through education.	Transparency regarding available options and supports

Understanding and respecting people's wishes- Supporting advance directives and in- community palliation where this is desired	Enhancing primary care services if needed. This may include bringing a health care team in to community (versus requiring people to leave to seek care)
Ensuring transition to the nearest community is culturally safe and opportunities to self-isolate are safe and supported with appropriate education and health monitoring.	Increased access to diagnostics and testing
Awareness that being placed outside of one's community and away from one's established supports can pose hazard and risk to a person.	Access to appropriate transportation and clinically appropriate response times to transfer people if they are sick
Approaches to self-isolate and receive care are appropriate, sustainable, and culturally safe	

Vancouver Island Transportation Pathway



SELF-ISOLATION IN COMMUNITY

Self-isolation at Home

From the point of on-set of symptoms consistent to COVID-19, a person should practice self-isolation. Self-isolation at home is the best choice for most people, where self-isolation at home is not possible, refer to (Algorithm CP-3).

If someone has a positive COVID-19 result and live with other people, they can still self-isolate at home. Stay and sleep in a room with good airflow that is away from others. Use a separate bathroom if they can. If they are in the same room with anyone, avoid face-to-face contact and wear a facemask. Friends and family can drop off food outside the room or home. Note that if one person in the household is infected, the whole household must self-isolate even if the other household members do not have symptoms. If the person lives live with an Elder or someone with a chronic health condition, that person may be better protected if they stayed in the home of other family members or friends nearby.[4]

Through FNHA Health Benefits, individuals may be eligible for self-isolation supports, They should call 1-888-305-1505 between 8:30 a.m. to 4:30 p.m. seven days per week to talk to the FNHA Health Benefits Isolation Support team.

Self-Isolation in Community

For most, leaving family, friends and community is a last option. As part of pandemic/Communicable Disease Planning, many communities have, or are in the process of creating, space to support one or more person to safely self-isolate in community. Self-isolation at home is the best place for most people; community self-isolation will likely be the next best choice, where this is not possible, refer to (Algorithm CP-3).

FNHA is working with communities to refresh their pandemic plans and prepare for self-isolation in First Nations communities. A series of options to enable self-isolation in community will be made available through FNHA for First Nation communities. These options may also be used by Island Health to engage municipalities regarding planning and preparation of self-isolation in non-Indigenous communities.

COMMUNITY COHORT CENTRES

COVID-19 Community Cohort Centres (CCC) are in place to provide individuals who live in rural, remote and First Nations communitites. Individuals who meet criteria and choose to leave community are provided with a space to safely self-isolate closer to acute care should their health deteriorate.

If a patient chooses to access a CCC; a practitioner will support an individual throuh their options. Status should contact First Nations Health Benefits at 1.888.305.1505 to discuss transport and accommodations for sympotomiatic and non-symptomatic individuals.

[4] https://www.fnha.ca/Documents/FNHA-A-Guide-To-COVID-19.pdf

Another options for out-of-community isolation are community cohort centres. First Nations, non-status and non-Indidenous individual are able to use these cohort centres. Primary Care providers will be required to seek approval for the patient to be sent to a CCC. The Community Cohort algorithm (CC-1) can be referred to support you through this process.

Community Cohort Centres

Island Health has arranged for ad hoc access to 3 hotels on Vancouver Island to supoprt self-isolation nearer to acute care sites.

Victoria Location - Howard Johnson
Nanaimo Location - Travelodge
Campbell River Location - Anchor Inn

Acute Care Cohort Receiving Sites

Island Health has 3 dedicated acute care cohort sites. These sites are for patients who are COVID-19 positive and require acute hospital care.

- RJH – for all Geo 3 and 4 COVID positive patients
- NRGH – for all Geo 1 and 2 COVID positive patient, except for patients cohorted at CVH
- CVH – for all Geo 1 patients who are MOST M1, M2, M3, and C0

Referral to a Community Cohort Centre

Due to COVID-19 precautions, self-isolation at home or in the community may not be possible. Need for accessing the CCC is determined through conversation with the patient/family and the circle of care and support; these discussions are highly individualized and may occur at any point during the patient journey.

The primary care provider will determine any co-morbidities associated to the patient's health that would increase their risk of hospitalization. A primary care provider may make a recommendation for a patient to travel to a CCC; the decision rests with the patient/family ensuring that all of the information to support self-determination has been shared and understood.

Referral Considerations

The following factors need to be considered before making a referral to a CCC:

1. The patient has been screened for COVID-19, has a presumptive or positive COVID-19 test result, and
2. The patient lives in a rural, remote or First Nations community, and/or
3. A patient is unable to safely self-isolate in the home or community.

Suitability for CCC

1. The circle of care should talk to the patient and escort, if applicable, about the need to self-isolate within their hotel room for up to 14 days.	Talk about provisions that may be needed to help ensure a comfortable and safe isolation period can be carried out.

a. In order to avoid transmission of COVID-19, patients/escort should not leave the room.	
2. All facilities require no-smoking in or on the premises.	Refer to quitnow.ca for support or talk to the primary care provider for cessation support.
3. Do they currently receive home support for their assistance?	It may be possible for home support to be provided in the CCC. This would need to be explored between the circle of care team and the Cohort Centre Lead
4. Are there other medical devices required to support a person's health	Be sure to create a checklist of all items to bring from home or have the circle of support arrange for item to be delivered to the CCC, if possible.
5. Does the patient want/need to have a family member or escort accompany them?	The patient may choose a person to accompany them for emotional support and/or to provide assistance with their activities of daily living. Pets are not permitted.
6. If the patient will be referred, please confirm if the patient has a means for buying groceries and/or meals for their stay.	There is a process for reimbursement for these expenses. If the patient does not have means, please call: health benefits for First Nations individuals and Island Health for non-First Nations individuals.

Cohort Referral Process

Individuals and groups of individuals may be referred a CCC by:

1) Primary care provider
    a. Health Directors should contact the primary care provider if they identify an individual(s) unable to safely self-isolate in their home or community
2) Public health official (Medical health Officer or Communicable Disease Team or a communicable disease nurse or Medical Office from FNHA)

Making the referral

Once it has been determined, and agreed by the patient, that a CCC is appropriate, the provider or public health official should:

1. Contact the CCC Manager/lead listed as the referral contact for the appropriate CCC location (see below) to discuss the referral.
2. Following acceptance into the CCC, complete a Community Cohort Centre Referral (see algorithm CC-1).
3. Once the referral has been received, a coordination call will take place between the primary care provider and CCC Lead/Delegate.

Should you have any questions during the process, please connect with the appropriate below.

CCC Referral location and contacts

Victoria Location	**Manager**	**Leader**
Howard Johnson 4670 Elk Lake Victoria, British Columbia V8Z 5M2 250-658-8989 Stephen Crann	Amanda Proznick Amanda.Proznick@viha.ca 250.519.3492 x32464 Mobile: 250.514.5182	Heidi Meseyton Heidi.Meseyton@viha.ca 250.519.3492 x32499
Nanaimo Location	**Manager**	**Leader**
Travelodge 96 Terminal Avenue North Nanaimo, BC, V9S 4J2 Monique de Chert	Helia Sillem Helia.Sillem@viha.ca 250.755.6238 x56238 Mobile: 250.616.8170	Donna Harvey Donna.Harvey@viha.ca 250.755.6200 x54724
Campbell River Location	**Manager**	**Leader**
Anchor Inn 261 Island Highway Campbell River, BC V9W 2B3 250-286-1131	Lindsay Risk Lindsay.Risk@viha.ca 250.850.2154 x62154 Mobile: 778.348.0247	Hannah Westby Hannah.Westby@VIHA.CA

APPENDICIES

Appendix A: Conversation Cue Card

To Support Early Transport with Trauma-Informed, Patient–Centred Conversation

This card is designed to help guide the conversation when offering transfer to a Community Cohort Centre for indigenous and non-indigenous people, so that a person with currently mild symptoms has closer (timely) access to ICU care if they deteriorate.

In order to best support this conversation in all patients and in particular with indigenous people, it is essential that this should be a "trauma informed" conversation, taking full account of the historical and cultural context in which people live. A key component of best practice includes the provision of culturally safe care that respects individual customs, values, and beliefs of the First Nations peoples and communities served by the FNHA (FNHA, 2013a).

1. Initiate the discussion

Key concepts: offer of early transport, patient centred, trauma lens, cultural safety. Explain that the patient has symptoms that could be consistent with COVID-19 and that it would be good speak about access to care and early transport.

- We want to work together to best support you to make your own choices around receiving care through the lens of cultural safety and humility as we partner together during this challenging time.
- Acknowledge the strength of the Indigenous community, the leaders, health workers, and membership on how they are working together to develop a health care support for their community. It would be important to acknowledge that you are a visitor to their traditional lands. Introduce yourself as a settler, or visitor, a health worker here to provide health support.
- Who would you like to be part of this discussion? (i.e. family, close friends, person you trust, nurse, physician, NP, etc.)
- Do you have any questions for me at this point? Is there anything you're concerned about / past experiences you want to share?
- Have you thought about what level of care you would like? (i.e. use the MOST levels as reference, but this might not be the time to complete the MOST form)
- Identify the transport issues from the community (i.e. air only, long drive, etc.) along with the fact that the provincial patient transport system will probably be over-stretched during the busy phase of the pandemic.
- Identify that some people with COVID-19 can deteriorate to needing ICU care, from being very mildly unwell, within a few hours. Identify that moving a person who is this sick is complicated and carries risk for the patient regarding the level of intervention needed en-route and whether they will be able to be in an ICU in the time frame that might save their life.

2. *Support patient in determining care and transport choices, including:*

"I want to go out now, while I am a little sick, so that I can be closer to a hospital if I become sicker. This also helps keep our transport system available for everyone else in my community who may be sicker than I am."

- Explain the cohort system, where they will be staying, that someone can go with them if necessary, that they can socially isolate at the facility, that food etc, will be looked after, and that there will be connectivity. Explain that they will be connected to a health team who can help monitor them and that their primary care provider can stay in touch with them via phone or virtual care

"I don't feel comfortable going out now. I am going to stay in my community, with close observation from my local team. I understand that if I become sicker, my local clinic or hospital may not have the equipment to take care of me. I know planning a medivac on short notice is difficult, and is not always possible, but staying home is more important to me as well as being closer to my supports."

"I want to stay in my community with the plan that if I become really sick, I do not want to be transferred out under any circumstances. I want to work closely with my local team to plan for this." See link: https://theconversationproject.org/wp-content/uploads/2017/02/ConversationProjectConvoStarterKit-English.pdf

- Revisit that this is optional and be clear that not wanting early transport might leave the person out of reach of an ICU in a timeline needed to save their life. Be clear that these decisions depend on personal values, beliefs, customs and that the person will be supported and will receive all care that can be provided locally if they choose to remain home.

Appendix B: Culturally Safe/Trauma Informed Approach

Approach to Creating a Culturally Safe Environment

Create a welcome space to increase respectful services support during this COVID–19 health crisis. Create signage and visuals based on Island Health's vision of C.A.R.E.

Guiding Principles

1. Proceed with no judgement. Beware of your body language, eye contact and way of being – physical presence communicates a lot and opens for a positive engagement with person receiving health support and the health worker.

2. Acknowledge the strength of the Indigenous community, the leaders, health workers, and membership on how they are working together to develop a health care support for their community. It would be important to acknowledge that you are a visitor to their traditional lands. Introduce yourself as a settler, or visitor, a health worker here to provide health support.

3. Create space where the Indigenous people feel emotionally, physically and culturally safe. Build trust and connection while supporting the client during the visit. Build a relationship before starting your assessment. Ask them how they are. Inform them of the COVID-19 care process and all the steps while assuring them they will be involved in choices and decisions related to their health care plan and transportation plan. Inform them of the transportation challenges and choices that will need to be made.

4. Have patience and give time for client to respond. Be vigilant and aware of biases or stereotypes that might be coming up for you or your colleagues and actively counter them to meet clients where they are at and to keep a culturally safe engagement with Indigenous clients.

5. As a result of a trigger, trauma, or other mechanisms, individuals may start to exhibit or experience reactions which may include altered ability to communicate. In these instances, it is best to slow the event as much as possible to support, or find support. Using the guide "First responders trauma informed practice" linked in the resources may be helpful.

We are in a powerful position as health care providers. To build a relationship and to create culturally safe care we need to explore how health support workers approach Indigenous clients. While we know Cultural Safety is much more than a Tip Sheet, please consider asking yourself these questions:

- Did I listen? Did I establish a rapport?
- Did I assure the person that I am here to work together and to support the client's choice in their health care?
- Did I ask if they want someone with them, a person that they trust, a family member, a friend, nurse, physician, NP, etc?
- Did I ask permission to swab and/or touch the client?
- Did I tell them what I was going to do and ask for permission?
- Did I hear the needs of the client?
- Did I take a moment to welcome them, was I aware of my tone and how I reached out to the client?
- Did I walk the person through the visit, so they understand the process?

- Did I explain the care options and let them know that the choice is theirs, and explain the transportation options?
- Did I ask if anything said was unclear or if they had any questions?
- Did I listen when faced with anger and frustration? Did I try to hear what the client may need?
- Was I conscious of my approach? More thoughtful of impacts than of my intentions?
- Do I know if what I shared was supportive, did I ask? Was I open to hearing feedback?

Appendix C: Self Care

During this stressful time, it is important to take care of yourself, protect yourself, and your family. It is important for you to find a way to look after yourself. This could mean finding time for yourself to take a walk, get connected to nature, plant a garden or to take time to unwind. Looking after yourself will create space to provide support in a respectful caring approach. Only when we are well, there is space to connect in a safe way and to promote wellness.

During this time of enhanced stress and new learning, it is imperative to allow time to learn, un-learn and apply your own style to build a healthy, safe interaction with the client. This will ensure a culturally safe health care service is provided and to ensure a positive experience for both the client and health care worker.

We are all in this together; we must ensure that everyone is included in our responses and how we offer care and support. Please keep in mind that every interaction matters.

Appendix D: Virtual Care and Monitoring

We want to work together to keep both patients and clinicians safe as well as ensure supports are in place for patients impacted by COVID-19. These systems require the ability for internet connection.

Virtual Services Resources
Information about virtual care services for patients:
https://www.islandhealth.ca/our-services/virtual-care-services

Information about virtual care services for providers:
https://medicalstaff.islandhealth.ca/COVID-19/virtual-care

A network of Information (BC Emergency Medicine Network)
https://www.bcemergencynetwork.ca/real-time-support/

First Nations Virtual Doctor of the Day
The First Nations Virtual Doctor of the Day program enables BC First Nations individuals to make virtual appointments with a doctor for non-COVID-19 related healthcare issues. The program supports First Nations people and their family members who live on-reserve or away-from-home (off-reserve) and who have limited or no access to their family doctor.

Where a person does not have a doctor of or lost access due to the COVID-19 pandemic, call 1-855-344-3800 to book an appointment. Medical office assistants are available to help seven days per week from 8:30 a.m. to 4:30 p.m.

HEiDi - virtual emergency physician

HEiDi provides virtual emergency physician support for the provincial 8-1-1. HEiDi's immediate goal is to increase capacity and assist nurses with decision support to meet the needs of the COVID-19 crisis, which has substantially increased the number of calls and time spent on calls due to inherent complexities. 8-1-1 nurses can transfer calls that meet specified clinical criteria to a Medical Office Assistant (MOA) who, in turn, will arrange for a virtual visit or call with a HEiDi physician.

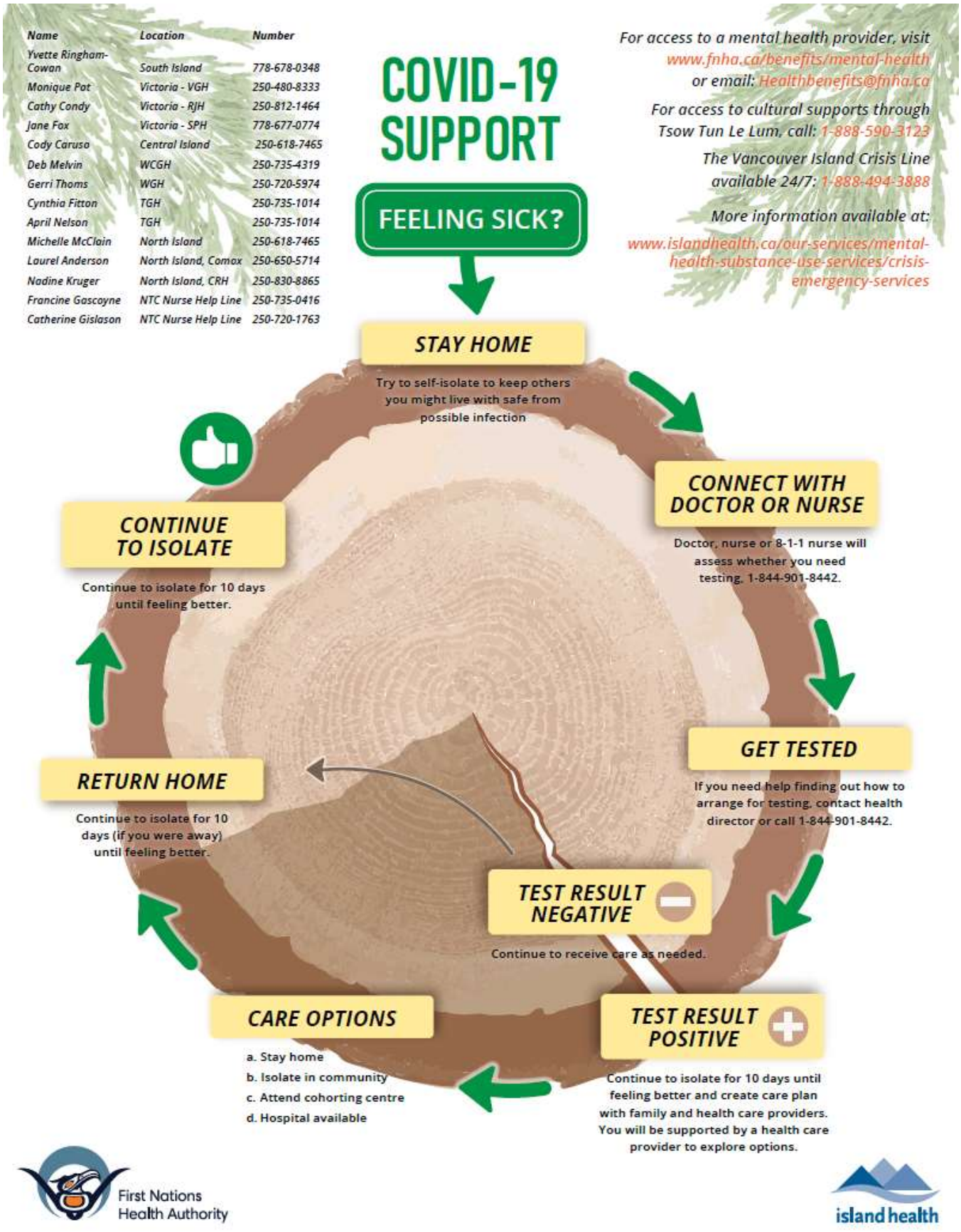
Virtual Monitoring

Intensive Home Monitoring
Uses remote patient monitoring technology to support people with mild to moderate COVID-19 symptoms, prioritizing populations most at risk of deterioration and poor outcomes. Patients can start the program before COVID-19 is confirmed, however it is advised that testing be arranged, if possible. Patients complete a daily monitoring plan designed to assess if their symptoms are improving or worsening, as well as reporting temperature and oxygen saturation multiple times a day. Patients are Community Health Nurses monitor the data and alerts, contacting Primary Care Providers (PCPs) to communicate changes in patients' condition as required. You can refer a patient to Intensive Home Monitoring by making a Community Health Services referral.

COVID-19 Virtual Monitoring
A Public Health remote patient monitoring service used to track patients who have tested positive or have been in contact with someone who tested positive. As Public Health is using the technology for surveillance monitoring, they refer patients who need symptom monitoring and support to Intensive Home Monitoring. Patients are on boarded to COVID-19 Virtual Monitoring through internal Public Health processes.

Home Health Monitoring
Continues to exist for patients with chronic disease (heart failure, COPD and diabetes). If a patient with chronic disease develops COVID-19 symptoms, they will be monitoring under Intensive Home Monitoring before switching over to Home Health Monitoring for longer monitoring, coaching and education. You can refer a patient to Home Health Monitoring by making a Community Health Services referral.

Appendix E: COVID-19 – Patient Pathway



Appendix F: COVID-19 – Notice and Follow-up Process for a Confirmed Case in a First Nations Community

First Nations Health Authority
Health through wellness

COVID-19 – Notice and Follow-up Process for a Confirmed Case in a First Nations Community

FNHA GUIDELINE

Pathway for disclosure in the event of a positive laboratory COVID-19 case in a First Nations community.

- The Medical Health Officer (MHO) of the Regional Health Authority (RHA) is informed of the positive test result directly by the provincial lab. The RHA MHO has the legal authority and responsibility for receiving Communicable Disease (CD) lab reports, making case determinations, and directing the appropriate CD management.
- Concurrently, the MHO from the RHA will notify the FNHA's Chief Medical Officer (CMO) of the positive test result, or the positive case would be identified through the FNHA's First Nations COVID-19 surveillance data linkage.
- The client is informed of the positive test results by the CD nurse from the RHA, primary health care provider, CHN, or health care provider who ordered the COVID-19 test.
- The RHA CD team will work directly with the First Nations community's nursing staff to support and provide CD follow-up for community member, in collaboration with the RHA and in accordance with staffing levels and capacity.
- The FNHA CMO notifies the FNHA's Communicable Disease Control (CDC) team of the positive case. The FNHA CDC team may be engaged by the RHA CDC team. The FNHA CDC team collaborate and liaise within the FNHA and with RHA colleagues to support CD follow-up within communities as requested.
- The FNHA CMO will notify the Regional Executive Director (RED) and the RED will notify the Chief and the community health director to inform them of a positive case in their community, emphasizing that no names or personal information will be provided.
- The circle of care (regulated health care professionals) and circle of support (community leaders, health directors) have information only on a need-to-know basis, and should not disclose personal information of a positive case. Privacy and confidentiality of personal health information will be upheld within the circle of care.

Personal information will not be disclosed by any employees or leaders without the express consent of the individual, unless the disclosure is permitted by law.

MAY 6, 2020

For First Nations individuals on release from Federal corrections facilities:

- Correctional Services Canada will inform the RHA MHO of the imminent release of a First Nations individual from their facilities, with details of the location where the individual intends to reside. The notification pathway above will be utilized to inform the appropriate First Nations community services.
- In the event that COVID-19 had been diagnosed in the facility before release, the individual on conditional release will be required to complete a monitored 14-day isolation period immediately. In the event that the individual had completed their warrant, a public health order would be put in to place to require that a similar supervised isolation period be completed.

Circle of Care: *the group of health care providers (e.g., nurse, physician and any other health care practitioner providing care to the client) who need the client's personal health information in order to provide health care.*

Circle of Support: *the group of support individuals (e.g., community leaders, health directors and any other support system that supports the Circle of Care and community at large) responding to the needs of the overall community's health and wellness.*

Richard Jock
Interim CEO, FNHA

Shannon McDonald
Acting CMO, FNHA

MAY 6, 2020

https://www.fnha.ca/Documents/FNHA-COVID-19-Pathway-for-Confirmed-Cases.pdf

Appendix G: Island Health/FNHA Communicable Disease Protocol- April 2020 (draft)

1.0 COVID-19 Roles, Responsibilities and Activities

1.1 First Nations Health Authority (FNHA)	**1.2 Regional Health Authority (RHA)**	**1.3 First Nations Health Service Organizations (in draft)**
Formed under the *Society Act*	Formed under the *Health Authorities Act*	
1.1.1 Medical Officers (MOs)	1.2.1 Medical Health Officers (MHOs)	1.3.1 First Nations Health Service Organizations (FNHSOs) • Where the FNHSO has an RN, that Nurse supports CD follow-up for Community members, in accordance with staffing levels and capacity • FNHSOs may also have support from a physician, nurse practitioner or remote certified nurse with the ability to do COVID-19 testing. Shipping processes and supplies may require support to implement.
• MOs are physicians, with both clinical and public health training • Do not have OIC-appointed MHO status • No *legal* authority and responsibility for receiving CD lab reports, making case determinations, and directing the appropriate CD management Can assist MHOs, Communities and FNHA health staff in carrying out RHA MHO-directed case follow-up activities	• MHOs are physicians, with both clinical and public health training • Have Order-in-Council (OIC) appointments • Have the *legal* authority and responsibility for receiving CD lab reports, making case determinations, and directing the appropriate CD management • This applies to all BC residents, including First Nations people on or off-reserve. The RHA MHO has specific statutory responsibilities to determine public health threats and to direct the response to local public health threats that FNHA staff and FNHSO CHNs should carry out[5]. Any logistical barriers should be discussed with the FNHA MO and FNHA Manager.	

(Reference: *BC Public Health Act*; CD Regulation; Provincial Health Officer Standard for MHOs).

1.1.4 FNHA CD Population & Public Health (CDPPH) CDC Nurse Team	**1.1.5 RHA CD Nurses and staff**	**1.1.6 First Nations Health Service Organizations (FNHSOs)**

[5] 1 As per BCCDC Communicable Disease Control Manual (April 2011).

• Centrally based in Vancouver • Provide CD consultation, education, training and resources to health staff working within communities • Collaborate and liaise within FNHA and with RHA colleagues to support CD follow-up within communities • Promotion of cultural safety, First Nations decision-making and control, and fostering meaningful collaboration and partnership with communities and RHA support follow-up • Consultative resource to • FNHSO health staff in community to carry out follow- • up as directed by the RHA	• Under the direction of the OIC MHO, the RHA CD nurses and staff coordinate CD follow-up and reporting within an RHA • This applies to all RHA residents, including First Nations people on or off-reserve • Follow-up and reporting completed as per BCCDC guidelines and RHA processes • Collaborate with FNHSO CHNs to complete follow-up within community	• 203 Communities • Multiple models of health service delivery, funding levels for health services based on Community membership, types of services offered

2 Who is made aware of confirmed (lab-test positive) cases of COVID-19?

2.0 Laboratory reports of all reportable CDs (including COVID-19) are sent to the RHA MHOs and Communicable Disease (CD) staff for follow-up, including testing completed by Health Care staff in a FNHSO, or FNHA-staffed heath care service location.

2.1 RHA public health staff conducting follow-up may become aware, in the course of their interview, that the case is an individual living in a First Nations community, or that a person living off-reserve receives services in a First Nations community, or has contacts within a First Nations community requiring follow up.

2.2 If RHA staff become aware of a confirmed case or significant case contacts in a First Nations Community, FNHA staff (CDPPH team (cdmgmt@fnha.ca, email monitored between 830-430, 7 days a week), Medical Officer-1-877-376-0691) should be informed as soon as possible (within 24 hours).

2.3 If required to co-ordinate CD management, the RHA CD staff will organize and chair a collaborative teleconference. Participants may include, based on nature of the situation and capacity:

- RHA MHO and CD staff
- FNHA Medical Officer, FNHA CDC Team representative
- Local FNHSO health staff directly involved in case management
- Other RHA partners or external stakeholders within the circle of care as appropriate

3.0 Verbal Reports of Respiratory Illness

Verbal or written reports of unconfirmed COVID-19 (symptomatic respiratory illness) in one or more individuals may be reported from a variety of sources, including public health or primary care teams both in a First Nations community and off-reserve.

Where the verbal report is received by the FNHA CD Nurse staff or Medical Officer a brief screening assessment is done to see if it meets the BCCDC guidelines case definitions for COVID-19. If yes, FNHA will advise follow-up with #811 or emergency care as appropriate, and notify RHA CD staff if indicated.

4.0 Background:

Principles and Goals – in creation of FNHA, the Tripartite Agreement states: "*A new Health Governance Structure that avoids the creation of separate and parallel First Nation and non-First Nation health systems and in which First Nations will plan, design, manage and deliver certain health programs and services in British Columbia and undertake other health and wellness-related functions".*

a. The FNHA Senior Medical Officers (MOs), CD Population and Public Health (CDPPH) CD Control (CDC) Nurses, Environmental Health Officers (EHOs) and First Nations Health Service Organization (FNHSO) health staff are essential parts of the public health team and system in BC and part of the circle of care for First Nations people and communities.
b. In BC, the public health team and system work in collaboration to ensure continuity of care for First Nations people and communities; the various roles are complementary to each other.
c. All individuals living in First Nations communities in BC have access to the same high-quality CDC service as the rest of the BC population.
d. Create no duplication or unnecessary redundancy in effort
e. Recognize the BC *Public Health Act* and CD Regulation legislative authority and the PHO standard, and the authority/responsibility of Order-in-Council (OIC) RHA-MHOs.
f. Recognize that the Tripartite Agreement establishes First Nations self-determination in all health and public health matters in First Nations communities.
g. Build public health capacity and strengthen CD knowledge in First Nations communities.
h. Ensure reciprocal accountability and effective communication among all parties in this protocol and First Nations communities.
i. Ensure cultural safety and humility within the BC public health system for First Nations people and communities.

Appendix H: Patient Resources

FNHA A Guide to COVID-19
Caring for yourself and your loved ones
https://www.fnha.ca/Documents/FNHA-A-Guide-To-COVID-19.pdf

FNHA COVID-19 information - public
What You Need to Know, Prevention & Protection, Symptoms & Testing, Health Benefits & Medical Support, Mental Health & Wellness, Substance Use & Harm Reduction
https://www.fnha.ca/what-we-do/communicable-disease-control/coronavirus/public

FNHA COVID-19 information – health professionals
CD Emergency Response Planning, COVID-19 Management, Infection Prevention & Control, Nursing Practice
https://www.fnha.ca/what-we-do/communicable-disease-control/coronavirus/health-professionals

Mental Health and Cultural Supports
A list of mental health and cultural supports available during the pandemic
https://www.fnha.ca/Documents/FNHA-COVID-19-Mental-Health-and-Cultural-Supports.pdf

COVID-19 Self-assessment tool
The Province of BC's COVID-19 self-assessment tool
https://bc.thrive.health/

Trauma and mental health (article)
https://www.fnha.ca/about/news-and-events/news/impacts-of-the-pandemic-on-mental-health-and-wellness

Trauma Informed Teaching and Learning
A one-page overview of trauma-informed teaching and learning principles and practices to support educators during a global health crisis; created to help educators who are managing the quick move to online teaching during the COVID-19 pandemic.
https://academiccommons.columbia.edu/doi/10.7916/d8-gc9d-na95

Drawing on Indigenous Strengths to Stay Connected and Well
In First Nations culture, our holistic practices can help ease feelings of personal, collective, and inter-generational stress during the pandemic. Taking care of our wellness will calm us while we fulfill critical roles within our families and communities.
https://www.fnha.ca/Documents/FNHA-Staying-Connected-During-the-COVID-19-Pandemic.pdf

Keeping kids active
A list of fun and interactive indoor activities
https://www.fnha.ca/Documents/FNHA-Keeping-Kids-Active-During-the-Pandemic.pdf

Keeping active at home (article)
https://www.fnha.ca/about/news-and-events/news/good-medicine-keeping-active-at-home

First responders' trauma informed practice

Tips for Providing a Trauma-informed Response during the Pandemic
https://www.fnha.ca/Documents/FNHA-First-Responders-and-Trauma-Informed-Care.pdf