# INDIGENOUS BLOOD PRESSURE SCREENING LEARNING & SHARING EVENT

With Kathy Brant & Maureen Buchanan

November 24th, 2020 from 12:00-4:00PM via Microsoft Teams

March 1, 2021

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*CHAP=Cardiovascular Health Awareness Program

# Executive Summary

The Indigenous Blood Pressure (BP) Screening Learning & Sharing Event, delivered by Kathy Brant and Maureen Buchannan, brought together the Indigenous Interprofessional Primary Care Team (IIPCT) and many stakeholders supportive of the IIPCT in their potential to adapt the Deseronto BP screening model and improve vascular health of Indigenous peoples in local communities. The event gave participants the opportunity to learn about the model, a culturally sensitive approach to community-based blood pressure screening. Maureen and Kathy provided an overview of the Deseronto BP screening program and highlighted the following **key elements needed for implementation:**

- **Persistent vision** that a community BP program provides culturally safe access to health services
- **Community connections**
  - Kathy Brant played a key role in engaging community members
- **Leadership**
  - Indigenous community governance-connection with the *Governance Circle*
  - Clinical leadership (Maureen Buchanan provided clinical leadership)
  - Champion(s) to lead local efforts and spread
- **Management support and commitment** (Napanee Area CHC was very supportive)
- **Holistic approach**- emotional, spiritual, mental, and physical
- **Recruitment and retention of volunteers and a process for ongoing training**
- **Collegial and collaborative team including volunteers**
- **Buy-in from primary care providers** who will provide follow up care
- **Localized Cardiovascular Health Awareness Program (**CHAP**) protocols and forms**
- **Automated data/health information collection system** to help monitor and sustain efforts
- **Accessible and convenient spaces/locations** for screening

The event also provided participants with the opportunity to inform an action plan. The following summarizes **ideas shared about what is needed for the IIPCT to begin planning the BP program**:

- **Use a virtual approach for planning and early engagement** given COVID restrictions.
- **Start with cultural grounding** amongst the team. Participants suggested **connecting with Cherylann Brant, Indigenous Community Wellness Worker** to help the team with further cultural grounding.
- **Learn more about the Mohawk teachings including use of the Strawberry metaphor.**
- **Begin staking the ground for engagement; make community connections** including connecting/consulting with community Elders and Knowledge Keepers to further forge relationships. Connect with the Community Development Worker (Kathy Brant).
- **Update and localize the Deseronto BP Protocol and process forms** adapted from CHAP.
- **Start small and locally**. **Do a staged approach** to engage the community starting with the clinic and Tyendinaga area before expanding to other Indigenous communities.
- **Determine key champions**.
- **Recruit 3-4 core volunteers** to help with planning. **Coordinate 3-4 hours of volunteer training**
- Figure out **where/how to hold the screenings and the training**. Also determine space in Deseronto.

The Indigenous BP Screening Event with the IIPCT was well-received. There was the sense of great collaboration amongst participants. Participants voiced their enthusiasm during the event and requested to be included in the journey of adapting and spreading the Deseronto Indigenous BP Screening model with Indigenous communities. IIPCT indicated that they would "*like to see the Indigenous BP Screening Program up and running."*

**Next immediate step:** IIPCT to lead and form a workgroup to begin planning via virtual platforms. IIPCT to connect with participants from this event to assist with planning and training, as needed.

# 1.0 Introductions & Welcome

## 1.1 Welcome

- Kathy Brant opened the Indigenous Blood Pressure Screening Event with a traditional welcome.
- Heather Jenkins provided instructions regarding the use of Microsoft Teams.
- Kathy Brant, an Indigenous Community Development Worker, and favoured Grandmother, Auntie and Knowledge Keeper and Maureen Buchanan, Indigenous retired Nurse Practitioner led the delivery of the event. Maureen and Kathy were the key leaders in the development of the Deseronto Indigenous Blood Pressure Screening Program.

## 1.2 Introductions

A virtual round of introductions was conducted with participants indicating their background and interest for participating in the event. **Participants at the meeting** included team representatives from the: Indigenous Interprofessional Care Team (IIPCT), Mohawks of the Bay of Quinte (MBQ) Community Well Being Centre, Kingston Community Health Centres-Napanee Area CHC site, Ontario Native Women's Association, Indigenous Diabetes Health Circle (Eastern Region), Cardiovascular Health Awareness Program (CHAP), Stroke Network of Southeastern Ontario with Quinte District Stroke Centre, and Ontario Renal Network and Renal Program at Kingston Health Sciences Centre (See Appendix A for detailed list of participants).

## 1.3 Main Objectives

- To learn about a culturally sensitive approach to community-based blood pressure screening.
- To inform an action plan for Indigenous blood pressure screening with the Indigenous Interprofessional Primary Care Team.

# 2.0 Description & Key Learnings of the Deseronto Blood Pressure Screening Program (See Appendix B for Presentation Slides)

## 2.1 Beginnings & Vision- Why was this Program Needed?

- Kathy Brant and Maureen Buchanan shared stories about their experiences with vascular conditions making the connection as to why the Deseronto Indigenous Blood Pressure (BP) Screening Program was needed.
- There are higher rates of vascular conditions including stroke, heart disease, and chronic kidney disease amongst Indigenous populations (up to 2 times higher than non-Indigenous populations). Indigenous people tend to present later in their disease trajectory and have more severe presentations (e.g., amputation rates are higher). There are also higher rates of vascular conditions among young Indigenous people. Hospitalization rates are higher amongst Indigenous populations. The high hospitalization rates have been associated with limited access to primary and preventative health care.
- High blood pressure is a major risk factor for vascular conditions. Many people with high blood pressure have other vascular risk factors including diabetes.
- It is widely accepted that the legacy of colonization has had a far reaching impact on the health of Indigenous peoples. In the context of historical oppression of Indigenous people, culturally safe care is effective care provided in a manner in which Indigenous identity and personhood is acknowledged and valued. A community development approach that embraces cultural safety is essential to the health and well-being of Indigenous people.

- Kathy described the community of Deseronto and her connections to the community. She added, "*There is great strength in community*."
- Maureen and Kathy indicated that the vision for the Indigenous BP program was to provide a culturally safe community engagement approach for BP screening. The program was launched in 2013. It was inspired by Mohawk teachings and an evidence informed protocol adapted from the Cardiovascular Health Awareness Program (CHAP) (See Items 2.3 & 3.0).
- Early planning involved figuring out how best to meet the needs of the people. Maureen & Kathy indicated that we do not talk enough about the perspective that, *"I'm important to be cared for"* and *"having a cultural identity and culture-based care is important for off reserve communities too."* There is a "*shyness*" about self-identification and talking about Indigenous ancestry -*"Am I enough?"*
- Maureen as an Indigenous Nurse Practitioner (NP) at the time, worked within a non-Indigenous Community Health Centre (CHC). There was "deepen awareness" through a series of community consultations linking with Indigenous Health Council (IHC) to determine how organizations (e.g., CHC) should meet the needs of Indigenous peoples.
- During early planning for the Indigenous BP project, the IHC was forming. There was dialogue with the IHC and subsequent approval of the Indigenous BP project by the IHC. The BP screening project was designed in consultation with the IHC. The IHC is a collective of Indigenous community members who have accepted the responsibility to speak for the needs of the community and exercise cultural governance of the Kingston CHC Indigenous Health Program including the Indigenous BP program.
- In keeping with cultural safety, the IHC, David Jock, Traditional Medicine Person, Maureen Buchanan, Indigenous Nurse Practitioner and Kathy Brant, Community Development Worker engaged the Kingston CHCs to create a culturally congruent evidence-based approach to BP screening.

## 2.2 Culturally Safe Approach Using Mohawk Teachings

- Kathy and Maureen explained that, "*Culture is good medicine*." Culture was the "*Heart*" of the Indigenous BP screening project.
- The Deseronto BP Screening project was a culture-based community development approach to BP screening based on Mohawk teachings derived from: **The Great Law of Peace (A Good Mind), Ohenton kariwateh'kwen (The Words Before All Else)** and **She:kon Skennen kowa ken (Greetings, do you carry the Great Peace?).** Kathy further explained the teachings as having-
    - A *Good Mind* and treating everything and everyone fairly as if they are family. A cornerstone of the program was that aunties and uncles by screening blood pressure were taking care of extended family and neighbors, embodying the teaching of the *Good Mind*.
    - Deep gratitude and equality with all of Creation or *The Words before All Else*.
    - Gratitude to be of service to one another, as expressed in the greeting*, "Do you carry the Great Peace?"*
- The **Strawberry** is an important metaphor and is part of the teaching of the Indigenous BP program (see Figure 1, p. 5). The strawberry represents **Konnonronhwka**, meaning ***I show you I care*** *(Jan Longboat, Mohawk Elder[1] )* reflecting the central ethic of the BP program*:* ***Treat Everyone like Family.*** The strawberry is a metaphor for the connection of the heart to all organs and parts of the human body, as is the berry connected to the plant by a vast interconnection of leaves, runners and roots. It helps us understand the connection between mind, body, spirit and emotions and the heart as a guide to maintain personal balance. It is also a metaphor for community because it

[1] (Wabano Center for Aboriginal Health, 2016)

creates a community of plants by way of runners. The berry embodies that ethic of- ***I show you I care***.

**Figure 1: Konnonronhwka**
**Artwork by Christie Belcourt**

- Kathy explained further that the BP program is rooted in the *Great Law of Peace* and asks, "*Are you still carrying that great peace?*" One starts to build a relationship with another person with that greeting. Kathy indicated that her responsibility is to help with relationship building. Kathy further elaborated that we need to:
    - Take care of each other, "*You are the most precious person*" and "*I show you I care*"
    - Have an active commitment to compassion
    - Help people with building their health and carrying a *Good Mind*

## 2.3 Culturally Safe Volunteer Training & Screening

- Kathy and Maureen described the volunteer component of the program.
- Community volunteers including aunties and uncles underwent training which included use of automated BP devices following an evidence-based BP protocol from the Cardiovascular Health Awareness Program (CHAP) (See Item 2.4 & Appendix C). The Stroke Network SEO supported the training.
- The educational process of training volunteers used **Indigenous methods** of learning including **circle protocol and opening with the *Words before All Else*, followed by storytelling** about personal relationships to vascular health. Based on personal stories, volunteers saw the much higher rate of vascular conditions in the lives of Indigenous volunteers and extended families as compared to non-Indigenous volunteers which gave rise to discussion about the **impact of colonization on health**. The Desertonto BP training and screening used the **Medicine Wheel** to discuss a holistic approach (emotional, spiritual, physical and mental) to health and wellness and the **concept of imbalance** as a key underlying concept for vascular conditions. Through this lens, modifiable risk factors are examined. Finally, the concept of **non-interference is explored**. Non-interference from an Indigenous perspective embraces autonomy and acknowledges that each individual has their own journey, gifts and challenges and it is up to them how they conduct their lives. In this light, there is discussion about the balance and synergy between non-interference and respectfully inviting individuals into motivational "change talk" with self-management principles.
- A nurse also assisted with the volunteer training (e.g., how to take accurate BP measurements with use of automated BP machines).
- The nurse also followed up with volunteers after the BP screening sessions.
- Up to recently there was a training session held once per year.
- It is important to have the following elements for volunteer screening:
    - Pool of trained volunteers

    - Core group of volunteers as champions
    - Volunteer schedule with rotating of days
- Volunteers were central to the BP screening program. They were the "*gentl*e" leaders of the program and were valued as "*peer health mentors*."
- Volunteers indicated that they had a "*great time*" participating in the program.

## 2.4 Evidence-Based BP Protocol from Cardiovascular Health Awareness Program (CHAP)

- An evidenced-based BP protocol, based on the Cardiovascular Health Awareness Program (CHAP)[2] with interventions borne out of randomized control trials, was adapted to local context (See Item 3.0 for beneficial impact of CHAP).
- A video was played providing a brief general description of CHAP (click **here** for the video).
- CHAP was a CIHR[3] funded research study developed in 2000 by Dr. Janusz Kaczorowski, who at the time was at the Department of Family Medicine at McMaster University, Hamilton and Dr. Larry Chambers, Elisabeth Bruyère Research Institute, University of Ottawa.
- CHAP utilizes peer health educators in a familiar community setting (e.g., local pharmacies and social housing) to identify risk and promote cardiovascular health including BP monitoring.
- The BP protocol was adapted to the local setting and was informed by many including primary care physicians (See Appendix C).
- The BP protocol was further modified by Dr. Imaan Bayoumi, Dr. Benjamin Chen, and Maureen Buchanan NP with input from the Stroke Network SEO.
    - Dr. Chen and Dr. Bayoumi were the physicians who reviewed the BP protocol and overall project.
    - The BP protocol had lower thresholds for connecting to providers due to the locations of the BP screening, transportation issues, and social determinants of health. For example, there was a lower threshold for when to arrange transportation to Lennox & Addington County General Hospital (L&ACGH) Emergency Department (ED).
        - Dr. Sloan asked how often that people were sent to the L&ACGH ED.
            - Maureen indicated that it was very rare that transfers to ED were necessary. Maureen recalled only 2 times over many years that this occurred.
    - The BP protocol was extended to atrial fibrillation screening. If the device noted irregular heartbeat, connection was made with the Community Health Nurse (CHN) as per protocol.
- The protocol was always centered around and led by the participant.
- The evidence-based BP protocol guides the actions of the volunteers, Community Development Worker, and the CHN to facilitate effective and timely intervention by a primary care provider.

## 2.5 Review Evidence/Impact from CHAP (See also Item 2.4 above)

- Janusz Kaczorowski who has been involved with CHAP since its inception, reviewed the evidence and benefits for CHAP (See Appendix H for presentation slides).
- CHAP has been an effective community-based intervention at the population level. A large study recognized internationally & published in *British Medical Journal* illustrates its success in

[2] Kaczorowski, J., Chambers, L.W., Dolovich, L., Paterson, J.M., Karwalajtys, T., Gierman, T., et al. (2011). Improving cardiovascular health at population level: 39 community cluster randomized trial of Cardiovascular Health Awareness Program (CHAP). *BMJ.* 342, d422. doi: 10.1136/bmj.d442. Retrieved from http://www.bmj.com/content/342/bmj.d442

[3] Canadian Institutes of Health Research

contributing to population health-"*Improving cardiovascular health at the population level."* Click **here** for the article.
    - Communities that implemented CHAP demonstrated a statistically significant reduction in hospital admissions (3.02 fewer annual hospital admissions for cardiovascular disease per 1000 people aged 65 years and over).
    - Empowers a person's ownership of health.
- The program can be run in areas with limited experience with BP screening.
- CHAP is operational in many different settings such as in pharmacies and social housing. If there are financial issues, Ontario Works and Ontario Disability Support Program (ODSP) cover medications, if confirmed diagnosis of hypertension.
- Janusz described 3 different "users" of CHAP: 1) screening; 2) Diagnostic-need to screen for a 7 day period, mornings and evenings; and 3) ongoing-follow up
    - CHAP is brought to communities and is meant to be mobile.
    - CHAP can be contextualized to meet the needs of local communities.
    - Currently running in 2 communities with large Indigenous populations
    - Have translated to culturally appropriate resources
    - Extended to other countries such as Philippines and Thailand.
- Connections have been made with additional conditions such as type 2 diabetes and atrial fibrillation screening and with links to other wellness programs such as smoking cessation. CHAP has partnered with other health organizations such as the YMCA.
- Physical activity is captured and aligns with participant preferences (e.g., yoga). Healthy eating is also captured including how to eat well on a limited budget; describes what kind of food to avoid.

## 2.6 Typical Routine and Features of the BP Program within the Clinic Setting & Community Gatherings

**BP Screening in the Deseronto Clinic**

- Maureen Buchanan and Kathy Brant described the typical routine and features of the Indigenous BP screening program.
- Culturally congruent venues were chosen to facilitate a sense of belonging including having a kitchen table-like setting at the Deseronto clinic, the Tyendinaga Powwow and the monthly Diner's club.
    - Kathy Brant created a warm home-like atmosphere helping to bridge the cultural divide between Indigenous and non-Indigenous communities.
    - The "*de-medicalization*" with the "*kitchen table*" atmosphere helped build trust.
- Outside the Deseronto Clinic was posted a Welcome Sign.
- Kathy Brant welcomed people into the clinic using traditional greetings.
    - Kathy with her *welcoming smile,* was the first person they saw when stepping in the door.
    - Water, tea and fruit were offered.
    - Kathy/volunteers shared stories and engaged them in discussion.
- Consent/permission was received to participate in the BP screening.
- A *Risk Profile Questionnaire* (See Appendix D) with a *Peer Discussion Form* (See Appendix E) which served as an "intake assessment" was initiated and guided people to take a (w)holistic perspective. If the person did not have a primary care provider or was not rostered with the Napanee Area CHC (NACHC), the information was still collected and uploaded into the NACHC EMR.
- The volunteer welcomed them to have their blood pressure taken. Blood pressure was taken using validated equipment and interventions were carried out as per the BP protocol (See Appendix C). The volunteer might ask, "*Have you ever been treated for high blood pressure?"* Volunteers *"paint a general picture*" about blood pressure.

- The Community Health Nurse (CHN) provided further support and advice to volunteers. With the individual's permission, the CHN contacted the primary care provider with their BP information in an effort to "*pull-in*" needed primary care assessment of BP. Risk was assessed by the nurse who also followed the localized BP protocol and facilitated follow-up interventions, as needed. A "*Nurse Assessment*" form was completed which had also been localized to the Indigenous BP Screening Program using the CHAP template (See Appendix F).
- All the forms associated with the BP Program were re-designed with the four initial volunteers. The forms also served as "talking points" for the volunteers and health care providers.
- People were then referred to a primary care provider or services, as needed.
    - Kathy shared an example of when she was able to connect a pregnant female with a high blood pressure reading to a primary care provider.
    - Orphaned patients with abnormal findings were offered primary health care at the NACHC.
- The Community Development Worker and volunteers linked people to community health services such as the NACHC Indigenous Health Program and the Deseronto Library Walking Exercise Group.
    - In-person visits and phone calls often revealed other needs (e.g., Kathy connected them to the Food Bank or to a Shelter for Women, if needed).
    - The Indigenous BP program provided a "*toehold into other services*" such as diabetes education, foot care, smoking cessation, and sexual health education. Each service would then be an opportunity to connect with another service(s) (e.g., the foot care provider linked them to the smoking cessation coordinator); therefore improving access beyond one service and one provider.
- Kathy described the clinic setting as "*jovial*" where everyone worked well together- *"It was a collegial atmosphere that helped make the person feel at ease."*
- BP screening service at the Deseronto Clinic was open for 2 hours from 1:00-3:00 pm every second Tuesday. Follow-up telephone calls were made throughout the week.

**BP Screening at Community Events**

- The clinic screening model was built to move. One can take the clinic model and use it at powwows, drum socials, diner's club, and other community events.
- BP screening was held at least once/month at a community event.
    - BP Screening booths were set up at the community events.
    - Volunteers would engage people at the events –talking and sharing stories before welcoming them to have their blood pressure taken with continued discussion after the blood pressure was taken.
    - Phone numbers were exchanged with permission/consent for follow up.
    - Kathy/volunteer would link them to the CHN after the event and to community health services, as needed.

BP Equipment Tips:
√Use battery operated machines.
√Bring different cuff sizes.

## 2.7 Outcomes, Key Learnings & Considerations for Implementation

### 2.7.1 Outcomes

- The Deseronto screening project evolved into a program using a culture-based training model and community development approach to BP and irregularly irregular heart rate screenings based on Mohawk teachings.
- Kathy and Maureen along with others familiar with the program highlighted the following main outcomes of the Indigenous BP Screening Program:
    - Provided **cultural safety.**
    - Built **trust** (e.g., "*trusted the volunteers like family"*). Participants indicated that they *"enjoyed coming back."*
    - **Improved people's general knowledge about vascular health**.

- Provided a welcoming atmosphere which became **an access point to other services**.
    - Improved cultural access to other cultural activities
        - Indigenous NP and Community Development Worker would link them to cultural medicine-drum socials, tanning hides.
    - Improved access to primary care provider and services safely.
    - Orphaned patients became connected.
    - Opened the door to other screenings (e.g., captured older adults at risk for falling).
- **Effective team model established**: There was a "*strength of collaboration*" with the Community Development Worker, volunteers, NPs, nurses, physicians and allied health care providers.
- **Strength in combined western medicine with traditional medicine**-linking with Knowledge Keeper and Traditional Medicine Person.
- **Partnerships were formed**- "*Great way to pair with other chronic condition screening services*" such as cancer and diabetes screening.
    - Dr. Hugh Langley conducted the cancer screening while Kathy conducted BP screening at community events.
- There was a **high return rate for follow up** of newly detected hypertension, atrial fibrillation and for monitoring effectiveness of treatment.
- A review in 2015 noted:
    - 89 individuals were screened and the following **risk factors identified**:
        - 39% existing hypertension diagnosis
        - 18% smoked
        - 18% concurrent diabetes diagnosis
        - 18% had three or more vascular risk factors
    - In addition to identifying to those at risk, there was a **lowering of blood pressure.**
    - **100% of participants who had identified risk factors were referred to appropriate health services** (e.g., Diabetes Education Program, Advanced Foot Care, Indigenous Health Program, Smoking Cessation, and Chronic Disease Self-Management Workshops).
- In November, 2016, an abstract about the Deseronto BP Screening Project was selected among hundreds of abstracts to receive national recognition through a media release during the Heart and Stroke Foundation Canadian Stroke Congress. This media release highlighted one of the reasons for this project proposal: "*Indigenous people in Canada have experienced poor health outcomes and a substandard state of health and well-being because of inadequate medical diagnosis and treatment of preventable diseases*" (Heart and Stroke, 2016). The Deseronto BP project findings and key learnings were shared regionally at Stroke Prevention Clinic & Primary Care Events, the Regional Stroke Symposium, and with the Regional Stroke Steering Committee. Dr. Al Jin, Stroke Neurologist and Medical Director for the Regional Stroke Network was "*amazed*" by the project and highlighted the importance of spread beyond Deseronto. He highlighted, "*the incredible impact that this project could have on so many individuals in preventing stroke and other cardiovascular diseases."* He noted that this project, "*provided a safe way of people accessing care early to have their health risks managed."*
- Maureen recalled a case about a person who had been to the Indigenous BP Screening Program and had immediate referral to Maureen. This person had a history of stroke and stated that they were lost to follow up in primary care and ran out of medications. The individual had an underlying anxiety disorder and was afraid to access care and was unable to maintain self-care. The connection with the BP screening program led them to being able

to be pulled back into care with Maureen resulting in better management of their high blood pressure.

### 2.7.2 Challenges

- It has been challenging to sustain and grow the program given the lack of adequate infrastructure due to **not being a fully funded program**.
  - The program was resourced with support from the Napanee Area CHC for a Community Development Worker (0.2 FTE), a Community Health Nurse (0.1 FTE -2 half day clinics plus 1 hour/month for data entry), and with referrals to the Traditional Medicine Person and Indigenous NP. The Stroke Network SEO has provided annual support for the training and community sessions ($1,500.00/year).
  - A *Concept for Approval* proposal to sustain and spread the program was not approved by the South East LHIN to move to the next phase of business plan development. Recommendations were made instead that 1) IIPCT would soon be established and they would be key for spreading and continuing the model and 2) KCHCs are key to sustaining the Deseronto Indigenous program given their mandate in relation to Indigenous health.
  - Josh mentioned that there may be future opportunity with the Frontenac, Lennox & Addington (FLA) Ontario Health Team (OHT). A talking circle was held with the FLA OHT to explore ways to ensure the Indigenous voice is present at the health table. The FLA OHT is interested in having an Indigenous health focus. With more partners on board and raising the need at many tables, there is more likelihood of funding.
- Documentation with **data collection was hindered by manual processes**.
- **Some RPNs were not fully engaged**. Not all RPNs were comfortable in the role of assisting with the Indigenous BP program. Training was needed to support them. Some RPNs did take more of a lead (e.g., ensuring cuff size was right and looping back with volunteers).
- With regards to spread, Kathy tried to connect with a nurse at MBQ, who at that time indicated they were not interested due to **competing demands**.
- Indigenous BP Screening through the KCHCs is now on hold due to **lack of a space** in Deseronto. The Deseronto Clinic site of the NACHC space at 344 Main Street is for rent. Josh indicated NACHC has been recently unable to cover the rent expenses.
  - There is a new medical office in Deseronto housing health care providers. The space however is insufficient for group or community-based programs.
  - The store front space for rent which housed the clinic was the ideal location.
    - Kathy indicated that this space was most convenient and was conducive for people to "*drop in*". If located elsewhere, there would be fewer screenings as per Kathy's experience.
  - Josh and other participants indicated the urgent need to recreate this welcoming space.
    - Dr. Sloan mentioned that there is interest to rent the space in Deseronto in relation to the IIPCT work (this will need to be verified).

### 2.7.3 Key Elements for Consideration for Implementation of the Program

Kathy, Maureen and others familiar with the program shared the following elements that were necessary for implementation:

- **Persistent vision** for a community BP program to improve culturally safe access to health services
- **Recruitment and retention of volunteers & ongoing training**
- **Community connections**
  - Autumn Watson indicated that Kathy Brant "*is there doing it"* and can solicit volunteers *"right there and right then."*

    - Kathy Brant who is a long-time member of the village of Deseronto and Tyendinaga Mohawk Bay of Quinte communities, plays a key role of engaging community members (e.g., through friendly phone calls and assistance with transportation).
    - If people show interest then get their names, start the relationship.
- **Holistic approach**-follow the medicine wheel (emotional, spiritual, mental & physical)
- "Friendly" processes- "low key, **collegial, collaborative**"
- **Leadership**
    - Indigenous community governance with the *Governance Circle*
    - Clinical leadership-e.g., physician and NP
    - Community Development Worker & Community Health Nurse are key leaders
    - Champion(s) to lead this-Maureen and Kathy were the main champions
- **Management support and commitment** (NACHC was very supportive)
- **Buy-in from clinicians**-e.g., helps when faxing the info to the primary care provider for follow up or to primary care service knowing that a connection has been made.
- **Follow up process with primary care**
- **Localized protocols and forms** (e.g., BP protocol and consent forms)
- **Collaborative team** including volunteers, CHN, Community Development Worker
- **Collect health info via an automated system** (e.g., enter into EMR)
    - RPN and Kathy entered the information/data
    - Examine the codes related to blood pressure and enter same codes to facilitate tracking
- **Accessible and convenient space**-Deseronto clinic was in a good location, across from the post office. People could see the outdoor welcome sign.
- **Incorporate self-management principles**

Also, See Appendix G for a draft Implementation Plan to spread the Deseronto BP Program which was included in the draft business proposal to SE LHIN (Note: the plan was not fully worked out as the *Concept Approval* proposal was not approved past the first phase).

## 3.0 Round Table Discussion & Sharing Similar Experiences/Services

IIPCT inquired about the challenges in recruiting volunteers and having a big enough pool.

- Janusz Kaczorowski commented that CHAP did not have difficulty recruiting volunteers. CHAP trained over 600 volunteers in Ontario in a 10 week period. They conducted 1200 sessions over 12 weeks with 2700 people assessed. Some of the volunteers were retired health care providers and teachers.
    - Janusz provided suggestions in relation to volunteers:
        - Need a large pool of interested volunteers as some people may not be available
        - Have a plan for regular recruitment and training
            - Full day training initially then half day refresh training, as needed
            - Incorporate time for using equipment with hands-on practice of BP measurement
            - CHAP has a volunteer training manual in French and English
        - Figure out how frequent or how often to hold BP screenings
            - Need to have a schedule (e.g., every 2 weeks on a Tuesday) to obtain commitment
                - Jamie agreed that a schedule would be important and to schedule volunteers well in advance of the screening sessions (e.g., every 1st Monday from 09:00-12:00h).
        - Volunteers require a background check.

        - Need volunteers who will be comfortable in the role.
        - Recruit volunteers based on the target population (e.g., similar ages).
- Kathy indicated you need a leader to help manage the volunteers.
- Shandon Maracle indicated he is interested in being a volunteer and can approach his fellow paramedics about volunteering.
- Autumn Watson indicated that she has taken part in the Indigenous BP screening training. She indicated that BP screening is a good complement with her role as Diabetes Wellness Worker. Seeing Kathy and the volunteers in action at powwows was helpful for her learning.
- Christina Vaillancourt conveyed that BP screening aligns well with screening for chronic kidney disease and diabetes.
- Helen Mabberly described the Indigenous BP screening in Kingston. Volunteers had been trained and time was built in for RPN support. The BP screening took place at a few events and was moderated by Kathy. Helen indicated that the Kingston screening is on hold but is still needed.

# 4.0 Apply Learnings from the Deseronto Indigenous BP Screening Model -What Would it Take?

## 4.1 Needs (who, what- e.g., training, protocol, & processes)

Participants shared ideas for what would be initially needed for the IIPCT to begin planning the BP screening program:

- Combine knowledge and heart when "***staking"*** **the ground for engagement.**
- **Begin with cultural grounding-**
    - **Connect with Cherylann Brant**, Indigenous Community Wellness Worker to help prepare the team for cultural grounding-can arrange this with Zoom or MS Teams.
        - Cherylann Brant can help the team to be grounded together culturally.
    - **Learn more about the Mohawk teachings.** Sarah requested to **learn more about applying the Strawberry metaphor.**
- Figure out **who the target population is.**
- Determine **where to hold the screenings and the training**.
- **Make community connections** including connecting with community Elders and Knowledge Keepers to forge relationships.
        - Find key Indigenous leaders in the community.
        - Need to find an Indigenous person within the community who can develop those relationships. Kathy has many connections with surrounding Indigenous communities including Tyendinaga and Bancroft.
- **Localize BP protocol and processes**
        - Dr. Sloan, NP, Community Development Worker and RPN/RN can come together to modify the protocol and engage others in updating the protocol.
- **Recruit 3-4 core volunteers** to start and to help with planning. **Build up a pool of 12-15 volunteers**.
    - **Coordinate 3-4 hours of volunteer training.**
    - Hold screenings at least 2 times/month, have 4-5 locations starting with the clinic area.
        - Autumn stressed the importance of having community volunteers. Autumn has seen the program in action and recommends to be alongside Kathy witnessing what she does.

- **How to recruit?** Kathy and Maureen indicated that **word of mouth was most effective to build connections.** Kathy encourages people to do the volunteer training program

## 4.2 What would be some of the challenges?

- **New team**-how can they manage?
  - Participants reflected that having a dedicated team for Indigenous primary health care is a great asset.
- **Servicing a large rural community**
- **Recruitment of volunteers**
- **COVID** (commented that older people are now reluctant to venture outside their homes)

## 4.3 How might these challenges be addressed?

- **IIPCT providers are already interested** in starting the program. Participants acknowledged that it will take time for the team to figure out its way and build connections.
- There is great potential for **collaboration.**
  - Darcy Reid commented that there is already great support as witnessed by the number of people present at this event.
  - Autumn Watson offered that the Indigenous Diabetes Health Circle (IDHC) "*will always be able to provide support in any way.*" IDHC requests to be kept in the loop. Autumn would like to help get the program launched.
  - Janusz, on behalf of CHAP, offered CHAP support such as sharing of resources. Janusz indicated that CHAP is supportive of helping the Indigenous BP community program and is supportive of Indigenous communities localizing the CHAP BP protocol. CHAP is open to sharing their Implementation Guide and other helpful processes/forms (e.g., consent form) and resources including instructions/videos on how to take blood pressure. Click on this link to access helpful resources: **http://chapprogram.ca/** For free access to the CHAP Implementation Guide, email **info@chapprogram.ca**
  - Christina Vaillancourt and Justin Tennant indicated that chronic kidney disease & BP screening is an ideal combination, so there is potential for collaboration. Christina mentioned that she foresees much synergy with the groups present.
  - Derk Damron, on behalf of the Quinte District Stroke Centre is open to collaboration. Derk mentioned the potential for this holistic model to be spread elsewhere and wondering about the Aboriginal Health Access Centres.
  - Stroke Network team offered to continue to support training and education. The Stroke Network also offered to help support making connections regarding "cultural grounding", as needed.
  - Kingston CHCs are supportive of continuing the Indigenous BP screening.
  - Participants suggested connecting with a local pharmacy. Kathy indicated there is an IDA in Deseronto. Janusz recommended connecting with an independent pharmacy as they would be more open to collaboration.
    - Maureen indicated that this connection can enhance reassessment of BP, review of medications, and addressing medication adherence issues.
- Darcy and others suggested to **start small and locally first**; do **a staged approach to engage the community starting with the MBQ area.**
  - Autumn & other participants indicated that if Indigenous BP screening is based in a clinic, it will be less effective. Community-based screening is more inclusive and links people up with those who have no links or connections.
- **Consult with Elders in the community.**

- **Find an Indigenous person who is well connected in the community** and develop a relationship.
- With eventual spread, **need to establish relationships with the various communities** (e.g., at Sharbot Lake and Bancroft). There are likely leaders there linked with the Indigenous Governance Circle. These leaders know their communities and can help with buy-in and know who might volunteer.
- **Connect with Community Development Workers** (Kathy Brant & Jamie Kring) who can help make connections.
- **Some may already be interested in volunteering** (e.g., Shandon Maracle) and can reach many people of a similar age. Shandon indicated he could reach out to volunteer fireman at meetings.
    - Maureen agreed that it is much more effective having people of similar ages and the need to include younger ages.
    - Health care workers who might be off from work could be interested in volunteering.
  - Need **key leaders** to help with implementation and ongoing management.
    - Need local leaders to help mobilize the community; they will help determine how it needs to work.
    - A physician and NP could help support clinical leadership.
    - Need local champions who can help take the model to their communities.
  - Start with **localizing the protocols** with Tyendinaga area first before doing broader outreach. Maureen commented that localizing the BP protocol would be a good strategy for buy-in and change.
  - Darcy indicated the need for a **holistic approach** beyond physical/body to mental, emotional, and spiritual aspects of health.
  - Sarah asked –**what would this look like during COVID?** Members discussed possibility of **having a <u>virtual approach</u>** given our current required social distancing.
    - Participants expressed concern that much care is being deferred and need to connect with people even more now, even if only through virtual means.
    - Janusz estimated that some primary care physicians are currently doing 80% tele-consultation and noted that they are becoming more comfortable with virtual care.
    - Begin planning by using virtual platforms. Also consider that a piece of the BP screening implementation can be done virtually such as initial engagement.
      - Organize a Zoom call out for 1) Planning and 2) Beginning engagement such as for recruitment of volunteers.
        - Jamie indicated that during COVID perhaps it is possible to recruit volunteers.
      - Autumn indicated that IDHC has delivered education/services virtually.
        - Reached many people however, "*cannot feel the energy*."
        - Some require more health care and need to see clinicians in person.
          - Participants agreed that human interaction is so important.
      - Nurses can also do some virtual training with the volunteers.
    - **BP Equipment:**
      - Possible to conduct some virtual screening given many have blood pressure equipment at home.
      - It is possible to arrange home BP monitoring.

        - Janusz spoke about a study from 8 years ago which indicated 50% of providers were using home BP measurements.
        - Providers are arranging more home BP monitoring which is considered best practice (see Hypertension Canada Guidelines.)
        - Challenge is most often one needs initial human interaction for teaching to ensure BP measurement accuracy.
    - Newer home devices are of better quality. Janusz advised using machines that can take BP three times & then computes an average of those 3 readings in the clinic or at community events.
    - Ensure home BP machine is a recommended device. Click here for recommended BP devices by Hypertension Canada.
    - Sarah Taylor suggested a "loan" system for BP equipment. Pending readiness of the person, lend out BP monitor and BP cuff, perhaps for 6 week periods and provide education and monitoring support.
    - Christina Vaillancourt offered that there may be potential to access BP equipment through The Kidney Foundation of Canada.
    - Josee Sunday indicated BP devices within Non-Insured Health Benefits Program (NIHB) have to be prescribed if Indigenous people are to be covered financially. Autumn added that not all Indigenous people have access to NIHB.
    - A process for sanitizing the cuffs and equipment would be needed.
    - A secure program is required where home monitoring info is shared.

## 5.0 Wrap up/Next Steps?

- IIPCT would "*like to see the Indigenous BP program up and running*." They would like to start small and local, laying the groundwork for future spread to other communities with Indigenous peoples. Future spread may entail them helping to provide coordination and outreach.
    - Jamie Kring commented, "*Looking forward to getting this going soon*."
    - Kiowa Berhardt offered words of encouragement that this can be done and barriers can be overcome. The IIPCT needs to take this back, make some decisions, and start the work.
- Participants agreed that the discussion during this event has informed the beginning of an action plan.
- **Next immediate steps** were summarized:
    - **Form a workgroup** to begin planning
    - **Connect with Cherylann Brant** regarding cultural grounding
    - Review protocols and process forms and begin the work of engagement for updating and **localizing the forms** (e.g., adding their logo).
    - **Determine key champions** to lead this work
- IIPCT thanked participants for their support and sharing of resources.
- Participants thanked Maureen and Kathy for spending time with them in reviewing the Deseronto BP Screening Program and beginning to sketch out an action plan.
- Participants indicated the event was helpful and worthwhile.

Miigwech!

**Appendix A**

**Participants**

**Maureen Buchanan**, Retired Indigenous Nurse Practitioner **(Presenter, Moderator)**

**Mohawks of the Bay of Quinte (MBQ)/Indigenous Interprofessional Primary Care Team (IIPCT)**
Susan Barberstock, Director, Community Wellbeing Centre & IIPCT; Kiowa Berhardt, RN, IIPCT; Kendra Courneyea, Administrative Support, IIPCT; Jamie Kring, Community Development Worker, IIPCT; Shandon Maracle, Paramedic & Community Volunteer; Darcy Reid, Adult Mental Health Worker, IIPCT; Dr. Jeff Sloan, Physician, IIPCT; Josee Sunday, Practical Assistant Worker, Diabetes Education, Community Wellbeing Centre; Sarah Taylor, Nurse Practitioner, IIPCT

**Kingston Community Health Centres (KCHCs)**
Helen Mabberly, Manager, Family and Community Health
**Napanee Area Community Health Centre (NACHC)-A Part of KCHCs**
Kathy Brant, Community Development Worker **(Presenter, Moderator)**; Andrea Campbell, Indigenous Nurse Practitioner; Josh Cowan, Director, Regional Services and Partnerships
Diana Barlow with the **Ontario Native Women's Association-Napanee Office**

**Indigenous Diabetes Health Circle (formerly SOADI)**
Autumn Watson, Diabetes Wellness Worker (Eastern Region)

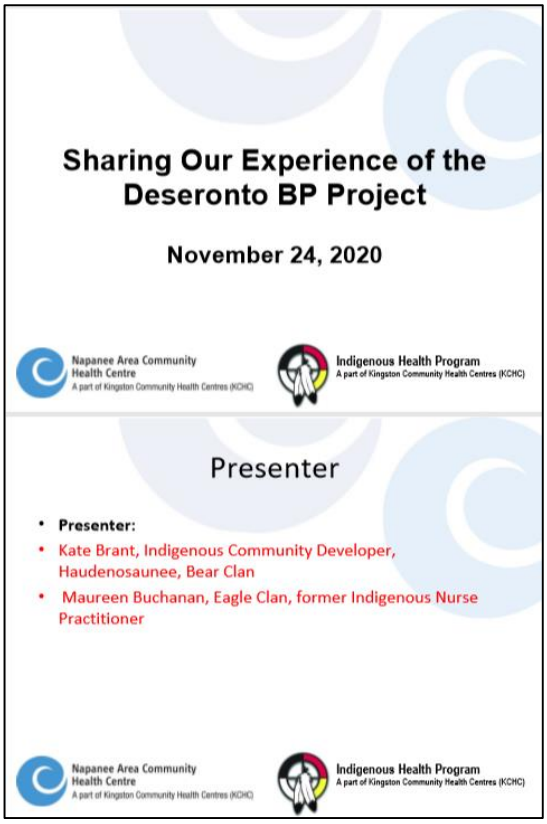
**Cardiovascular Health Awareness Program (CHAP)**
Janusz Kaczorowski, Principal Investigator, CHAP; Professor and Research Director, Docteur Sadok Besrour Chair in Family Medicine; GSK Chair in Optimal Management of Chronic Disease; CIHR-ICRH/Heart & Stroke/Hypertension Canada Chair in prevention and control of hypertension; Department of Family and Emergency Medicine; University of Montreal; University of Montreal Hospital Research Centre (CRCHUM) Co-director: Health Innovation and Evaluation Hub

**Renal Program & Ontario Renal Network**
Justin Tennant, Manager, Renal Program, Kingston Health Sciences Centre (KHSC); Christina Vaillancourt, Senior Analyst, Indigenous Kidney Health Portfolio, Ontario Renal Network

**Stroke Network of Southeastern Ontario (SEO)**
Derk Damron, District Stroke Coordinator, Quinte District Stroke Centre, Quinte Health Care; Heather Jenkins, Regional Stroke Education Coordinator, Stroke Network SEO **(Moderator)**; Cally Martin, Regional Stroke Director, Stroke Network SEO; Colleen Murphy, Regional Stroke Best Practice Coordinator, Stroke Network SEO **(Moderator)**

## Appendix B

## Sharing Experience of Deseronto Blood Pressure Screening Presentation Slides





## Deseronto, Pop 2259

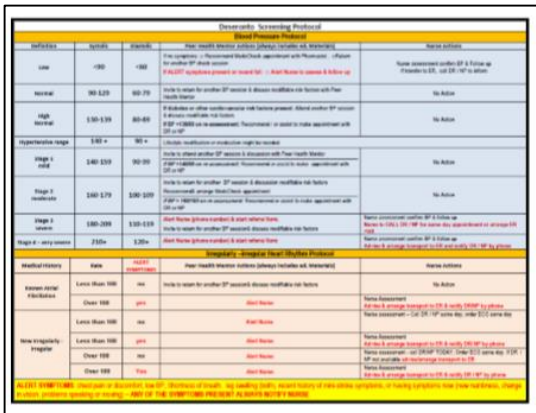
- Located next door to Mohawks Bay of Quinte
- Estimate of 19% Indigenous ancestry

### Deseronto BP Screening Project

- Culture -based vol. training
- Aunties screen neighbors and extended family
- Kitchen table atmosphere
- Welcoming , warm greeting
- Treat everyone like family
- A lot of visiting
- Refreshments & fresh fruit
- Evidenced-based BP protocol
- Guides the actions of volunteers
- CHN *with consent* pulls in primary care follow up
- Every two weeks

Napanee Area Community Health Centre
A part of Kingston Community Health Centres (KCHC)

Indigenous Health Program
A part of Kingston Community Health Centres (KCHC)



## Outcomes & Key Learnings

| 2015 BP Clinic Utilization | |
|---|---|
| Total Encounters | 221 |
| Unique Individuals | 136 |
| Indigenous / Mêtis | 21.0% |

- Strong return rate (27.0%) for follow up & monitoring treatment effects
- Created effective access point into further health care supports:
  - 100% with identified risk factors referred to services (e.g., diabetes education, smoking cessation)
  - Any person not followed by a primary care provider was rostered to NACHC
- Created culturally safe strategies to increase participation of persons with Indigenous ancestry in BP screening and discussion of vascular risk factors
- Opened the door for other chronic disease screening

## Appendix C

## Deseronto Blood Pressure/Heart Rhythm Screening Protocol

**Deseronto Screening Protocol**

**Blood Pressure Protocol**

| Definition | Systolic | Diastolic | Peer Health Mentor Actions (always includes ed. Materials) | Nurse Actions |
|---|---|---|---|---|
| Low | <90 | <60 | If no symptoms: □ Recommend MedsCheck appointment with Pharmacist ; □Return for another BP check session<br>If ALERT symptoms present or recent fall: □ Alert Nurse to assess & follow up | Nurse assessment confirm BP & Follow up<br>If transfer to ER, call DR / NP to inform |
| Normal | 90-129 | 60-79 | Invite to return for another BP session & discuss modifiable risk factors with Peer Health Mentor | No Action |
| High Normal | 130-134 | 80-84 | If diabetes or other cardiovascular risk factors present: Attend another BP session & discuss modifiable risk factors<br>If BP >130/80 on re-assessment: Recommend / or assist to make appointment with DR or NP | No Action |
| **Hypertensive range Lifestyle modification or medication might be needed** | | | | |
| Stage 1 mild | 135-159 | 85-99 | Invite to attend another BP session & discussion with Peer Health Mentor<br>*If BP >140/90 on re-assessment:* Recommend or assist to make appointment with DR or NP | No Action |
| Stage 2 moderate | 160-179 | 100-109 | Invite to return for another BP session & discussion modifiable risk factors<br>Recommend& arrange MedsCheck appointment<br>*If BP > 160/100 on re-assessment:* Recommend or assist to make appointment with DR or NP | No Action |
| Stage 3 severe | 180-209 | 110-119 | Alert Nurse (phone number) & start referral form.<br>Invite to return for another BP session& discuss modifiable risk factors | Nurse assessment confirm BP & follow up<br>Nurse to CALL DR / NP for same day appointment or arrange ER visit |
| Stage 4 – very severe | 210+ | 120+ | Alert Nurse (phone number) & start referral form | Nurse assessment confirm BP & follow up<br>Advise & arrange transport to ER and notify DR / NP by phone |

**Irregularly –irregular Heart Rhythm Protocol**

| Medical History | Rate | ALERT SYMPTOMS | Peer Health Mentor Actions (always includes ed. Materials) | Nurse Actions |
|---|---|---|---|---|
| Known Atrial Fibrillation | Less than 100 | no | Invite to return for another BP session& discuss modifiable risk factors | No Action |
| | Over 100 | yes | Alert Nurse | Nurse Assessment<br>Advise & arrange transport to ER & notify DR/NP by phone |
| New Irregularly - irregular | Less than 100 | no | Alert Nurse. | Nurse assessment – Call DR / NP same day; order ECG same day |
| | Less than 100 | yes | Alert Nurse | Nurse Assessment<br>Advise & arrange transport to ER & notify DR/ NP by phone |
| | Over 100 | no | Alert Nurse | Nurse assessment - call DR/NP TODAY; Order ECG same day. If DR / NP not available advise/arrange transport to ER |
| | Over 100 | Yes | Alert Nurse | Nurse Assessment<br>Advise & arrange transport to ER & notify DR / NP by phone |

**ALERT SYMPTOMS:** chest pain or discomfort, low BP, Shortness of breath, leg swelling (both), recent history of mini-stroke symptoms, or having symptoms now (new numbness, change in vision, problems speaking or moving) – **ANY OF THE SYMPTOMS PRESENT ALWAYS NOTIFY NURSE**

**Appendix D**

**Deseronto Blood Pressure Screening: Risk Profile Questionnaire**

Step 2

Naganee Area Community Health Centre

## Deseronto Blood Pressure Screening Project

### Risk Profile Questionnaire: DATE:_____First visit or Repeat

**CLIENT INFORMATION:** Last: _____ First: _____

Birth Date:(mm.dd.yyyy) _____ Age: _____ Male:O Female:O

Address: (street & town) _____

Postal Code:_____ Family Dr or Nurse Practitioner (NP)_____

Dr / NP Location (city): _____ Dr. Phone: _____

### *Risk Factors*

1. Would you say your health is

**Excellent O Very Good O Good O Fair O Poor O**

2. Have you ever been told you had

| | | |
|---|---|---|
| **High Blood Pressure** | **Yes O** | **No O** |
| **Atrial Fibrillation** | **Yes O** | **No O** |
| **Heart Attack** | **Yes O** | **No O** |
| **High cholesterol** | **Yes O** | **No O.** |
| **Diabetes?** | **Yes O** | **No O** |
| **Kidney Disease** | **Yes O** | **No O** |

3. What is your ancestry?

| Mother | Father | |
|---|---|---|
| | | Indigenous(First Nations Metis, Inuit) |
| | | White |
| | | Black |
| | | Latin American |
| | | South Asian (East Indian, Pakistani) |
| | | East Asian (Chinese, Vietnamese, Filipino) |
| | | Other |

### *In the last week*

4. Did you use any tobacco products?

***Daily O Occasionally: O Not At All O***

5. How many times did you eat hi-fat or fast foods?

***Zero O 1—2 -O 3 or more O***

6. Did you drink **2 +** alcoholic drinks per day?

***Yes O No O***

7. Did you have **5 +** servings of vegetables or fruits a day? ***Yes O No O***

8. Did you add salt to foods during cooking or at the table?

***Rarely O Sometimes O Often O***

9. How frequently did you feel overwhelmed or stressed?

***Rarely O Sometimes O Often O***

***FOR THE VOLUNTEER TO FILL OUT:***

***BLOOD PRESSURE :*** Lt arm O Rt arm: O

**Systolic :** _____ **Diastolic :** _____

**Pulse:**_____ **Regular O Irregular O**

**ACTIONS Taken according to protocol:**

O Reviewed Risk Profile with Participant

O Provide educational info on risk factors

O Invite to return for another BP session

O Called RN to assess Participant

**Recommend or assist to make appointment**
*(Participant consented)*

O Dr. or Nurse Practitioner O Pharmacist

**Refer to:**

O Diabetes Education Program

O Chronic Disease Self management group

O No Follow Up Required

O Traditional Indigenous Programs
NACHC Indigenous Health Program OR Wellness Centre

***PARTICIPANT HAS HYPERTENSIVE BP OR IRREGULAR–IRREGULAR HEART RATE & NEEDS A DR OR NP? REFER TO:***

O NACHC or O QCHC Nurse Practitioner or O Healthcare Connect (1800 445 1822)

**Appendix E**

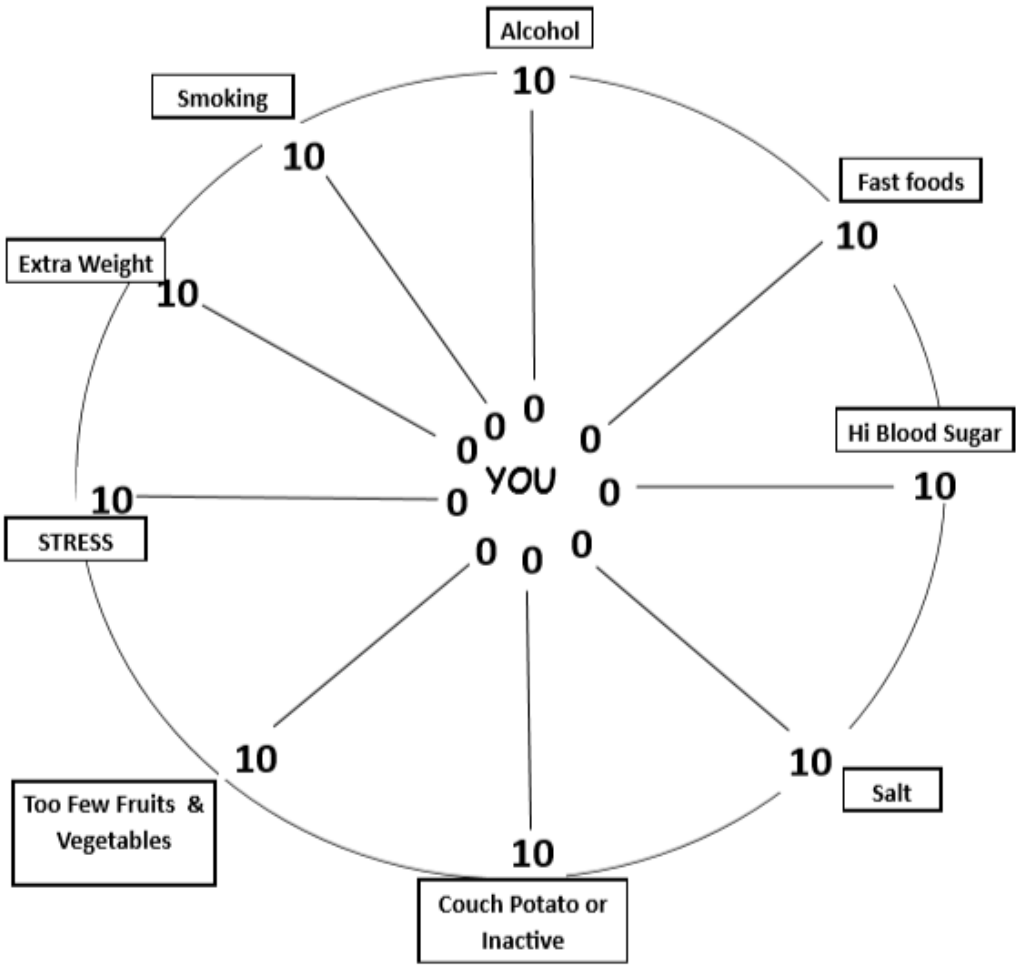
**Deseronto Blood Pressure Screening: Peer Discussion Form**

Deseronto Blood Pressure Screening Project

**Peer Discussion Form—date:_____**

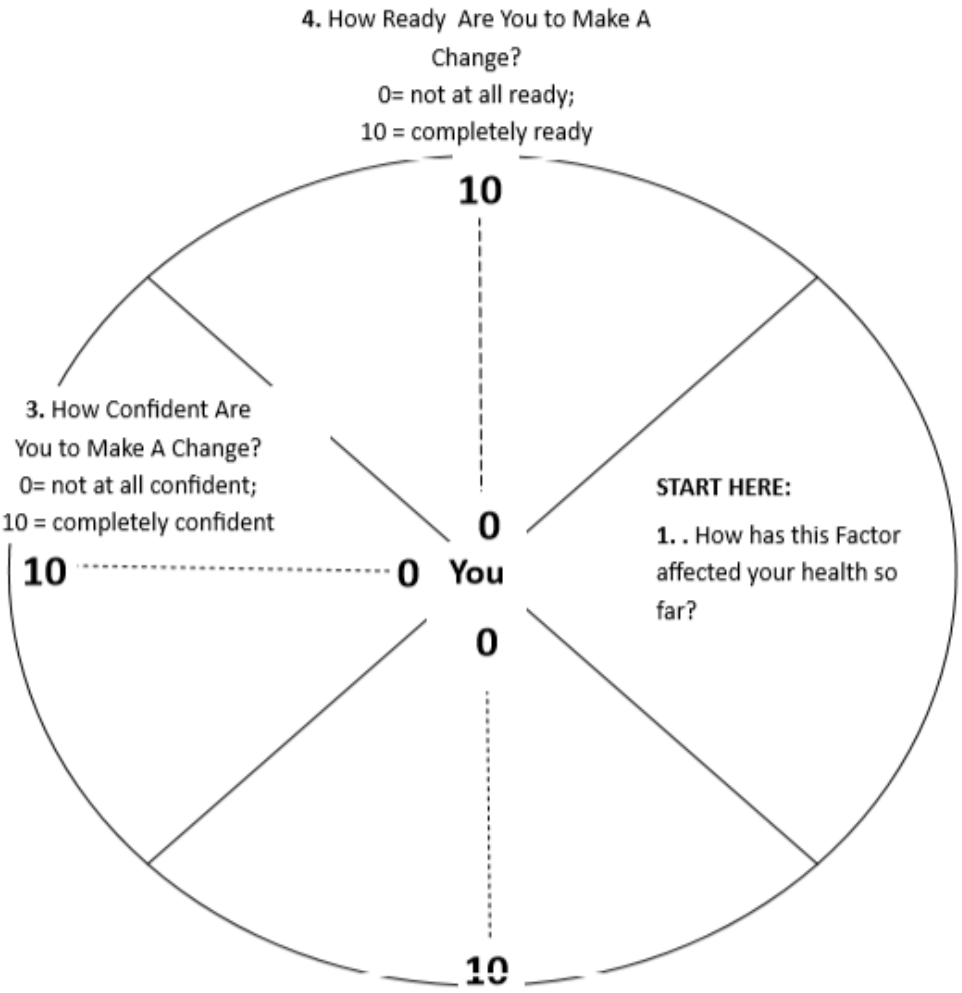
Are you ready to make change? Step 1: Below are factors known to contribute to Early Stokes, Heart Attacks and Dementia. Circle the factors you think may be NEGATIVELY affecting your health & wellbeing. Then rate the impact each factor has on your health:

0 = VERY LITTLE NEGATIVE MPACT 10 = EXTREMELY NEGATIVE IMPACT




1

Choose one factor :_____



***Would you like information about***

| | | | | | |
|---|---|---|---|---|---|
| O | Healthy Eating | O | Local Cooking Classes | O | Traditional Foods |
| O | Healthy Exercise | O | Local Exercise Opportunities | | |
| O | Quitting Smoking | O | Local Quit Smoking Supports | | |
| O | Diabetes & Heart Health | O | Local Diabetes Education Program or Groups | | |
| O | Stress Management | O | Local Stress Management Supports | | |
| O | Local Indigenous Traditional Healing | | | | |

***If this is a return visit:***

Has a doctor recently diagnosed you with any of the following conditions?

***O High blood pressure (hypertension)  O Diabetes  O High cholesterol***

| Risk Factor | No Change | Increase | Decrease | Quit | Details |
|---|---|---|---|---|---|
| smoking | | | | | |
| Alcohol use | | | | | |
| Eating hi fat foods | | | | | |
| Eating fruits & veg | | | | | |
| Salt use | | | | | |
| Stress | | | | | |
| Physical activity | | | | | |
| Weight | | | | | |
| Blood Pressure | | | | | |
| Wellbeing | | | | | |

FUTURE BLOOD PRESSURE SCREENING DATES :

Wednesday June 18 10—12 @ 300 Main St. unit 1—Deseronto

Wednesday July 9 10—12 @ 300 Main St. unit 1—Deseronto

Wednesday July 23 10—12 @ 300 Main St. unit 1—Deseronto

Sat & Sun August 9 & 10 Tyendinaga Powwow @ XXXX adddresss

Wed .Aug 27 10—12 @ 300 Main St. unit 1—Deseronto

**Appendix F**

**Deseronto Blood Pressure Screening: Community Health Nurse Assessment Form**

Napanee Area Community Health Centre
A part of Kingston Community Health Centres (KCHC)

## Deseronto Blood Pressure Screening Project

### Nurse Assessment Form

**CLIENT INFORMATION:**

Last : ☐☐☐☐☐☐☐☐☐☐☐☐

First : ☐☐☐☐☐☐☐☐☐☐☐☐

Birth Date: _____

Phone: ☐☐☐-☐☐☐-☐☐☐☐

**Reason for Referral:**

- ☐ **Systolic BP 160—179**
- ☐ **Systolic BP ≥ 180**
- ☐ **Low BP : systolic < 90; diastolic < 60**
- ☐ **irregular heart rate**
- ☐ **Alert Symptoms**

**BP AND HEART RATE REASSESSMENT:** BP confirmed ☐ auscultation ☐ automated ☐ both

**Left:** Systolic: _____ Diastolic _____ **Right** Systolic _____ Diastolic _____

IRREGULAR IRREGULAR CONFIRMED: ☐ Apical ☐ automated RATE: _____

NOTES: _____

**CLIENT INTERVIEW:**

a. Does client have a Family Dr / NP ☐ yes ☐ no ; Last seen: _____

b. Previous diagnosis of hypertension (HTN) ☐ yes ☐ no; atrial fibrillation (Afib) ☐ yes ☐ no

c. **Treated for HTN** ☐ yes ☐ no ; if yes , how long ago _____; recent changes? ☐ yes ☐ no

d. If yes, take regularly? ☐ yes ☐ no; Taken today? ☐ yes ☐ no

e. **Treated for Afib** ☐ yes ☐ no; if yes, how long ago _____; recent changes? ☐ yes ☐ no

f. If yes, take regularly? ☐ yes ☐ no; Taken today? ☐ yes ☐ no

g. **Taking other meds?** ☐ yes ☐ no ; if yes ☐ prescribed AND/OR ☐ OTC.

h. Diabetes ? ☐ Yes ☐ no

i. Any falls or close calls ☐ Yes ☐ no

j. Other serious health problem? _____

k. Alert symptoms: ☐ **yes** ☐ **no (chest pain or discomfort, Low BP, Shortness of breath, bilateral leg edema, TIA symptoms or recent TIA-like symptom history (new numbness, change in vision, problems speaking or moving)**

NOTES: _____

**ACTIONS:**

- ☐ reviewed Risk Profile with client
- ☐ provided education _____
- ☐ Ordered ECG
- ☐ Called DR/NP for discussion or follow up app't
- ☐ Assist setting appt: specify when
- ☐ Send To ER & DR / NP called to inform

Refer to: ☐ pharmacist med check

- O Refer to: ☐ Dr / NP
- O No Family Dr / NP? Refer to:
  - O Healthcare Connect (1800 445 1822)
  - O NACHC 613 354-8937
  - O QCHC NP
- ☐ FAX risk profile + assessmt form to PCP
- ☐ No Follow up required

**Appendix G**

**Sample Draft Implementation Plan Template from Draft Proposal to SELHIN: Expansion & Spread of the Deseronto Indigenous Blood Pressue Program**

| Key Activities/Deliverables | | MRP | Timelines |
|---|---|---|---|
| **A. Engagement Plan** | | | |
| **A1** | Indigenous Health Council approval to expand and spread the Deseronto BP Screening Project | | |
| **A2** | Indigenous Vascular Health Collaborative Work Group formed | | |
| **A3** | Investigate interest with possible communities | | |
| **A4** | Hold engagement meetings with communities (determined with the Indigenous Health Council) to introduce the project | | |
| **A5** | Hold follow-up engagement meetings with communities requesting to participate | | |
| **A6** | Seek approval of implementation plan with stakeholders including IHC | | |
| **A7** | | | |
| **A8** | | | |
| **A9** | | | |
| **B. Communication Plan** | | | |
| **B1** | Identify stakeholders | | |
| **B2** | Identify key messages and when to deliver "what/when" with partners | | |
| **B3** | Develop communication tools (ie briefing notes, project plan, key message document) | | |
| **B4** | Modify Deseronto Educational Resource with other communities for use | | |
| **B5** | Deliver key messages to all stakeholders | | |
| **B6** | Communicate Outcomes | | |
| **B7** | | | |

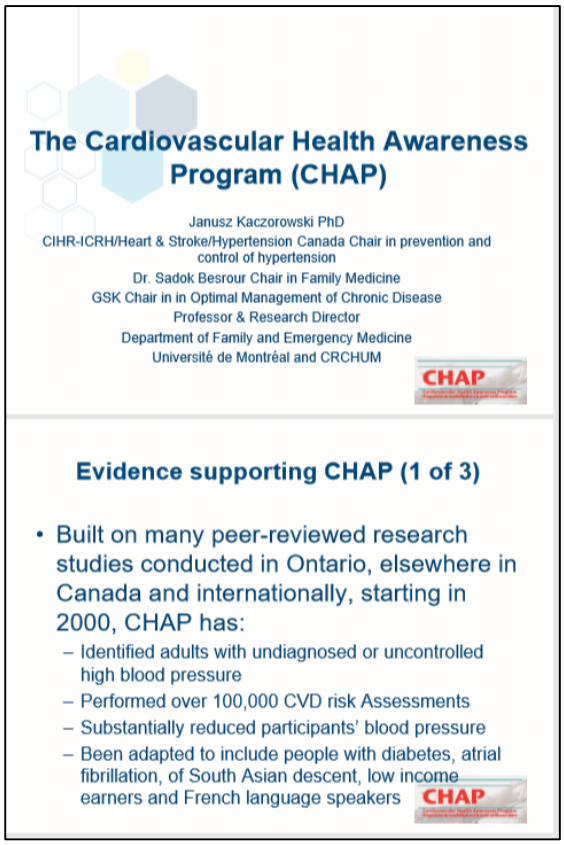
| Key Activities/Deliverables | | MRP | Timelines |
|---|---|---|---|
| **B8** | | | |
| **C. Evaluation Plan** | | | |
| **C1** | Create a data/evaluation sub work group | | |
| **C2** | Determine indicators (process and outcome) | | |
| **C3** | Review current protocols and forms for use for Data Collection | | |
| **C4** | Integrate Risk Profile Questionnaires and Community Health Nurse Assessment forms with primary care system-EMR | | |
| **C5** | Debrief after initial training sessions in 2 new communities | | |
| **C6** | Prepare Client Questionnaire - Conduct client interviews to review satisfaction and effectiveness | | |
| **C7** | Prepare Provider Questionnaire-Conduct provider interviews to review usefulness and effectiveness | | |
| **C8** | Determine reporting plan | | |
| **C9** | | | |
| **C10** | | | |
| **C11** | | | |
| **D. Deseronto BP/HR Screening: Capacity Building & Sustaining** | | | |
| **D1** | Assess increasing frequency of BP/Heart Rate Screening clinics | | |
| **D2** | Human Resources: Assess Impact and Plan if more anticipated volume (e.g., more Community Development Worker & Community Health Nurse time devoted; data coding) | | |
| **D3** | Assess further equipment needs (e.g., portable blood pressure machines, blood pressure cuffs, lap top) | | |
| **D4** | Review and update supplies- forms, protocols, risk profile questionnaires, agreements, letters of understanding | | |
| **D5** | Work with Data/Evaluation Sub Group to streamline data collection and reporting process | | |

| Key Activities/Deliverables | | MRP | Timelines |
|---|---|---|---|
| **D6** | Track activity and outcomes-see Evaluation Plan | | |
| **D7** | | | |
| **D8** | | | |
| **D9** | | | |
| **E. Spreading Deseronto BP/HR Screening: Education and Training; Capacity Building** | | | |
| **E1** | Assess learning needs | | |
| **E2** | Plan education and training in 2 communities | | |
| **E3** | Prepare training materials with 2 communities | | |
| **E4** | Deliver education and training in 2 communities including key learnings | | |
| **E5** | HR: Assess and Plan | | |
| **E6** | Assess Equipment needs (e.g., blood pressure cuffs, lap top) | | |
| **E7** | Track activity and outcomes-see Evaluation Plan | | |
| **E8** | | | |
| **E9** | | | |
| **E10** | | | |
| **F. Expand from Screening to Management: Formalize Referrals; Explore & Implement Indigenous Health Management Programs** | | | |
| **F1** | Assess readiness to expand from screening to management program incorporating traditional medicine components | | |
| **F2** | Explore Indigenous Health services that meet needs of Indigenous communities | | |
| **F3** | Develop Regional Indigenous Vascular Health Coordinator role to help coordinate and link services | | |
| **F4** | Plan for linking with Indigenous Health Services | | |
| **F5** | Formalize links to Indigenous Health Services; explore linking allied health services with Indigenous Health Services | | |
| **F6** | Explore expansion of links to allied health services (e.g., diabetes education, smoking cessation) | | |

| Key Activities/Deliverables | | MRP | Timelines |
|---|---|---|---|
| **F7** | | | |
| **F8** | | | |
| **F9** | | | |
| **G. Other Regional Planning Components** | | | |
| **G1** | Cultural Sensitivity Training | | |
| **G2** | Stanford Model of Chronic Disease Self-Management Peer (CDSMP) leader training to volunteers, the initial group being those volunteers working in Deseronto BP Screening project | | |
| **G3** | | | |
| **G4** | | | |
| **G5** | | | |

**Appendix H**

**Cardiovascular Health Awareness Program (CHAP) Presentation Slides**



## The Cardiovascular Health Awareness Program (CHAP)

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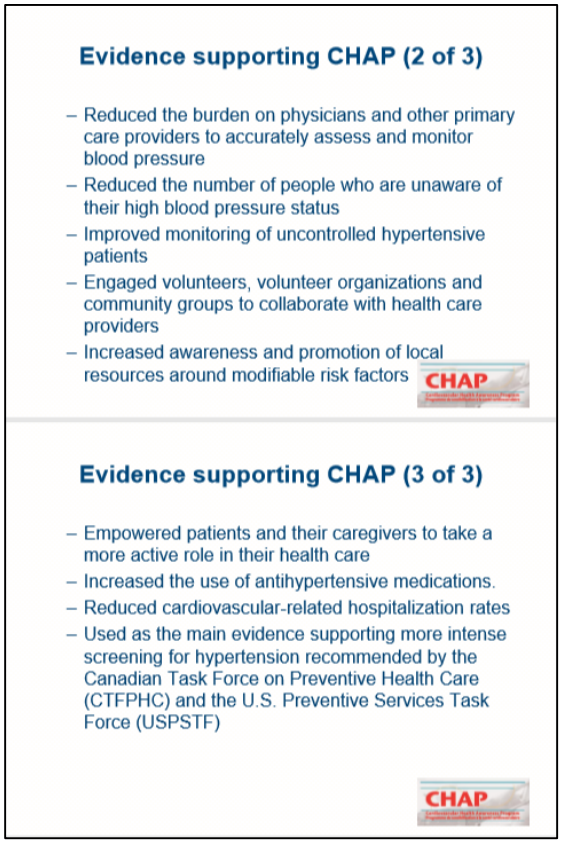
CHAP

## Evidence supporting CHAP (1 of 3)

- Built on many peer-reviewed research studies conducted in Ontario, elsewhere in Canada and internationally, starting in 2000, CHAP has:
  - Identified adults with undiagnosed or uncontrolled high blood pressure
  - Performed over 100,000 CVD risk Assessments
  - Substantially reduced participants' blood pressure
  - Been adapted to include people with diabetes, atrial fibrillation, of South Asian descent, low income earners and French language speakers

CHAP



## Evidence supporting CHAP (2 of 3)

- Reduced the burden on physicians and other primary care providers to accurately assess and monitor blood pressure
- Reduced the number of people who are unaware of their high blood pressure status
- Improved monitoring of uncontrolled hypertensive patients
- Engaged volunteers, volunteer organizations and community groups to collaborate with health care providers
- Increased awareness and promotion of local resources around modifiable risk factors

CHAP

## Evidence supporting CHAP (3 of 3)

- Empowered patients and their caregivers to take a more active role in their health care
- Increased the use of antihypertensive medications.
- Reduced cardiovascular-related hospitalization rates
- Used as the main evidence supporting more intense screening for hypertension recommended by the Canadian Task Force on Preventive Health Care (CTFPHC) and the U.S. Preventive Services Task Force (USPSTF)

CHAP

## More information

- CHAP program:
www.CHAPprogram.ca

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