CHRONIC DISEASE AND MENTAL HEALTH IN A PRIMARY HEALTH CARE SETTING

A Field Practicum Report

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Abstract

This practicum report summarizes my experiences as a Master of Social Work (MSW) student in my field practicum placement at the North Primary Health Care Network. Primary Health Care is an integrated and coordinated health service that is client focused, community designed, and team delivered. During the practicum placement, I increased my understanding of the services offered at the North Primary Health Care Network. I also gained an understanding and knowledge in the areas of chronic disease, public health, home care, and primary health care counselling. This report will discuss my involvement in the care pathways and the knowledge I gained from the clients, health care providers, managers, directors, and family physicians. I will discuss the strengths-based perspective and the intervention models, cognitive behavioural therapy (CBT), solution focused brief therapy (SFBT) and motivational interviewing (MI) that are utilized in primary health care. Lastly, I will discuss the values and ethics of social work in a primary health care setting.
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Introduction

This field practicum report is based on my Master of Social Work (MSW) practicum experience in Primary Health Care. Prior to my practicum placement, I was unaware of the full scope of primary health care and lacked knowledge about the social worker's role in this type of health care setting. Between September 6th and December 21st, 2018, I was fortunate to complete my field practicum placement at the North Primary Health Care Network (North Network) under the supervision of my professional associate, who has a Master of Social Work degree.

During my practicum, I shared an office space with my professional associate, who was the Director of the North Network. I was able to observe my professional associate in her role as a director while she managed and coordinated the delivery of services in the network. She supervised various professionals in the agency and ensured the Saskatchewan Health Authority's policies and procedures were implemented. Despite having a very busy schedule of meetings, the Director often made time to attend the interdisciplinary meetings where she provided clinical guidance and support to her staff members. As I observed my professional associate, I learned that a director must have excellent communication skills that aid in the fostering of partnerships with other community agencies and be responsible for problem solving issues, dealing with union matters, and financial budgets.

In this report, I will be discussing my practicum learning goals and the activities I completed to meet those goals. I will provide a brief history about primary health care in Canada and discuss the social determinants of health and mental health in primary health care networks. I will discuss the role of change management in Saskatchewan health and the theoretical
approach used in primary health care. Lastly, I will discuss what I learned in the North Primary Health Care Network and how this has strengthened and honed my skills as a social worker.

**Practicum Goal, Objectives and Activities**

**Practicum Goal**

The goal of my practicum was to acquire an advanced understanding of integrated and coordinated health services that were client focused, community designed, and team delivered. During the placement, I intended to increase my understanding of the services offered at the North Primary Health Care Network; specifically, I was interested in learning how to develop, coordinate and deliver a multidisciplinary care pathway for individuals with chronic diseases. In doing so, I would focus on delivering clinically supervised counselling support using solution focused brief therapy (SFBT) and cognitive behavioural therapy (CBT).

**Practicum Objectives**

The objectives for my field practicum were: to gain an understanding and knowledge in the following areas: chronic disease, public health, home care, and primary health care counselling; to research best practice findings in developing a care pathway for individuals with a chronic disease or condition; and to work with an interdisciplinary health care team in the coordination of care for individuals.

**Practicum Activities**

Prior to my practicum placement at the North Primary Health Care Network, the following activities were proposed:

- To complete a literature review on the integration of the social determinants of health into primary health care practices and pathway development. This would assist in my
analysis of current practice to recommend additional services for counselling chronically ill clients and supporting professionals who provide direct services.

- To conduct a literature review focused on solution focused brief therapy and cognitive behavioural therapy as therapeutic approaches and their relevance for specific application in the delivery of primary health care counselling support for individuals.

- To observe and develop an understanding of the coordinated services offered at the North Primary Health Care Network.

- To attend and participate in the regularly scheduled service coordination meetings with the multidisciplinary team.

- To assist in pathway development and develop strategies for home care workers to integrate positive mental health practices into their daily interactions with clients.

- To observe and co-deliver counselling sessions led by the primary health care counsellors with the goal of learning current approaches that are used in assessment and intervention with people who have a chronic disease or condition.

- To provide clinically supervised counselling services to clients with a focus on therapeutic approaches such as motivational interviewing, solution focused brief therapy, and cognitive behavioural therapy.

- To maintain a caseload of 5 – 10 clients, as assigned by my Professional Associate.

- To identify and provide recommendations to my Professional Associate for the improvement of mental health and social work practices in the management of chronic diseases/conditions in primary health care.
Rationale for Practicum Placement

For the past 13 years, I have worked in the area of mental health and addictions. I was employed at Child and Youth Services and provided counselling to youth and their families; more recently, I am a Senior Social Worker in the KidsFirst Program. In the spring of 2018, I started hearing some "buzz" words which included primary health care, stepped care, and networks. At that time, a rumour had surfaced that there was a possibility the KidsFirst Program would be moving under the Primary Health Care portfolio. Upon hearing about this potential move, my curiosity was piqued, and I started wondering what actually happened in the Primary Health Care networks and what the role of a social worker was in a primary health care setting. During my practicum, I learned about the role of a social worker, which I will explain later in this practicum report.

Primary Health Care

In this section, I will first provide a brief history of primary health care in Canada and discuss the social determinants of health. As I have an interest in mental health, I will be discussing the integration of mental health and primary health care. Lastly, I will discuss Primary Health Care Networks.

Brief History of Primary Health Care in Canada

In Canada, the key characteristics of the health care system focus on health delivery, consumer choice of provider, and physician autonomy. However, many family physicians operate in isolation from each other, with loose links to community services and/or specialized care providers (Nasmith et al., 2010). Although this isolation is shifting due to the increased focus on team-based primary care in several provinces, a basic fragmentation still exists in the health care system (Nasmith et al., 2010). During my practicum, I had the opportunity to interact
with physicians at a community planning event and was surprised to learn that many of them worked independently and had minimal contact with each another. It was great to hear the physicians express the benefits of having peer support and the value of sharing resources with one another.

In April 2001, the Prime Minister established the Commission on the Future of Health Care in Canada, which resulted in Commissioner Roy Romanow reviewing medicare and connecting with Canadians to discuss the future of health care (Commission on the Future of Health Care in Canada & Romanow, 2002). In 2002, the Romanow report discussed the need for an overhauled approach to the health care system and called for comprehensive interprofessional health care teams and increased health promotion (Brown, French, McCulloch, & Clendinning, 2012). The Romanow report recommended transforming the way the health care system worked by breaking down the barriers that existed between health care providers and putting the focus on consistent efforts to improve the health of all Canadians (Commission on the Future of Health Care in Canada & Romanow, 2002). By having primary health care as the central point of the health care system, this would result in a reduction of costly and inefficient repetition of tests and overlaps in care provided by different providers, as well as a replacement of unnecessary use of hospital, emergency, and costly medical treatments with comprehensive health care available 24 hours a day, 7 days a week (Commission on the Future of Health Care in Canada & Romanow, 2002).

Since the Romanow report was published, Canadian provinces have implemented changes in primary health care. For example, in British Columbia, interprofessional care networks were developed for patients with chronic health conditions and the Divisions of Family Practice was created for family physicians to address gaps in patient care and promote family
medicine. In the eastern Canadian Provinces, Newfoundland and Labrador divided the health care system into 30 team areas to serve the entire population (Brown et al., 2012). The western province of Alberta folded nine regional health authorities and three government agencies into one province-wide health system, now known as Alberta Health Services (Veitch, 2018).

Alberta Health Services has been responsible for programs and services spanning the entire continuum of care, including home care, primary care, addiction and mental health, acute care, clinical support services, ground and air ambulances, corrections health, public and population health, Indigenous health, seniors health, and continuing care (Veitch, 2018). Silos do not exist in Alberta Health Services and all parts of the health system work together to provide seamless care for patients and families (Veitch, 2018).

In 2017, the Saskatchewan Government decided to follow the lead of Alberta Health Services and consolidated the 13 regional health authorities into one province-wide health system currently known as the Saskatchewan Health Authority (SHA) (Veitch, 2018). During the amalgamation, SHA used lessons from Alberta which were: political and health system leadership needed to be aligned and share a common vision; healthcare transformation is a long-term process that has no end point; to strive for continuous improvement; physician leadership is critical to achieving interprofessional care and integration of services; to look at the health system as a whole and have strategies to leverage community-based services; and invest in information management technologies that support data sharing across professional and organizational boundaries (Veitch, 2018).

In the Saskatchewan Health Authority, there is an expectation that healthcare is to be guided by constant quality improvement with systems in place for the purpose of gathering and using health information (Nasmith et al., 2010). In order to improve coordination of services, the
use of integrated care pathways have been developed, which takes a patient from first contact with a health care provider, to a specialist, and then to ongoing care by other providers (Mahiben, Hasan, & Zeltner, 2015). Additionally, collaboration of health care professionals has led to the establishment of outpatient clinics in geographic locations (Mahiben et al., 2015) which have become the hub or home base for clients’ health care needs (Nasmith et al., 2010).

When focusing on health promotion, it is important to understand that social determinants of health, such as lifestyle factors, adequate housing, a clean environment, and good nutrition have an impact on the health of individuals accessing primary health care (Commission on the Future of Health Care in Canada & Romanow, 2002).

**Social Determinants of Health**

In this section of the report, I will be discussing the integration of the social determinants of health into primary health care practices. Canada is a wealthy nation yet many Canadians experience a multitude of persistent and costly health inequities (World Conference on Social Determinants of Health, 2011). For example, Aboriginal Canadians experience much higher rates of poverty, chronic disease, poor living conditions and food insecurity (World Conference on Social Determinants of Health, 2011). Additionally, other population groups affected by poverty are single mother led households, immigrants, and persons with disabilities (World Conference on Social Determinants of Health, 2011).

The World Health Organization’s definition of public health is a comprehensive understanding of the ways in which lifestyles and living conditions determine health status (Commission on the Future of Health Care in Canada & Romanow, 2002). The Commission on Social Determinants of Health defines social determinants of health as the structural determinants and conditions of daily life responsible for health inequities, while focusing on
improving people's access to health care, schools, education, work, and leisure (Rasanathan, Montesinos, Matheson, Etienne, & Evans, 2011). To address health inequities, primary health care and social determinants of health place a strong emphasis on health promotion and prevention, and on increasing the ability of people to access the resources required to stay healthy and protect themselves from disease and illness (Rasanathan et al., 2011).

Primary health care's vision is to have a sustainable system which results in superior patient experiences and a healthy Saskatchewan population (Saskatchewan Ministry of Health, 2012). In primary health care, there is major focus on chronic disease management but in order to combat chronic diseases such as depression, anxiety, chronic obstructive pulmonary disease (COPD) and diabetes, it is necessary to address the social determinants of health (Gore & Kothari, 2013). Social determinants of health are factors such as income, social support, early childhood development, education, employment, housing, and gender (Andermann, 2016).

There are many ways that health care providers can take action on the social determinants of health in the different levels of care. At the patient level, health care providers can ask patients about social challenges in a sensitive and caring way and help them to access support services in a timely manner (Andermann, 2016). At the practice level, physicians and health workers can offer culturally safe services, use dedicated facilitators to help patients access supports services more easily, and ensure care is accessible to those most in need (Andermann, 2016). At the community level, health care providers can partner with local organizations and public health, become involved in health planning, pathway development, and engage in activism by supporting social movements that advocate for basic income, affordable childcare and progressive taxation (Andermann, 2016).
Many types of health organizations, including medical clinics and hospitals are aware that illnesses can be prevented if people take better care of their health (Commission on the Future of Health Care in Canada & Romanow, 2002). During my practicum, I noticed that health care providers wanted their patients to have equitable access to health care services that were provided in a timely and coordinated manner. They stressed the importance of providing accurate and up-to-date information to patients, who could then make informed decisions about their own physical and mental health.

**Mental Health and Primary Health Care**

Because the focus of my report is on mental health and chronic disease, I reviewed a number of documents that pertained to mental health and primary health care. In this section, I will be discussing the importance of having integrated mental health services in the community and the value of collaborative relationships between health care providers.

Community mental health can be defined as encompassing the principles and practices needed to promote mental health by addressing population needs in ways that are accessible; building on the goals and strengths of people who experience mental illness; promoting a wide network of supports, services and resources; and emphasizing services that are both evidence-based and recovery-oriented (Thornicotf, Deb, & Henderson, 2016). A solution to the stigma of mental health is to encourage clients and their families to be involved in policy making, medical training, service provision, and service evaluation (Thornicoff et al., 2016).

According to Kates, Crustolo, Farrar and Nikolaou (2002), the role that family physicians play in delivering mental health care was greatly recognized. When mental health and primary care services are integrated, there is improved collaboration and communication between the counsellor and physician. This collaboration leads to increased functioning for patients and a
reduction in stigma associated with mental illness because the patient has also been included in the care plan (Kates, Crustolo, Farrar, & Nikolaou, 2002).

In a primary health care clinic, counsellors are responsible to provide treatment to individuals, couples and families, as well as to facilitate psychoeducational groups for anxiety, depression, and stress management (Kates et al., 2002). Treatment should follow a stepped care model and patients should be presented with a choice of therapies that are effective for a particular condition. Therapists should receive weekly supervision to ensure regular discussion of cases occurs, especially if a patient is not responding to low intensity therapies such as cognitive behavioural therapy (CBT) and psychoeducational groups (Clark, 2018). In Regina, the primary health care counsellors use two different measurements to assess for depression and anxiety which also helps guide their treatment plan. Patients are considered 'recovered' if their depression score on the Patient Health Questionnaire (PHQ-9) and anxiety score on the Generalized Anxiety Disorder (GAD-7) are above the clinical cut-off at the start of treatment and are below the clinical cut-off at the end of treatment (Clark, 2018).

**Primary Health Care Networks**

In the past year, I have noticed that primary health care has been a big topic of discussion in the community. Many people often ask me what primary health care is and they want to know what happens in the networks. For this section of the report, I will provide a snapshot of primary health care and describe the services that are offered at the North Primary Health Network where I completed my practicum.

According to the Saskatchewan Medical Association, primary health care encompasses a harmonious coexistence of health care providers working in a collaborative, flexible and adaptable partnership with the patient-family centre to achieve the common goal of better
outcomes for all (Saskatchewan Medical Association, 2011). Under the Saskatchewan Primary Health Care portfolio, community services include: Public Health Services, Home Care Services, Palliative Care, Rural and Acute Long-Term Care, Chronic Disease Management, Mental Health, First Nations Traditional Services, and Primary Health Care networks.

Primary health care networks were designed to provide community-based care that is delivered closest to the where the client resides, and services are received at the right time, and by the right provider. These networks focus on using interdisciplinary teams which provides the client with coordinated care in a timely fashion (Ingjaldson, 2018). The pyramid of primary health care focuses on the social determinants of health such as lifestyle choices, education, housing, income levels, early childhood development, culture, and community safety. Based on the City of Regina census data, network borders were developed to serve the populations residing within the four urban areas which are the North Network, Central Network, East Network, and South Network (Ingjaldson, 2018).

The North Primary Health Care Network where I did my practicum is responsible for providing services to urban areas including Argyle Park, Normanview, Rochdale, and Uplands (See Appendix A), as well as in the rural areas of Lumsden, Regina Beach, Craven, Southey, and Cupar (See Appendix B). This network houses different programs such as Public Health, Home Care, and Senior Housing. Within these programs, the multidisciplinary team consists of community care aides, licensed practical nurses, registered nurses, occupational therapy, physiotherapy, respiratory therapy, and assessor coordinators (social workers).

**Activities in Practicum Placement**

During my practicum in the North Network, I had the opportunity to participate in many activities to meet my practicum goals. In this section of the report, I will be discussing these
activities which range from coordinated services, coordination meetings, roles of interdisciplinary team members, chronic pain, pathway development, components of chronic disease and mental health. I will also discuss the educational opportunities that I partook in and the training that I provided in the community and to the public health nurses.

**Coordinated Services**

Primary care is regarded as a natural point of integration and coordination between clinical care, public health, and community services (DeVoe et al., 2016), as it ensures clients' needs are met in a timely and coordinated manner without having to rely on accessing an acute service like the hospital. During my practicum, I observed and developed an understanding of the coordinated services offered at the North Primary Health Care Network. For example, Home Care provided support services for individuals who wished to remain independent in their homes. These individuals may have had a physical disability, were elderly, or had surgery and required some assistance in their daily living.

Coordinated services are intended to support clients and allow earlier discharge from the hospital, meet their on-going long-term care needs in the community and prevent institutional placement. The range of services put in place ultimately depended on the assessed needs of the individual. For instance, if an individual had surgery on their shoulder and had limited arm movement, the assessor coordinator would meet with the individual to complete an assessment and determine if they needed assistance from a community care aide (CCA) with bathing and dressing and nursing to change bandages. At that time, the assessor coordinator could discuss with the client about having a physiotherapist and/or an occupational therapist involved to help improve arm movement.
The following services are available in primary health care: Home Care Services has Community Care Aides who provide personal care to individuals needing assistance with dressing, grooming, and bathing; Household Management assists clients with cleaning, laundry, and meal preparation; Nursing deals with procedures and treatments (i.e., immunizations, dressing changes, medication management, diabetic supervision and teaching, and IV therapy); Occupational Therapy assesses a client's level of functioning, and recommends, monitors, and evaluates devices to improve or maintain functional abilities; Physical Therapy provides assessment and physical therapy regimen for clients unable to access resources in the community; Social Work focuses on the assessment of clients' needs, referrals to appropriate services in the community, counselling and case management; Community Support Workers supports clients in situations of physical or psychological instability or where social isolation presents a problem; Meals on Wheels provides hot meals 5 days a week (at a cost by the client); Respite services (at a cost paid by the client) are provided to relieve the primary caregiver of caregiving responsibilities at periodic intervals (Saskatchewan Health Authority, 2017).

**Coordination Meetings**

During my practicum at the North Network, I attended and participated in regularly scheduled service coordination meetings known as 'huddles'. The purpose of these huddles was to have professionals work together as an interdisciplinary team and break down any barriers for clients. These interdisciplinary huddles were held daily where the various professionals discussed any problems their clients had pertaining to their health care, either at home, in a personal care home, a hospice or the hospital. For example, during one huddle, a manager spoke about the importance of fall prevention with the interdisciplinary team. Using the Plan-Do-Study-Act (PDSA) cycle, the manager noted the goal was to reduce falls for clients regardless of
where they resided. He expressed the need to understand why the individual fell and then determined the next steps to needed to reduce further falls, such as providing a client with a night light and ensuring clear pathways in the home.

In the North Network, the use of a collaborative framework was essential to ensure expected outcomes of the clients' care were met while being responsive to their needs (Saskatchewan Medical Association, 2011). During an early morning Community Care Aide huddle, I was able to see this collaborative framework put into action. On that particular day, there were three community care aides who were not at work due to illness and someone needed to cover their clients and do home visits. Initially I expected the community care aides, who were working that day, to be annoyed because they were too busy with their own work. Instead of cancelling the home visits, the community care aides discussed amongst themselves as to who had the capacity in their schedule to complete them. In order to ensure continuity of care for the clients, the community care aides worked together as a team to develop a plan for coverage and displayed great professionalism while doing so. I must admit, seeing the community care aides in action was impressive because in my experience at Child and Youth Services, appointments were usually cancelled when a clinician was ill and rescheduled.

Throughout my practicum, I regularly attended the daily huddles and noticed the interdisciplinary team's goal was to always be client-centred. In the huddle room, there three huge white boards which were called visual boards; one board had clients' names attached to the community care aides; the second board had clients' names attached to the nurses; and the third board had clients names' attached to the assessor coordinators. On these white boards, a brief case plan was listed beside the clients' name, as well as the assigned worker from the interdisciplinary team. During these huddles, the interdisciplinary team would discuss the
available information about the clients and whether there were changes to the care plan. If any changes occurred, the visual board was updated to reflect the current case plan for the clients. These huddles were a great way to ensure continuity of care for the clients and for the interdisciplinary team members to have time to consult with one another.

**Role of Assessor Coordinator**

In this section, I will be discussing my practicum activity goals, which was to maintain a caseload of 5 - 10 clients. Unfortunately, this activity was not doable because of the legal guidelines pertaining to students documenting on the Medical Access System. Instead, I had the opportunity to work with social workers who were known as assessor coordinators. In the North Network, the assessor coordinator's role is to complete assessments on clients at specific times of the year, as determined by their admission into the personal care home and/or if home care services are still required. At these assessments, the assessor coordinator would get an update on the client's current circumstances and functioning in order to reassess their needs. To improve the flow and coordination of care, the assessor coordinators could access the client's electronic medical record on the Sunrise Clinical Management (SCM) system, as well as collect collateral information from family members and home care workers prior to meeting the client.

In order for me to complete assessments, I needed to obtain training in the following programs/processes: Procura, Minimum Data Set (MDS-Home Care Assessment), Regina Risk Indicator Tool (RRIT), Mini-Mental State Examination (MMSE), Montreal Cognitive Assessment (MOCA), and Program Access Committee (PAC) Criteria. Procura is a software application that is used nationally and internationally by homecare organizations to document aspects of client care. Procura reduces the risk of error by increased documentation and reporting services, as well as it synchronizes client data (Information Technology, 2018)
The Minimum Data Set (MDS-Home Care Assessment) is a tool that enables assessor coordinators to complete comprehensive assessments on their clients. This assessment is built into Procura and integrates client information and outcome measurement scales utilized in care planning. The Minimum Data Set assessment is very similar to a biopsychosocial assessment, as the information collected from the client assesses their health, cognition, mood, social functioning, physical functioning, substance use, support system, medication history and any special therapies or programs they are accessing (Morris et al., 2010). Also built into Procura, is the Needs Assessment, which is a summary of the Minimum Data Set assessment and contains information about the client's care needs and identifies their service care plan which may consist of case management, home care services, occupational therapy, physical therapy, respite, or long-term care (Regina Qu'Appelle Health Regina, 2017).

In the North Network, assessor coordinators used the Regina Risk Indicator Tool (RRIT) to collect objective information that could assist them in predicting a client's potential risk of requiring long-term placement or if needing supportive home care services, respite, or convalescence. Clients who had impaired functioning, advanced age, presence of dementia, poor health, recent hospital admissions and absence of caregiver support were deemed high risk and usually needed long-term care (Regina Qu'Appelle Health Region, 2003).

Assessor coordinators are responsible for completing the Minimum Data Set, Needs Assessment, and the Regina Risk Indicator Tool on all clients. These assessments determine what type of service request is required, whether it is case management, occupational therapy, physiotherapy or home care. Additionally, the Decision Algorithm for Supportive Housing (DASH) Tool is another tool that assessor coordinators use when assessing the clients daily living and deciding whether they require home care, supportive housing or long-term care.
placement (Morris et al., 2010). During the assessor coordinator training, the trainers reviewed the DASH tool, which was a sequence of instructions that pertained to the client and their marital status. If the client had low scores (1, 2, 3) then they were eligible for home care services. If having higher scores (4-5), then a client may receive supportive housing. If a client is unmarried and has minimal scores (0-6) for cognitive performance, they are eligible for home care services and supportive housing. If the unmarried client has poor cognitive performance and has bladder incontinence, then they would qualify for long-term care (Morris et al., 2010).

The training I received was facilitated by two senior social workers in the Saskatchewan Health Authority and they stressed that assessor coordinators needed to comply with the Home Care Guidelines. The trainers further stressed the importance of accurate and thorough documentation for determining the right placement to meet the client's needs. To ensure quality control of care, the trainers spoke about the Procura and Minimum Data Set audits that are completed by the senior social workers. They also spoke about the documentation standards and the accountability required from an assessor coordinator, as well as the importance of confidentiality under the Health Information Protection Act (HIPA). Initially, I was shocked at how much training was required for the assessor coordinators. However, as I reflect on this now, the assessor coordinator's ability to assess and provide appropriate recommendations is paramount for the future of individuals' needing home care services and long-term care placement.

After receiving my training, my professional associate approved me to complete six Home Care assessments. My role was to set up the assessment time to meet with the client in the personal care home. I used the Minimum Data Set assessment tool when I interviewed the client, their family members, and the personal home care workers/owners. This tool was helpful when
making my decisions regarding services to support and supplement the individual's needs. For example, a middle-aged male had been in the hospital due to major swelling on his leg and was required to wear an air cast boot. Upon discharge from the hospital, the client's case plan was to receive home services in the morning for assistance in putting on the air cast boot; home care nursing to assist in changing the dressing on his leg; and assessor coordinators to provide case management. At the time of the assessment, the client expressed concern because his air cast boot did not fit right. Referral requests were then made to the occupational therapist and the physiotherapist. However, due to the client's pressing issue of pain, an emergency consultation was held with the physiotherapist, who agreed to meet the client that day to address concerns with the air cast boot. While working in the area of Mental Health and Addictions, I had to use different assessment tools and consult with psychologists and psychiatrists. Therefore, I found it fairly easy to use the Minimum Data Set assessment tool and consult with the physiotherapist.

In my career as a social worker, I have mainly worked with youth and parents. I must admit that I felt a bit nervous at first because I had the perception that elderly clients would be difficult to engage. However, I noticed that the interview process was similar to the past interviews I had completed at Child and Youth Services, which allowed me to feel at ease with the client. The only area where I felt a bit uncomfortable was discussing advanced care directives with the clients, as I did not want to offend or upset them. I soon learned that this was not the case, as the clients were very open about discussing who their legal guardian or substitute decision maker was.

After completing the assessments, I realized that my initial perception about the elderly clients being difficult to engage was completely wrong. Instead, I found these individuals to be very engaging, funny, and great storytellers. Overall, I was really impressed by their level of
functioning and the programming they received in the personal care homes. Although some needed extra assistance, many of them were still active despite their age and appeared to have a bright outlook on life. For example, one 88-year-old woman still drove to church and visited friends, while another loved to go shopping and get her hair styled.

However, for some older adults, their quality of life can be diminished when they are no longer able to perform daily activities due to illness (Piane, 2015). This was the case for an elderly gentleman with dementia, who had attempted suicide because he felt like a burden to his family. At the case management meeting in the hospital, the assessor coordinator spoke with the client and his wife about respite care options because his wife was concerned about leaving him unattended at home. In order to access respite care at the Santa Maria Senior Citizens Home and William Booth Special Care Home, the assessor coordinator advised a needs assessment would have to be completed approximately two months before accessing respite. The assessor coordinator informed the couple about respite services at Regina Pioneer Village at a cost of $9.10 per day, for as long as the client wanted and up to two days per week. They were also informed that respite beds were based on income (up to a maximum of $16.00 per day).

During my practicum, I also had the chance to attend the Program Access Committee (PAC) meeting. This committee was comprised of a coordinator, a social worker, and a nurse. During this meeting, the committee reviewed the needs assessment completed by the assessor coordinator, who was either present in the room or participating via telephone. The Program Access Committee had many questions about the client's current functioning, his/her short-term memory and whether he/she could continue to live independently. This committee either accepted the client for long-term placement or provided recommendations to the assessor coordinator, such as accessing other services because the client did not yet meet the criteria for
extensive home care. I noticed these decisions were made in the best interest of the client and done in a thoughtful and respectful manner. I also realized how important it was to use the assessment tools correctly and to have proper documentation about the client because this information helped the Program Access Committee in their decision making for long-term care placements of individuals.

**Chronic Disease and Chronic Pain**

During my practicum, a large portion of my activity goals were focused in the area of chronic disease. Therefore, I reviewed the literature on chronic disease and chronic pain. Chronic Obstructive Pulmonary Disease (COPD) is often associated with chronic pain but it remains poorly understood (Andenaes, Momyr, & Brekke, 2018). Shortness of breath is the main symptom of COPD which results in people having moderate to severe pain in their neck, shoulder blades, and lower back (Andenaes et al., 2018).

Chronic pain is defined as moderate to severe pain lasting more than 6 months that is experienced almost every day, and significantly interferes with daily activities (Spero, 2019). For individuals who have diabetes, chronic pain makes self-management much more difficult and often leads to higher blood glucose levels. The types of pain often reported by people with diabetes include headaches, back pain, pain in the feet or hands, arthritis, and muscle and joint fatigue (Spero, 2019).

Chronic pain is a serious and debilitating condition that is associated with higher economic burden, poorer quality of life, lowered physical functioning and worsened mental well-being (Racine, 2017). Individuals with chronic pain often experience sadness, frustration, anger, and low self-esteem due to the loss of independence (Batstad & Rudmin, 2016). Additional psychological factors such as feelings of helplessness and hopelessness towards pain, a desire to
escape from pain, pain-related catastrophizing and avoidance, and problem-solving deficits might be potential determinants for suicide (Racine, 2017). Because pain is invisible, family members, coworkers, and healthcare professionals often do not know or cannot see what that person in pain is going through (Spero, 2019), which can further exacerbate feelings of loneliness, sadness, anger, and frustration.

It is optimistic to know that many chronic diseases are preventable and can be managed to reduce, delay, or avoid debilitating impacts on patients and families (Saskatchewan Ministry of Health, 2012). By developing a province-wide vision, setting measurable goals, and focusing on the social determinants of health, Saskatchewan's health care sector can contribute to a healthy population (Saskatchewan Ministry of Health, 2012). When patients are equipped with the right information and supports, they can do a great deal to manage their own health and chronic disease (Saskatchewan Ministry of Health, 2012).

**Chronic Disease Management Meetings**

During my practicum, I attended weekly and monthly Chronic Disease Management (CDM) meetings with a family physician, directors, managers, and other care providers. At these CDM meetings, discussions were held to address any concerns related to the health care of individuals and the flow of service delivery. In order to avoid fragmentation of services, the goal was to ensure there was standardization of work processes in place. Additionally, the CDM meetings ensured there was follow through on any commitments that were made by the care providers involved.

Physicians and other healthcare professionals in clinical practice should have educational opportunities in the process and benefits of pulmonary rehabilitation consistent with evidence-based guidelines (Rochester et al., 2015). At the Chronic Disease Management meetings that I
attended during my practicum, there were discussions about having licensed practical nurses, registered nurses, community care aides, paramedics, physiotherapists, and occupational therapists trained in spirometry testing, as this would allow the respiratory therapists time to focus on providing education. Spirometry testing is used to measure airflow into and out of the lungs. The individual receiving the spirometry test breathes into a machine called a spirometer, which records the amount of air breathed in and the speed of their breath. However, the expressed concern was that the community care aides do not have medical knowledge or a professional regulatory body that would allow for them to do this testing.

Pathway Development

Prior to my practicum placement, one of my activity goals was to assist in pathway development and develop strategies for home care workers to integrate positive mental health practices into their daily interactions with clients. Although I did not develop strategies for home care workers, I was able to assist in pathway development. A care pathway is a set of management guidelines that improves the quality and flow of healthcare for individuals with a chronic disease or medical conditions. A pathway takes a patient through a series of steps that links to information related to prevention, screening, testing, diagnosis, and management of the chronic disease. The pathway provides the health care practitioner with all of the relevant leading practice information on a chronic disease and how to access resources (Saskatchewan Health Authority, 2018).

When I first met the manager of Chronic Disease, I was informed that the project for the chronic disease pathway started in 2009 but implementation of the pathway had ceased. However, in 2014, the chronic disease project was visited again by a physician with the University of Saskatchewan, with a focus on Chronic Obstructive Pulmonary Disease (COPD).
In 2018, intensive work was undertaken by physicians and various health care providers, which resulted in the completion of the clinical COPD pathway. Health care providers have since decided to replicate the COPD pathway for five other chronic diseases, which are diabetes, chronic heart disease, chronic artery disease, asthma, and anxiety/depression. In the original design for the COPD pathway, the following areas were addressed: prevention, targeted screening, testing, diagnosis, clinical management, and follow-up.

In the COPD pathway, clinical assessment begins with a thorough history and physical examination of the individual (O'Donnell et al., 2008). The following criteria are recommended to help the family physician target who to screen for spirometry testing and establish early diagnosis in individuals at risk of COPD. Risk factors include: patients who are older than 40 years of age and are current or ex-smokers; and if they answer 'yes' to any one of the following questions: Do you cough regularly?; Do you cough up phlegm regularly?; Do simple chores make you short of breath?; Do you wheeze when you exert yourself or at night?; Do you get frequent colds that persist longer than those of other people you know? (O'Donnell et al., 2008).

After receiving the above targeted screening, the individual has a spirometry test completed by a respiratory therapist and a doctor interprets the results of the test. Once a person is diagnosed with COPD, they are encouraged to connect with a Primary Health Care Network and meet with a respiratory therapist for clinical management.

At the start of my practicum, I met with a respiratory therapist (RT) to learn about her role. She explained respiratory therapists complete the spirometry testing, but a physician must provide the diagnosis of COPD. She noted a respiratory therapists' role also includes completing tracheotomy changes, checking ventilators, running spirometry clinics, providing education, and facilitating a pulmonary rehabilitation course.
Patient Facing Pathway

In this section, I will be discussing the development of a patient facing pathway that I participated in during my practicum. In order to increase patient awareness and knowledge of pulmonary rehabilitation, professionals, patient advocates, and education experts should collaborate in the development of education materials for patients with chronic respiratory disease (Rochester et al., 2015). The patient facing pathway is a set of guidelines that improves the quality and flow of healthcare for individuals with a chronic disease. This type of pathway takes a patient through a series of steps that links to information related to prevention, screening, testing, diagnosis, and management of the chronic disease (See Appendix C).

In order to develop the patient facing pathway, meetings were held with patients and their families, alongside other health care professionals to influence the information presented in the management of COPD. For instance, one participant thought it would be beneficial to advertise COPD using a picture of himself on a poster, which could be displayed where trades people work or on a public bus, with the idea that the community could relate to him. One of the goals of the patient facing pathway was to create public awareness of pulmonary rehabilitation through communication campaigns (Rochester et al., 2015). Patients and health care providers suggested using social media to post information about smoking cessations and using Facebook to facilitate discussions about COPD.

The main objective of the patient facing pathway was to mimic the information that was found in the COPD clinical pathway that physicians refer to. Both of these pathways can be found on the Saskatchewan Health Authority website. The patient facing pathway is an interactive guide that is easy to navigate and provides education to individuals and their families about COPD (Saskatchewan Health Authority, 2019). Although the COPD clinical pathway has
the same layout of headings (prevention, targeted screening, testing, diagnosis and management)
the language is more technical and geared towards health care professionals (Saskatchewan Health Authority, 2019).

**Pulmonary Rehabilitation**

In the COPD clinical pathway and the patient facing pathway, pulmonary rehabilitation (PR) is a recommended part of managing COPD. Pulmonary rehabilitation is a comprehensive intervention based on a thorough assessment followed by patient-tailored therapies that include exercise training and education. These therapies are designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote long-term healthy behavior (Rochester et al., 2015). Pulmonary rehabilitation reduces patients' symptoms; improves limb muscle function, exercise capacity, emotional functioning, quality of life, knowledge, and self-efficacy; and is an essential component of integrated care (Rochester et al., 2015).

The components of COPD education include self-management, effective inhaler technique, early recognition and treatment of acute exacerbations, identification of community resources and end-of-life care issues (O'Donnell et al., 2008). In Regina, the Pulmonary Rehabilitation Course was facilitated by a respiratory therapist (RT) and ran twice a week from early September to the end of November. At the first two classes and the last class, the respiratory therapist had participants complete 6-minute walk tests, which provided pre/post information about improvements in their breathing. Respiratory therapists, health educators, and social workers spoke at these classes on topics that included management of COPD, spirometry testing, action plans, advanced care planning, oxygen funding, living well with chronic conditions, stages of change, depression and anxiety, and stress management.
Because I only had minimal knowledge about COPD, I attended the first class of the Pulmonary Rehabilitation Course. The respiratory therapist provided psychoeducation on COPD and what it meant to have this chronic disease. She noted individuals must understand the disease in order to be the best advocates for themselves. It was interesting to hear one of the patients speak about his experience with COPD and the importance of understanding the chronic disease because then it felt like he "had a fighting chance". He also spoke about the value in being connected to a primary health care network and the Eagle Moon Health Office, as well as the benefits of attending pulmonary rehabilitation where he met other individuals with COPD. The respiratory therapist stressed the importance of participants practicing positive self-care such as eating healthy, exercising, quitting smoking, getting vaccinated and treating lung infections. During the class, the respiratory therapist had participants practice different types of breathing exercises to manage/prevent sudden shortness of breath, as well as manage symptoms of anxiety when experiencing breathing difficulties. She also taught participants various exercises that would help keep their lungs in good shape.

As part of the pathway component, I presented on the topic of Stress Management for the Pulmonary Rehabilitation Course and facilitated group discussion with the participants. Many group participants spoke about their difficult journey to get a diagnosis of COPD and reminisced about their feelings once they received it. It became evident that mental health services were greatly needed for individuals diagnosed with COPD, as they seemed to have symptoms associated with anxiety and depression. For example, one participant spoke about not being able to leave her home due to her low mood. She remembered feeling worried at that time, as she perceived people would judge her when have coughing fits. She also spoke about having panic attacks when unable to breathe. Another female participant reported feeling very upset with her
doctor, as he was not personable when confirming her diagnosis. Lastly, a male participant spoke about his feelings of anger because his quality of life deteriorated. He noted feeling sad that he could not complete chores in his yard or engage in physical play with his grandchildren. I found this group of individuals to be very respectful and supportive towards one another. In fact, some of the participants joked about attending the next Pulmonary Rehabilitation Course together in January 2019 because they enjoyed each other's company.

**Supplemental Oxygen**

Although pulmonary rehabilitation is recommended for the management of COPD, some individuals face barriers such as transportation issues, financial issues, and lack of extra oxygen. As a result, respiratory therapists end up advocating for their clients to have enough oxygen to participate in pulmonary rehabilitation. During a chronic disease management meeting, the question was raised as to whether pulmonary rehabilitation negatively sets up people because oxygen is provided for them while they attend classes but not otherwise. Once the pulmonary rehabilitation course is finished, the individual no longer has access to supplemental oxygen and their health is negatively impacted due to lack of exercise. As individuals become housebound and unable to attend maintenance groups, their mental health begins to deteriorate, resulting in depression and anxiety.

In this section, I am going to discuss the significant differences that exist in the provision of home oxygen across Canada (Lacasse & Bernard, 2015). To address the concerns about supplemental oxygen, a group of directors, managers, and health care providers formed a provincial oxygen planning committee. As part of the COPD pathway, I was involved in these provincial meetings and completed research on access to oxygen. I was tasked with contacting the oxygen companies in Canada and speaking to the representatives. I inquired about the
criteria for the home oxygen program, what kind of coverage was available, the different types of packages for oxygen, and the rules on accessing supplemental oxygen. After collecting information from the 10 provinces, it seemed that Alberta's Home Oxygen Program was the best program because there was no cap on the oxygen supply and residents were provided with an unlimited amount of oxygen cylinders.

When I spoke to a representative through the Saskatchewan Aids to Independent Living (SAIL), I was informed that it was up to the individual to choose the oxygen company that would provide the best service and pricing needs to suit their needs. I remember hearing this and thinking individuals are likely to be in shock after being diagnosed with COPD and this practice was unhelpful and unkind. Although pulmonary rehabilitation is recommended to improve an individual's health, SAIL will only provide 10 oxygen cylinders per month. According to a respiratory therapist, the provision of 10 cylinders would have been enough for an individual in the past because the goal was to just keep them comfortable in their home. However, this is no longer the case today because people who have COPD are managing the disease and living longer lives. When I attended the Pulmonary Rehabilitation Course, individuals spoke about their productive lives which consisted of exercise and spending time with friends and family in the community.

Because Saskatchewan is the only province that does not provide supplemental oxygen, health care providers involved in the provincial oxygen planning meeting discussed doing a cohort study to review an individual's pre/post rehabilitation results with a follow up in three months to see how they were doing. During the oxygen planning meeting, a researcher with the Saskatchewan Health Authority recommended filling out paperwork to provide to the Research Ethics Board before starting the cohort study. At that time, the provincial oxygen working
group's next steps were: to complete research on emergency room visits and track why the individual was short of oxygen; respiratory therapists to track the six minute walking tests; use of an activity scale to measure quality of life; check to see if people paid privately for oxygen; ask patients to participate in the cohort study and have them explain how pulmonary rehabilitation helped them; and invite the Saskatchewan Lung Association to be involved in the provincial oxygen working group. Overall, I was so amazed by those involved in the provincial oxygen planning committee, as they were highly committed to challenging the current provincial state of oxygen delivery.

**Diabetes Pathway Development**

Besides being involved in the latter part of the COPD pathway development, I had the opportunity to participate and facilitate in the pathway development for diabetes at all stages (early consultation, implementations and patient facing development). I found it very interesting to be involved in the planning stages of this pathway. Things that I would not have thought about such as referral forms, invitations and RSVPs, agendas, funding for physicians, and facilitator roles for the diabetes community pathway design event were arranged and set up.

Prior to the diabetes pathway design event, the planning committee thought it would be beneficial to complete six client chart reviews and document the individual's journey of having diabetes. However, the clients' consent to have their medical file reviewed for the purpose of sharing their information was not obtained due to confidentiality issues; therefore six client charts were not reviewed. Ultimately, the family physician spearheading Chronic Disease Management did not think file reviews were needed because the charts would provide too much information for the participants to focus on. For this pathway designing event, the main goal was to identify gaps and overlaps in services and deconstruct the existing way of managing diabetes.
As the pathway design event neared, I realized I needed to improve my knowledge about diabetes. I proceeded to review information about this chronic disease from the Diabetes Canada website. Under the screening for and diagnosing of diabetes, physicians use a healthcare provider tool which calculates risk and measures fasting plasma glucose (Diabetes Canada, 2019). The risk factors for Type 2 Diabetes are being 40 years and older, having a first degree relative with Type 2 Diabetes, belonging to a high risk population (African, Arab, Hispanic, Indigenous, South Asian Descent), and having low socio-economic status (Diabetes Canada, 2019).

As I reviewed the information on the website, I noticed that high risk people for pre-diabetes and diabetes should be educated and screened in primary health care settings. Regarding early diagnosis, it was recommended individuals work with an informed team of health care professionals who can screen, monitor, care, and treat complications (Diabetes Canada, 2019). The team should consist of physicians, nurses, diabetic educators, dieticians, physiotherapists, occupational therapists, social workers, community workers, psychologists, and Aboriginal traditional knowledge keepers and/or Elders (Diabetes Canada, 2019). In Regina, Metabolic and Diabetes Education Centre (MEDEC) provides diabetes education, care and support to adults, youth, and children with Type 1 and 2 Diabetes, pre-diabetes, gestational diabetes, and hypoglycemia (Diabetes Canada, 2019).

The purpose of the diabetes community pathway design event was to talk about existing services, services that needed to be built, and services that patients and health care providers would like to have. The diabetes community pathway design event was supposed to get health care providers to change the way they think and give patients what they needed. The ultimate
goal of the pathway design event was to help professionals to focus on chronic disease rehabilitation and map the process for health care improvement.

The diabetes pathway event was held at the Pasqua Hospital Auditorium and approximately 40 people attended. Participants were placed into small groups and given specific topics to brainstorm. Everything from prevention to follow-up care was discussed, and plans and resources were set in place to build a comprehensive and interactive tool that health care providers could use to navigate and connect patients to the most appropriate services (Saskatchewan Health Authority, 2018). In my small group, physicians and managers from the Ministry of Health spoke about what was entailed in the testing and diagnosis of diabetes. Although individuals and families were invited to share their experiences about having a chronic disease, only one individual attended the diabetes event. This individual spoke openly about having diabetes and became very emotional when discussing how this chronic disease had affected him and his family members' lives.

On day two of the diabetes community pathway design event, physicians focused on mental health concerns and the difficulties in treating comorbidity (presence of a chronic disease like diabetes with depression and/or anxiety). They expressed concern when diabetic patients gain weight while taking antidepressants but then choose to stop taking the medication, resulting in further bouts of depression. The physicians identified treatment barriers for individuals which included poverty, lack of transportation, inability to find childcare, and minimal education in school about chronic diseases. According to a physician in the group, when a patient has proper information, they can make better decisions about their treatment. Overall, the expressed need for interdisciplinary teams and case management was expressed by most health care providers.
During the small group discussion, some health care providers had issues pertaining to the access and flow of services. The physicians recommended to have better flow of information between health care providers and to have access to referral forms that were easy to fill out. Also, there were complaints about the electronic health records/medical records system that is used in the Saskatchewan Health Authority. For example, a health care provider spoke about not having immediate access to hospital information when providing care to patients.

After the diabetes pathway design event, the diabetes planning committee met to organize the information that was obtained from physicians and other providers. The information was placed into categories and a "parking lot" was created to set aside concerns that did not fit into the categories. The main concerns identified from the pathway design event were barriers for rural patients, the lack of availability of healthy food, obesity management, mobility and transportation issues, low income, lack of exercise, and depression. According to the Physician Dyad for Regina Urban Primary Health Care, diabetes co-exists with many other chronic conditions and it is vital to get it under control right from the point of diagnosis. He noted that diet, education and physical activity are major factors in changing health outcomes for patients (Saskatchewan Health Authority, 2018).

Role of Primary Health Care Counsellors

Although the original plan was to observe and co-deliver counselling sessions led by the primary health care counsellors, with the goal of learning current approaches in assessment and intervention with people who have a chronic disease, this did not come to fruition due to the policy around students documenting on the Medical Access System, as earlier stated. However, I was able to interact with the Primary Health Care (PHC) counsellors and learn about their roles. The purpose of having counsellors in the primary health care networks is to provide counselling
for individuals who have mild to moderate mental health concerns, in particular anxiety and depression. The PHC counsellor's role is to provide brief therapy and explore strategies for coping and problem-solving with the client.

**Anxiety and Depression CBT Group**

During my practicum, I had the pleasure of facilitating an Anxiety and Depression group that was based on cognitive behavioural therapy (CBT) principles. This CBT group was facilitated by two primary health counsellors and was held once a week at the Meadow Primary Health Care Centre for five weeks. Participants either self-referred or were referred by their primary health care counsellor and/or other health care providers in the community. Due to the small space at the Meadow Primary Health Care Centre, only 10 participants were registered for this group. Prior to the group sessions I met with the two counsellors and was provided with specific sections to facilitate in the psychoeducational group. To prepare for my sections, I researched additional information to share with the participants about anxiety and depression.

Although this group was well attended, there was one participant who was always disruptive and displayed oppositional behavior towards the facilitators and other participants.

In order to manage this participant's disruptive behaviour, I reviewed the group rules and asked individuals to talk to the primary health care counsellors at the end of the session if they were having more pressing needs. However, this participant was disruptive again and wanted to engage in arguments about using CBT while expressing a lack of wanting to feel better. At the end of the session, one of the counsellors met with the participant to discuss whether the group was appropriate for him. The counsellor displayed a calm demeanor while listening to the participant, who appeared to be suspicious about strangers he had encountered in the community. The counsellor completed a quick mental health assessment and then recommended the
participant contact his psychiatrist to discuss his concerns, as well as speak to his family
physician about a referral for individual counselling.

Once this participant left the primary health care centre, the counsellor spoke to her
manager about this individual's disruptive behaviour and his perceptions about strangers in the
community. The manager directed the counsellor to provide documentation on the individual's
file, in hopes that the involved psychiatrist would see the update of circumstances. It was
decided that the participant could continue to attend the group but that the counsellors would
need to establish good boundaries with him. In the follow-up group sessions, this participant did
manage to maintain appropriate behaviour and complied with the group rules.

The benefit of working in a primary care setting enables a counsellor to share cases with
the family physician and discuss additional referrals to other community resources (Kates et al.,
2002). While a broad range of problems can be managed by a Primary Health Care (PHC)
counsellor, it is important to note that some counsellors may not have the skills or expertise to
assess every problem or to implement certain treatment approaches. Although primary health
care should complement mental health services, it should not replace traditional outpatient
clinics or programs. For some individuals, depending on their mental health diagnosis and
psychiatric involvement, they may require intensive outpatient services through the Adult Mental
Health Clinic or Inpatient Mental Health Services at the Regina General Hospital.

Peer Support Model

Prior to my practicum placement at the North Network, one of my activity goals was to
identify and provide recommendations to my Professional Associate for improvements of mental
health and social work practices in the management of chronic diseases or conditions. During
the practicum, my Professional Associate requested that I review peer support models in Canada
because there was an interest in implementing peer support for employees who have experienced critical incidents. The current support that employees receive in primary health care is speaking to their peers, manager, or an Employee Family Assistance Program (EFAP) counsellor.

When I reviewed the literature on peer support models, it was a costly venture due to the ongoing training of counsellors. Essentially, the Leadership Team would need to be supportive and committed to the implementation of a peer support model. Two major concerns that were identified in having a peer model was around confidentiality and professional boundaries, as employees would be acting in a counselling role for their co-workers. I completed an annotated bibliography and provided recommendations for implementation in the area of Peer Support for health care providers to the Regina Leadership Team (Primary Health Care Directors) for consideration in future planning. In speaking with my professional associate, she was cautious about having the peer support model due to the issues of confidentiality and training and wanted to ensure that proper steps were taken before implementing this model.

**Brain Story and Public Health Nurses**

At the start of my practicum, my Professional Associate and the manager of the Public Health Nurses requested I complete 'Brain Story' for the purpose of providing education to the Public Health nurses. Brain Story is a certification course offered on-line through the Alberta Family Wellness Initiative (Alberta Family Wellness Initiative, 2018). Brain Story puts scientific concepts around the development of the nervous system, health, and wellness into a social context and shows how these topics connect and interact. This core training is based on a set of principles that experts across the field of neuroscience (study of the brain and how it interacts) and early childhood development believe are important for people and policymakers to
understand in order to make informed decisions about health, education, justice and social services (Alberta Family Wellness Initiative, 2018).

Using information from Brain Story, I facilitated a presentation to the Public Health Nurses that focused on brain development, adverse childhood experiences (ACEs), and maternal mental health. I noted that experiences at key periods of development in a child's life changes their brains in ways that increase or decrease risk for later mental and/or physical illness. I explained that an individual with high adverse childhood experiences (ACEs) may have endured neglect, multiple types of abuse (physical, sexual, and psychological), family dysfunction, and stress. In addition, I noted that adverse childhood experiences are associated with health-related risk factors such as substance abuse, risky sexual behavior, obesity, cardiovascular disease, cancer, and diabetes (Ximenes, R., Ximenes, J., Nascimento, Roddy, & Leite, 2019).

In discussion with the public health nurses, some of them were unaware of the KidsFirst Program, while others stopped referring mothers because there was a perception that only families living in the inner-city area were accepted. I provided an overview of the KidsFirst Program, which is a voluntary program for children (ages 0-3) that enhances parenting knowledge, provides support for the family and builds on family strengths. Services include prenatal referral and support; in-depth family assessment; home-visiting services; mental health and addiction services; early learning and child care opportunities; and family support opportunities (KidsFirst Regina, 2019).

During my discussion with the public health nurses, if anxiety and depression are present, they will refer mothers who consent to services to the Primary Health Care counsellor or the Maternal Wellness Program. The Maternal Wellness Program has a registered psychiatric nurse or social worker who conducts assessments on mothers and provides emotional support,
coping strategies and information about community resources (Saskatchewan Health Authority E-Link, 2018). Participating women are discharged from the Maternal Wellness Program once permanent supports are in place with their primary healthcare providers, mental health clinician, or when their score on Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) shows improvement.

The Edinburgh Postnatal Depression Scale (EPDS) (See Appendix D) was designed to identify patients who are suffering from postpartum depression and consists of a 10-item questionnaire. This scale is used within eight weeks of postpartum but can be frequently used to identify depressive symptoms during pregnancy (Morgan, 2016). It is important to routinely screen women during the postpartum period because they are at a higher risk of developing psychiatric symptoms and conditions like anxiety, depression, bipolar disorder, and psychotic depression. Additionally, there is a link between maternal depression and adverse outcomes in children (Alberta Family Wellness Initiative, 2018). Therefore, screening and prevention provides a great opportunity to improve mental health outcomes in mothers and avoid the intergenerational transmission of mental health problems to their children.

**Change Management in Saskatchewan Health**

In this section of the report, I will discuss Continuous Performance Improvement and the Plan-Do-Study-Act cycle. These two principles were commonly used during my practicum. These principles are derived from the Lean Performance Management approach. This approach has been a guiding philosophy in the reorganization of health services undertaken in the amalgamation of the provincial system.
Lean Practice

In Saskatchewan's health care system, Lean is a patient-centred approach that has been used to help health care professionals provide reliable, safe, and timely health care. Lean thinking has been useful in shifting the focus of improvement from individual tasks to the process (Brandao de Souza & Pidd, 2011). Lean thinking requires a balance between quantitative and qualitative skills, which enables health care practitioners to develop proficiency by using quantitative tools in order to have continuous improvement (Brandao de Souza & Pidd, 2011). Lean practice is not based on finding quick, temporary solution to problems, but rather understanding the root cause of delays and other impediments to the flow of care (Brandao de Souza & Pidd, 2011).

Continuous Performance Improvement

Adapted from lean methodologies, continuous performance improvement (CPI) standardizes health-care processes and delivery of uniform outcomes (Hagan, 2011). This standard works to removes obstacles and glitches that confuse health care providers and frees them to concentrate on their patients care instead of dealing with wasteful processes (Hagan, 2011). Continuous performance improvement is about providing value to patients by improving the quality, safety, and accessibility of services (Hagan, 2011). In the Saskatchewan Health Authority, new concepts and delivery systems are continually evaluated and modified with the input of providers, patients, administrators, and communities (Saskatchewan Ministry of Health, 2012). During the meetings I attended with managers and Directors, I noticed that the underlying goal was to always improve patient and family access to services, while ensuring that work standards were continually updated and followed by staff. A work standard is a Lean tool
that has a series of steps to ensure best practices are met. I am quite familiar with work standards, as Child and Youth Services has been using them for several years.

**Plan-Do-Study-Act Cycle**

Quality improvement (QI) approaches continue to grow in popularity in patient health care (McNichols, Lennox, Woodcock, Bell, & Reed, 2019). The Plan-Do-Study-Act (PDSA) cycle is widely recommended as an effective approach to quality improvement when developing, testing, and implementing change (Reed & Card, 2016). The four stages of the Plan-Do-Study-Act mirror the scientific experimental method of formulating a hypothesis, collecting data to test this hypothesis, analysing and interpreting the results, and making conclusions to repeat the hypothesis (Reed & Card, 2016). By running small tests that gradually increase in scale, the idea can be adapted bit by bit until it is ready for large-scale implementation (National Institute for Children's Health Quality, 2019). The purpose of the Plan-Do-Study-Act method lies in learning as quickly as possible whether an intervention works in a setting and to making adjustments accordingly to increase the chances of delivering and sustaining the desired improvement (Reed & Card, 2016).

One of the main problems encountered in using the Plan-Do-Study-Act cycle is the misperception that it can be used as a standalone method (Reed & Card, 2016). In health care, Plan-Do-Study-Act training overemphasises the simplicity of the framework and underemphasizes the different ways in which the method can be adapted to solve increasingly complex problems (Reed & Card, 2016). This frequently leads people to dive into using the Plan-Do-Study-Act method without enough investigation and framing of the problem (Reed & Card, 2016).
During my practicum, I noticed how fast-paced primary health care was which I found to be quite exciting. As a problem was identified, the interdisciplinary team did not waste time talking about it but rather tried to come up with quick solutions. I recall mentioning my observations to one of the managers, who agreed that it was great to deal with problems quickly. However, this manager noted there needed to be a balance between discussion and action because acting too quickly could lead to mistakes.

**Change Capacity**

If continuous performance improvement is to create meaningful and sustainable change, then continuous performance improvement must be integrated into the culture of the organization and become the new way of doing things (Wellman, Hagan, & Jeffries, 2011). Factors contributing to an organization's change capacity are strong work relationships, positive experiences of change, trusted leaders, and reasonable pacing of change (Nelson, 2016). For instance, executive leaders organize efforts for improvement of work and community physicians engage in projects to improve processes. By having frontline staff participate in a continuous performance improvement event and work on processes that are important for their clients, this begins to change the organizational culture (Wellman et al., 2011).

In the continuous performance improvement event, the focus always remains on the patient and family as the "customer," but acknowledges that the care and service provided are direct reflections of the ability of the staff and physicians (Wellman et al., 2011). However, it is important to note that change fatigue can set in when: multiple changes occur at the same time; changes do not contribute to organizational success; changes affect people negatively; and people rarely have input into the changes (Nelson, 2016). During my practicum, I did not notice
any of the interdisciplinary team members experiencing change fatigue. If anything, most of the professionals seemed to enjoy their jobs and spoke highly of my professional associate.

**Theory and Practice**

In this next section, I will be discussing the strengths-based perspective and how it applies within a primary health care setting. I will also be discussing intervention models such as cognitive behavioural therapy (CBT), solution focused brief therapy (SFBT) and motivational interviewing (MI) that are beneficial to use in primary health care.

**Strengths Based Perspective**

In primary health care, I think the strengths-based perspective fits well because social workers and interdisciplinary team members see great outcomes when working with the inherent strengths of individuals, family groups, and organizations (Pulla, 2017). The strengths perspective recognizes that people face adversity, become resilient and resourceful, and learn new strategies to overcome adversities (Pulla, 2017). In the primary health care setting, the interdisciplinary team recognizes that clients know themselves best and encourages them to be active participants in their care plan and decision making.

The strengths perspective requires formation of appreciative, collaborative relationships with clients and social workers must engage individuals as equals while creating a language of strength, hope, and movement (Saleeby, 1996). The goal of primary health care is to foster collaborative practice and relationships amongst the interdisciplinary team which will improve services for clients. Rather than working with just one professional, the client can establish long-lasting relationships with the interdisciplinary team who can better meet their needs. During my practicum placement, I noticed that the assessor coordinators were highly skilled at engaging their clients and sought to identify their strengths when completing the home care assessments.
Positive beliefs about one's self and one's condition play a significant role in health maintenance especially when people believe they can recover, they have an array of positive emotions about that prospect in the context of their daily lives (Saleeby, 1996). When I attended the Pulmonary Rehabilitation Course, the clients at the first session presented as very sad and withdrawn. It was interesting to see these same individuals again at the end of the course, as they were happy, relaxed, and engaged. Many of the clients noted that the information and support they received during the course was helpful and it provided them with hope to lead healthy and productive lives.

**Cognitive Behavioural Therapy**

Primary health care is a faster-based environment which results in mental health counselling being briefer (Mignogna et al., 2018). Brief cognitive behavioural therapy (CBT) is an evidence-based therapy that can be effectively used in a primary health care setting (Mignogna et al., 2018). Core components of brief CBT include delivery of the intervention in four to six sessions that are approximately 30 to 45 minutes long. When using brief CBT, clinicians must be: flexible in the pacing of content delivery during sessions; redirect patients back on topic; provide resources for additional help outside the brief CBT intervention; give patients the option to talk about personal issue at the end of the session; and understand that clients may dislike completing homework in-between sessions (Mignogna et al., 2018). Although I did not observe the primary health care counsellors during their counselling sessions, they did note use of CBT with their clients. Because their involvement with clients was supposed to brief, the counsellors indicated that CBT was an effective intervention model to use.

Internet-mediated cognitive behavioural therapy (I-CBT) is described as a feasible and effective online alternative to the standard manualized face-to-face CBT (Holst et al., 2018). As
part of the Chronic Obstructive Pulmonary Disease (COPD) pathway, health care providers deemed it necessary to have a link to the internet cognitive behaviour therapy (I-CBT) and the Chronic Health Conditions Course, which is a resource offered through the Online Therapy Unit at the University of Regina (See Appendix E). This link needed to be included under the clinical management/patient management section within the COPD clinical pathway and the patient facing pathway (See Appendix F). I-CBT is beneficial for individuals who have been diagnosed with a chronic disease and are experiencing mood related issues, may struggle with stress and have difficulties coping with chronic pain. Within the link to the internet cognitive behaviour therapy (I-CBT) and the Chronic Health Conditions Course, individuals can self-refer themselves for counselling if they need face-to-face counselling or additional services.

**Solution Focused Brief Therapy**

In a primary health care setting, solution focused brief therapy (SFBT) is a counselling approach that would be useful for clients. SFBT is a directive, brief therapeutic approach focused on building client's strength and establishing coping skills to be used in present and future goals regarding a presenting problem (Stermensky & Brown, 2014). Solution focused approaches promote the philosophy that clients are their own best experts in solving their problems (Mckenzie, 2016). Solution focused brief therapy uses the “miracle question” early in therapy where clients are asked to imagine that a miracle happened when they were asleep and their problem was solved (Mckenzie, 2016). Clients are asked: What would that look like? How would things be different? The miracle question is used in goal setting and inspiring hope that the clients presenting problems can be solved. The therapist works with the client to construct concrete and specific ways in which they can change their life (Mckenzie, 2016). As some
clients may only meet with the Primary Health Counsellor a few times, SFBT would be great to use because clients could start to identify their own strengths while solving their problems.

**Motivational Interviewing**

The final intervention technique I will be discussing is motivational interviewing (MI). Motivational interviewing is an evidence-based approach that helps clients explore and resolve their ambivalence to change within an atmosphere of acceptance and compassion (Saskatchewan Prevention Institute, 2017). Motivational interviewing is designed to strengthen a client's own motivation and movement toward a specific goal by drawing out and exploring their arguments for change (Saskatchewan Prevention Institute, 2017).

As I reflected on the participant's disruptive behaviour in the Anxiety and Depression CBT group, I realized that traditional advice giving would have created resistance to change, especially if it was focused on behavioural change for which he had minimal or no readiness to change (Hardcastle, Taylor, Bailey, & Castle, 2008). In this particular case, the key principles of motivational interviewing may have worked better because it was the participant's task to articulate the reasons for change and resolve any feelings of ambivalence he had (Hardcastle et al., 2008).

Due to the fast-paced environment in primary health care, motivational interviewing would be a great counselling approach to use because it is client-centred, enables clients to explore their beliefs about their health and generate solutions for positive change (Hardcastle et al., 2008). Motivational interviewing can also support change for clients who have a chronic disease and are ambivalent about changing behaviours associated with diet, exercise, and medication adherence (Saskatchewan Prevention Institute, 2017).
Social Work Values and Ethics

Macro social work is the practice of helping individuals and groups solve problems and make changes at an organizational, societal, and global level (Brueggemann, 2006). Since the turn of the 20th century, social workers have been involved in the healthcare of individuals and in today's society, there is an emphasis on the social determinants of health and the role that social workers play in addressing an individual's complex needs (de Saxe Zerden, Lombardi, & Jones, 2019).

The philosophy and expertise of social workers complements primary health care services very well. For example, social work contributes to patient care by providing mental health assessment and intervention; offering counselling; doing case management; helping clients navigate complex health care systems; linking patients with community resources; and educating and training other providers about the psychosocial aspects of health and illness (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown, 2018). During my practicum placement, I learned social workers were either called Assessor Coordinators or Primary Health Care counsellors. Regardless of their job titles, the philosophy of the social workers did not change, as they were great advocates for their clients. The social workers role was invaluable to the interdisciplinary team because they displayed strong assessment and case management skills and were knowledgeable about various counselling therapies and resources in the community.

Some of the challenges that can arise in the integration of social work in a primary health care setting are difficulties in establishing exactly what the social work's role is, strained collaborative relationships, inadequate and underutilized use of social work expertise, not being collocated with other team members, and not having adequate physical space for the provision of patient care (Ashcroft et al., 2018). For the most part, I noticed that the role of social work in the
North Primary Health Network was clear. However, on one occasion, an individual belonging to a different discipline had the perception that a certain social worker could 'fix' the client's problem, without understanding that the client has the right to self-determination. In this scenario, the client was refusing to meet with the health care professional and did not want to take his medications. The social worker explained that she had spoken with the client about the importance of taking the medication but ultimately, it was his choice whether he wanted to take the medication and that he had the right to refuse services which were voluntary. As I reflected on the scenario, the social worker’s value was very clear, as she was being respectful of the inherent dignity and worth of that client (Canadian Association of Social Workers, 2005). The social worker also respected the client's right to make informed choices based on voluntary, informed consent (Canadian Association of Social Workers, 2005).

In a primary health care setting, primary health care counsellors reported having great relationships with the physicians. However, they noted feeling isolated at times because there was only one counsellor available in each primary health care network. To reduce the isolation, the primary health care counsellors attended regular supervision meetings with a senior social worker who has a Master of Social work degree. These meetings allowed the primary health care counsellors to receive clinical support and educational training. The primary health care counsellor positions are filled with social workers who hold a Bachelor of Social Work degree and/or a Master of Social Work degree.

To improve the integration of social work in primary care setting, it is beneficial to have professional guidelines and best practices for social workers (Ashcroft et al., 2018). It is recommended that social workers seek opportunities to educate colleagues and assertively advocate for social work's diverse views of health and practices (Ashcroft et al., 2018). Lastly,
an organizational culture with strong leadership that encourages collaboration and respected integration of interprofessional practices is important (Ashcroft et al., 2018). During my practicum, my professional associate was a strong advocate for social work. She was focused on defining the social work role and establishing clinical standards for social workers in the primary health care setting. My professional advocate also displayed a strong pursuit of social justice, as she advocated for clients to have fair and equitable access to resources (Canadian Association of Social Workers, 2005). For example, one of her staff members made a negative comment about a client, who was living a transient lifestyle and had mental health issues. My professional associate stressed that this individual had the right to access services and would be treated with respect and dignity when he presented at the facility.

**Conclusion**

As I reflect back to my first day at the North Primary Health Care Network, I recall my office door sign had the Primary Health Care emblem with the following words: access, relationships, teamwork, and knowledge. Underneath those words was the slogan: Right Service, Right Provider, Right Place...All the Time. While completing my practicum at the North Network, I learned that there was no wrong door for services and the goal of a network was to ensure navigation and flow, while assisting clients in navigating to other health care services as needed.

There are many advantages of a primary health care model because clients receive improved patient care and additional supports, the team of professionals brings different perspectives to the health care system, and prevention is deemed beneficial for improving one's lifestyle (Brown et al., 2012). Throughout my practicum, I had numerous opportunities to observe and participate in activities that furthered my knowledge in the area of primary health
care. I truly appreciated and valued the way the interdisciplinary team worked in the North Network. I noticed that no one professional on the team "owned" the client; rather the client was always seen at the centre of the care. The interdisciplinary huddles created a platform for professionals to speak respectfully about their clients, with a focus on fostering independence, safety, and improved life for them.

In a review of the literature, I read that patients should always come away from an appointment with a clear plan of action for managing, maintaining, and protecting their own health (Saskatchewan Ministry of Health, 2012). This really resonated with me, as I think there is a perception that professionals should oversee the client's case plan. However, in the primary health care framework, the goal is to have open communication with the client, respect their values, and optimize the client's participation in clinical decision making (Saskatchewan Medical Association, 2011).

Given the rate of depression associated with chronic medical illnesses and the impact of depression on the outcome of treatment regimens, screening for depression should be done routinely (Voinov, Richie, & Bailey, 2013). As I reflect on my practicum experience, I noticed that mental health was weaved through Public Health Services, Home Care Services, Palliative Care, Primary Health Care clinics and Chronic Disease Management. For many people who have chronic disease or chronic pain, their anxiety and depression symptoms may exacerbate the progression of the disease, which could lead them to having suicidal ideation and/or intent. When I recently reviewed the online COPD patient pathway, I was pleased to see that mental health support was listed and clients could access services through an online resource through the Online Therapy Unit at the University of Regina (Saskatchewan Health Authority, 2019).
As of April 1, 2019, the KidsFirst Program officially became part of the Four Directions Community Health Centre, which falls under the Primary Health Care portfolio in Saskatchewan. I am thankful for completing my practicum at the North Network because I received knowledge about how a network functions which has helped me in my current role at the KidsFirst Program. I learned about the functions of a pathway for chronic disease and how important it is to involve individuals with a chronic disease in any decision making. The value of having clients, physicians and community partners collaborate to create better services is paramount to client-centred care and I look forward to applying this model of care with my current and future clients.


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Appendix A

Primary Health Care Urban Network Boundaries

Please note: This map has been created by C. Giandio. Any changes, please contact her at p. 7375 or colleen.giandio@gphealth.ca

* - Urban populations taken from 2011 Census and do not include rural communities
Appendix B

Primary Health Care Regina Rural and Rural Network Boundaries
Appendix C

COPD: A Patient's Guide to Managing COPD and Improving Health

COPD and Me:

Following a COPD plan can significantly reduce, or even stop, the progression of your COPD and will make you feel better.

*Click on the boxes below to find out more detailed Information and resources about COPD or visit www.rqhealth.ca/COPD*

1. Prevention: Importance of quitting smoking
It's never too late to stop smoking. Not only will you feel better but food will taste better and you'll have more money to spend on the things you enjoy. Your doctor and pharmacist can help you quit and provide options from going "cold turkey" to the patch and other medications.

It's never too late to ask for help!

2. Screening for COPD: Are you at risk?
If you are 40 years of age or older and are a current or ex-smoker, you are at risk of developing COPD. If you find yourself stopping when walking, walking up 1 flight of stairs, or you make multiple trips to the doctor about coughing and colds, you should ask your health care provider about COPD.

3. How to Test for COPD
A spirometry test is the only way to diagnose COPD. Spirometry testing is quick, easy, and not painful. It takes only a few minutes to complete. Spirometry testing is easily accessible and be done in almost any location.

4. Diagnosis: What do I do now?
While being diagnosed with COPD can be scary, it will help you to access the best, most appropriate care and support. This can greatly improve your quality of life at any stage of COPD. Your health care provider will help to connect you with these resources.

5. Managing Your COPD: Tips to help you avoid the hospital
There are a number of ways to help you manage your COPD. Stop smoking, participate in COPD rehab classes, get vaccinated, take your medications as directed, use oxygen as needed and follow your action plan. When breathing becomes very difficult, you can also access specialists in palliative care.
Appendix D

Edinburgh Postnatal Depression Scale (EPDS)

Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: ___________________________  Address: ___________________________

Your Date of Birth: ___________________________  Phone: ___________________________

Baby's Date of Birth: ___________________________  Phone: ___________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time  This would mean: "I have felt happy most of the time" during the past week.
- No, not very often  Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Administered/Reviewed by ___________________________  Date ________________


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Appendix E
Community COPD Pathway
Appendix F

Managing your COPD

Stop Smoking
There are a number of resources to help you quit smoking in Section 1 (Prevention) of this
handout. It is the single most important thing you can do for your health when
dealing with COPD.

Monitor Air Quality.
Try to avoid dust and fumes, and stay indoors on bad air days. Check daily air quality levels
and air pollution forecasts in your area. Environment Canada has this available on their
website. Click on the Air Quality link to the top, right side of the Forecast section.

Stay Up-to-date on Immunizations
• Get a flu shot every year.
• Ask your health care provider about getting the pneumonia vaccine.

Learn About Nutrition.
Eat a well-balanced diet and maintain your ideal body weight. The Canada Food Guide is
a great place to start. You can also use the Fat Smart program resources available to all
Saskatchewan residents free of charge.

Stay Active
Ask your doctor about exercises to help you build strength and breathe easier. You can
also register for COPD Rehab and Live Well programs in your area. COPD Rehab will assist
you in understanding a variety of COPD topics including exercise, nutrition, symptom
management and using your COPD Action Plan. To enroll in COPD rehabilitation
programs, phone (306) 766-7200.

Get Emotional Support
Living with COPD may cause fear, anxiety, depression or stress. Speak to your health care
provider about options that work for you. There is also an online resource that is accessi-
ble to everyone through The Online Therapy Unit.

Follow-up With Your Health Care Provider
Regular visits with your health care provider improve your chances of staying healthy and
out of the hospital. Make sure you schedule and attend these appointment on a regular
basis.