Port Hope Northumberland Community Health Centre

*"Building a healthier community together"*

Community Health and Wellbeing | Shift the conversation / Changer la conversation | JUNE 8 - 9 JUIN 2016 Sheraton Parkway Toronto North Richmond Hill | Santé communautaire et bien-être

# Outreach to Diverse Populations

## Travelling Beyond the Walls



Recognizing that not everyone has access to health services through the usual channels

# Presenter Disclosure

| | | |
|---|---|---|
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**Relationships to commercial interests:**

| | |
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# The Model of Health & Wellbeing

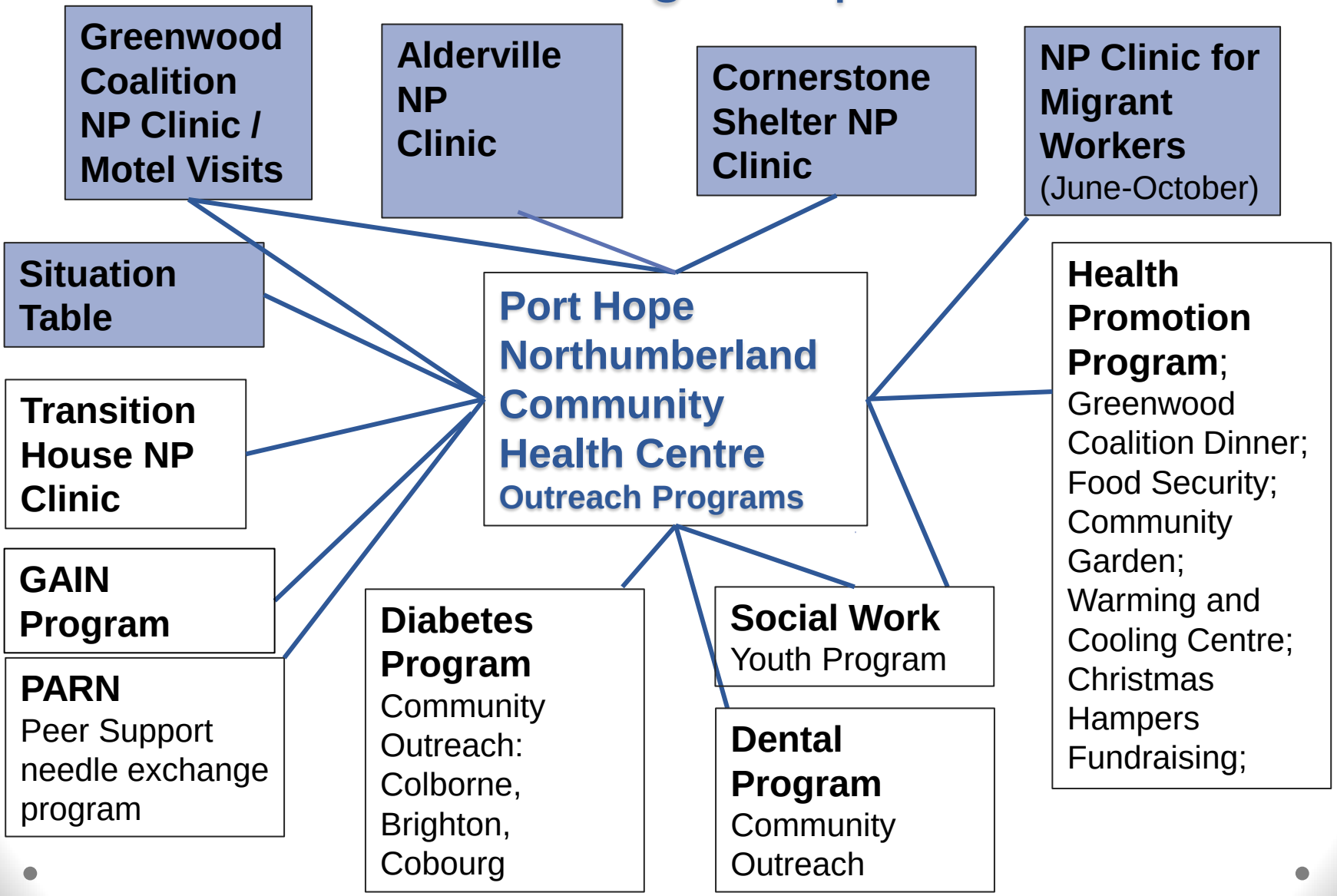


# The Social Determinants of Health

- Employment
- Adequate income
- Affordable housing
- Food security
- Education

# Organizational Perspective

## Outreach Target Population



# Definition of Outreach

An activity of providing services to any populations who might not otherwise have access to those services. A key component of *outreach* is that the groups providing it are ***not stationary, but mobile***; in other words they are meeting those in need of *outreach* services at the locations where those in need are.

# Target Groups




- Elderly with chronic conditions
- Youth at risk
- Those struggling with mental health issues or addictions
- Those living on a fixed income or limited income
- Transient populations

# How Poverty Affects Our Communities

**Financial Reality**

- Basic grocery cost per month for family of four: $655
- Average rental rate for a one-bedroom apartment in Cobourg: $813
- Ontario Works for a single person: $626 per month
- Ontario minimum wage: $11 per hour
- Northumberland residents living in poverty: 12.1 per cent
- Unemployment rate in Northumberland: 8.3 per cent

***SOURCE:*** *Northumberland Poverty Reduction Action Committee 2012/2013 status report, Haliburton, Kawartha Pine Ridge District Health Unit*

# Port Hope Northumberland CHC and Green Wood Coalition



Janet Marchand
Nurse Practitioner

# Outreach Collaboration with Green Wood Coalition

**The Green Wood Coalition** started in the summer of 2006 when Amy Brinkman came across the Green Wood Tower Inn. The motel offered monthly accommodation to individuals and families who might otherwise be homeless.

By 2009 the Green Wood Coalition was formally established as a non-profit organization. David Sheffield was hired in the role of Community Outreach Worker allowing an expansion of scope beyond the motel to include the town and neighboring communities. Its focus remains **creating opportunity for a future for people living in poverty, mental illness, addiction, alienation or other disabilities.**

The Green Wood Coalition has evolved to offer a place of belonging, connecting people who are disconnected, filling gaps left by traditional agencies and ultimately building a community of hope.

**Part of the PHNCHC outreach program is enabled and delivered in collaboration with the Green Wood Coalition.**





# Green Wood Coalition Activities

**Weekly Community Dinner***

**Homeless Outreach***

**Improved Access to Health Care***

**Wraparound Life Planning***

**Redpath recovery program**

**Creative Arts Program**

**Community Garden**








*NP Outreach Activities

# Nurse Practitioner Outreach
## (since 2010)

- Weekly 2-hour clinic delivered at the Community Dinner; 5-17 clients seen
- Monthly walk around visit to the Green Wood Tower Inn
- Home visits/ street level outreach in the community as needed
- **Creating trusting relationships in a safe environment**
- **Referrals through word of mouth**
- **Consistent presence**



**Services provided:**

Diagnose illness and injuries, Perform physical examinations, Order and interpret diagnostic tests and procedures, Provide Education, and counselling, Patient advocacy, Participate in wraparound life, Planning, Food security, Refer clients to other health care professionals and specialists, Prescribe medication and preventive immunizations (e.g. Flu Clinic), Manage chronic diseases such as hypertension, COPD and mental illness



## Community Dinner

## Harvest Time





## Resident Artist

## Fan Day



# Poverty is a Health Risk Factor

**Cancer**
Those in low income groups experience higher rates of lung, oral (OR 2.41) and cervical (RR 2.08) cancers

**Diabetes**
Lower-income individuals are more likely to report having diabetes than higher-earning individuals (10% vs 5% in men, 8% vs. 3% in women)

**Chronic Disease**
Individuals living in poverty experience an elevated risk of hypertension, arthritis, COPD, asthma, and having multiple chronic conditions

**Cardiovascular Disease**
Those in the lowest income group experience circulatory conditions at a rate 17% higher than the Canadian average

**Toxic Stress**
Children from low income families are more likely to develop a condition that requires treatment by a physician later in life

**Mental Illness**
Those living below the poverty line experience depression at a rate 58% higher than the Canadian average.6

Source: Centre for Effective Practice

# Case Study:
## Addressing Health and its Social Determinants

Ron is a 57 year old man who was living on the beach for several months. He had lived at one of the shelters but had his belongings stolen. He felt it was safer outdoors. He also found it too difficult to live with the rules that were imposed at the shelters. He had been in contact with the Northumberland Hills Mental Health Outreach Worker, a Public Health Nurse and a Green Wood Coalition Outreach Worker. I was asked to see him for a problem with his hand.

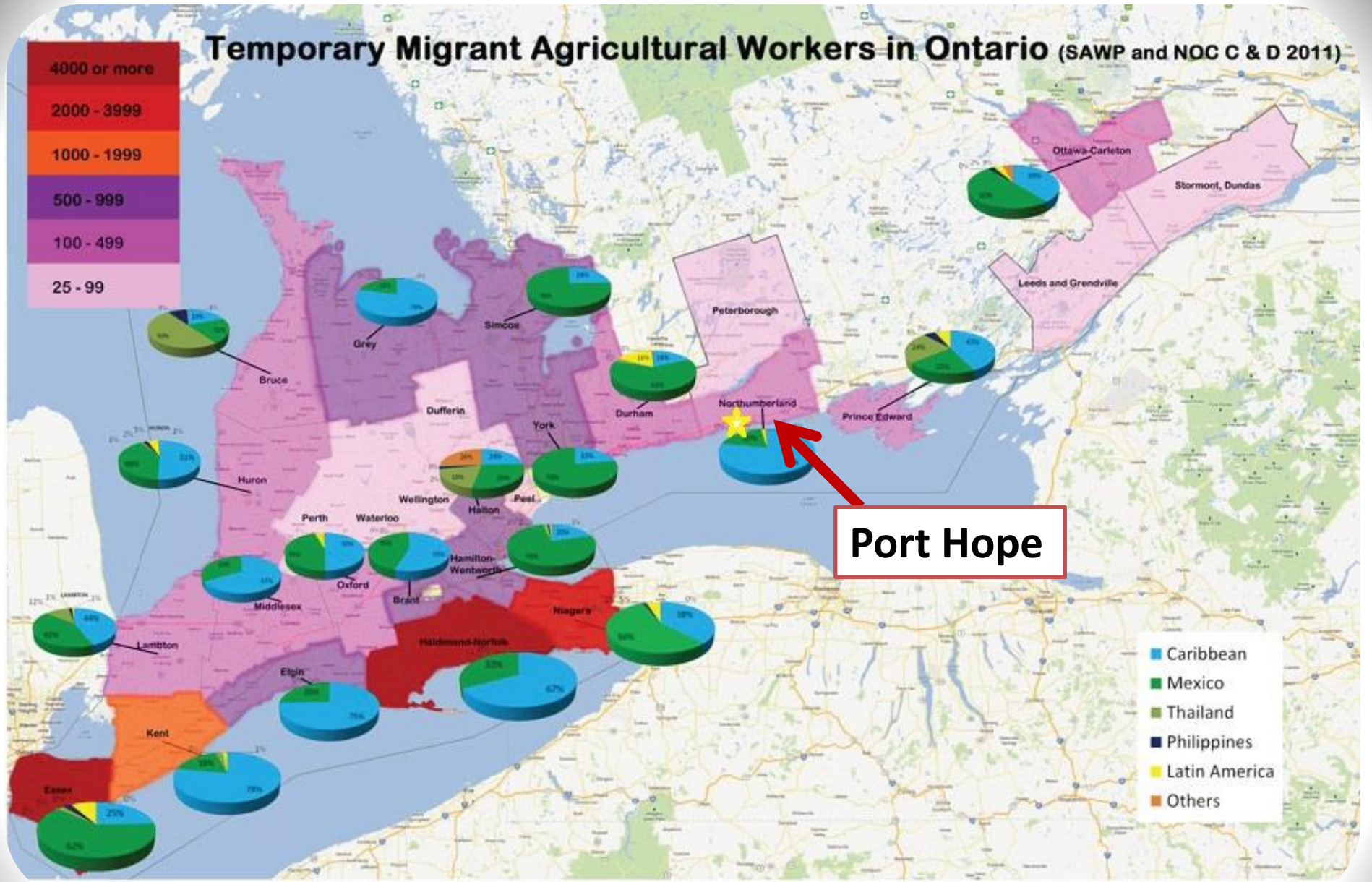
# Future Possibilities

- Basic income guarantee
- Creative housing projects
- Improve affordable transportation
- More community agency collaboration (Situation Table)
- Satellite clinics

# Port Hope Northumberland CHC and Migrant Farm Workers



Lydia Rybenko
Nurse Practitioner




d on HRSDC data, designed by www.migrantworkerhealth.ca

# Experience with Migrant Farm Workers

- June to October, 12 evenings
- New Canadians Centre in Cobourg
- 35-68 workers seen, average age 43.7 (27-54)



# Common Stressors



- Family
- Work environment
- Living conditions
- Racism
- Lack of social connectedness
- Injury and illness

# Common Conditions Seen

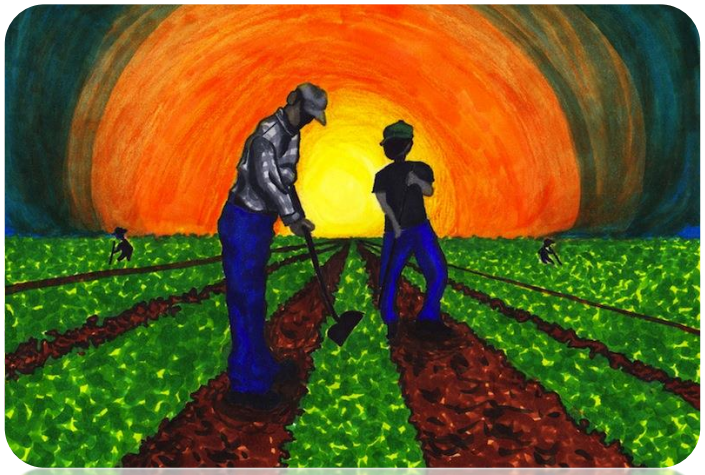
- Tendinitis, strains, back pain
- Gastrointestinal
- Sleep disturbances
- Infections
- Rashes
- Osteoarthritis
- Visits for blood pressure monitoring
- URI, sinusitis
- Physical exams
- Chronic disease management
  e.g. AF, DM



# Accomplishments

- Reaching a marginalized population
- Building trust, long term relationships
- Averting emergency department visits
- Going into 5th year of service
- Enhancing community partnerships

NEW CANADIANS CENTRE PETERBOROUGH



# Challenges – client care

- Disclosure of potential sexual activity and sexually transmitted infection symptoms
- Depression manifesting as somatic complaints
- Sourcing medications
- Advising chronic conditions may be limiting work ability
- Fear of employers discovering illness and sending worker home
- Difficult to access during day, no time off



# Challenges - system

- Encouraging migrant workers to access
- Occupational health expertise lacking
- Ideally weekly clinic
- Labs and imaging not open in evening
- No walk-in clinics in the area = use of emergency department



# Future Directions

## what is planned? what is needed ?

- Port Hope CHC will continue to provide services
- Provision of dental services
- Community Health Centres are positioned:
  - salaried staff
  - marginalized population
  - access to many disciplines
  - health promotion
  - chronic disease management

# Port Hope Northumberland CHC Alderville First Nations Outreach



Jane Spencer

Nurse Practitioner

# Background

## Alderville First Nations Reservation:

- 40 km from PHNCHC
- Anishinabee – Ojibway
- 350 Community Members – On Reserve
- 650 Members – Off Reserve (can still access Health Centre and NP Services



# Access to Services

- How we linked
- Non Community /Non Band members
- However, CAN access my services (OHIP)



# Statistics

- First Nations are 3-5 x higher incidence of Diabetes
- Life expectancy is 5-10 years less than the general population
- Elevated obesity rates (Adults 36%)
- Food insecurity and poor water quality (1/2 population has no access to potable water)
- Isolation
- Mental health issues
- Statistically elevated chronic diseases



# A Typical Day at the Clinic

# Grassroots Clinics

With CHN facilitated community-based screening clinics:
Health promotion/disease prevention/screening.

*Based on:*

- Client request
- Interest
- Dissatisfaction with current care
- Aboriginal health risks



# What We Know About Cancer and First Nations

Cervical Cancer

Breast Cancer

Colorectal Cancer



# Risk Factors

- Decreased Education
- Financial Insecurity
- Women in crises (don’t access HC)
- Distrust
- No health care provider OR don’t access (distance, time)
- Use of Traditional medicine

# Goals

- Culturally appropriate health promotion
- Education
- Accessible & equitable health services



# Grassroots Screening Clinics

- Evidenced based
- Comfortable/non threatening environment

  30 minutes with RN

  30 minutes with NP

**Receive:**

- Health Passport – normal parameters, results
- Print education
- Time for questions
- Link to other HC services
- Gift
- f/u booked at appointment

# Another Initiative: Women's/Men's Clinic

- Foster trust
- Primary/preventative care
- Decrease financial, travel barriers
- Encourage participation in health care
- Holistic health care programs

# Success

- 31 women and 17 men
- 48 participants now UTD
- 61% attending health programming/promotion services
- Women's clinic now q 6 months – (requested)

**Collaboration with PHNCHC:**

- Referrals: -Dental, SW, Dietician, DEC
- Many patients taken into my practice

# Travelling Clinic

**“Take the Clinic to the Community”**

Meet the needs of:

- Housebound
- Not attending clinic/health services
- Community members that NEVER enter Health Centre
- Distrust

# Method

- Van
- Travel
- KISS
- Invite: “connection”



# How We Did It?

- Community Newsletter “The Medicine Wheel” (350 households)
- Alderville – Facebook
- Community Posters
- Personal invite – (wives for husbands!)
- Word of mouth

# Success

- 222 clients seen over 2 years
- 29% increase of these clients to health services POST travelling clinic

# Barriers to Health Care

Barriers for **ALL** services:

- Lack of time
- No transportation
- No childcare
- Not feeling ‘part of own health care’
- Mistrust of ‘off’ Reserve health care providers

# Visibility

Not just primary care: NP

- Diabetes Education Days x 2
- Growth and Development Screening Clinics
- QIP Cancer Screening Project (banner/video)
- Giant colon
- Cancer screening: Pink Bus (breast Ca)
- Lunch & Learns
- Diabetes Support Groups
- Home Visits



# Optimism

**Return of culture:**

- Pow Wow
- Traditional Dancing/Ceremonies
- Traditional Healer (3/monthly)
- Ojibway language classes
- Sweat Lodge
- Solar farm – (Ont. Power Authority)
- Water treatment plant



**Food Security:**

- Food Box
- Community garden/patio planters
- Healthy Cooking classes
- Physical challenges: elder/adult/children

# Future visions

- STI clinics – confidentiality issue BUT increases access
- Well child visits – ‘friendly visit”/Teddy bear picnic
- Next Travelling Clinic – Diabetes focused.



# QUESTIONS?