

2008

PATIENT WAIT TIMES GUARANTEE PROJECT

A Policy Issue Paper on Manitoba First
Nations Foot Care Services

saint
ELIZABETH
HEALTH CARE



Saint Elizabeth Health Care & The Assembly of Manitoba Chiefs



PROJECT TITLE

This project is entitled “A Policy Issue Paper on Manitoba First Nation Foot Care Services”

DEFINITIONS

The following clinical terms are used in the document and defined here to ensure common understanding.

Podiatry/chiroprody: The medical care and treatment of the human foot. This care is provided by Podiatrists or Chiroprodists.

Pedorthist: An allied health professional specializing in therapeutic footwear.

Orthotist: An allied health professional specializing in orthotics.

Orthotic: a device (as a brace or splint) for supporting, immobilizing, or treating muscles, joints, or skeletal parts which are weak, ineffective, deformed, or injured

Prosthetist: A specialist in prosthetics

Prosthesis: The surgical or dental specialty concerned with the design, construction, and fitting of prostheses

Prostheses: An artificial device to replace or augment a missing or impaired part of the body

Therapeutic Shoes: Shoes that can be purchased off the shelf but meet the specifications for appropriate fit, based upon a pedorthist’s foot assessment

Custom Shoes: Specially made shoes designed to meet a client’s specific need; required when the need cannot be accommodated by modifying an existing shoe.

Basic Foot Care can be performed by Certified Foot Care Nurses and consists of:

- ✓ Basic foot and lower limb assessment
- ✓ Basic wound assessment and management
- ✓ Basic footwear assessment
- ✓ Corn and callus reduction
- ✓ Nail care
- ✓ Health education and health promotion related to care of the feet

Advanced Foot Care: The Nurses affiliated with the Northern Medical Unit and the University of Manitoba have advanced training and ongoing mentoring provided by local medical clinicians, specifically orthopaedic surgery, vascular surgery, and infectious diseases. These specialists provide on site support as well as a delegation of clinical function, which allows the nurses to perform:

- ✓ debridement of soft tissue and bone;
- ✓ prescriptive practices for initiation and/or continuation of anti-infectious agents; and
- ✓ direct referrals to medical specialists.

DISCLAIMER:

The ideas and opinions expressed in this document are those of the authors and do not necessarily represent the ideas and opinions of the organizations for which this paper has been created.

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MEDICINE CREEK
SOLUTIONS

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KEY FINDINGS

- ✓ In Manitoba, amputation rates are 18% higher for Registered First Nations than for all other Manitobans (Martens, Martin, O'Neil, & MacKinnon, 2007). Additionally, Manitoba Health (1999) reports that 91% of amputations amongst Registered First Nations resulted from diabetes-related complications.
- ✓ Manitoba Health does not insure podiatry services; instead, physicians who have neither the time nor often the expertise are insured to perform the same foot care and treatment provided by podiatrists. For example, many physicians do not perform toenail resections and refer their clients to podiatry. However, if clients can find a physician to provide this care, it is an insured benefit.
- ✓ While other provincial health insurance plans have moved toward insuring podiatry, British Columbia and Alberta, Manitoba has not – rather continues to pay the annual downstream costs of \$15 Million (2005) for amputations. It remains unclear why Manitoba Health chooses to not to insure preventative measures, as private plans and other provinces do, rather than incur the exponentially greater costs associated with amputations.
- ✓ Non-Insured Health Benefits (NIHB) de-listed allied health services when provincially insured services were not consistently offered across the country; this premature delisting created jurisdictional inequities and service gaps. The delisting of the NIHB travel benefit to access these services further compounds the issue of access to services to two thirds of Manitoba First Nation communities.
- ✓ The original FNIH foot care budget of \$176,000.00 was determined from actual expenditures on podiatry visits prior to 1998; these expenditures were then capped and re-profiled from the NIHB budget into nursing operations where standing offer agreements were initiated with foot care providers.
- ✓ Regardless of the on-reserve First Nation population almost doubling over the last 10 years, the funding remained the same for on-reserve foot care services with a recent exception for the Northern Medical Unit (NMU) communities.
- ✓ Although the NMU provides much needed and appreciated services in 9 isolated/remote First Nation communities; it is interesting to note that FNIH offers this organization almost twice as much money for services in half as many communities

- as those receiving funding through Contribution and Transfer Agreements [21 communities - \$136K (CA and TA); 9 NMU communities - \$258K]
- ✓ Not only are there inconsistencies and inequities with funding arrangements between First Nation and University affiliated organizations – there are also inequities between funding agreements amongst communities and tribal councils.
 - ✓ The ad hoc service responses and short sighted funding arrangements created a three tiered system in the provision of foot care services; – 34 communities without services, 21 communities with varying degrees of basic services and 9 communities with advanced (but no basic) foot care services.
 - ✓ Interesting, whether First Nation or non – the best foot care provisions in Manitoba are received by federal inmates & clients on social assistance/employment income assistance living off-reserve. Second would be those determined as other federal responsibilities, such as the RCMP & Veterans Affairs.
 - ✓ The discrepancies between Federal and Provincial entitlements result in Manitoba First Nation Social Assistance recipients receiving inequitable access to foot care services based upon place of residence. Those living off-reserve are entitled to medically prescribed podiatry, whereas those living on-reserve are ineligible.
 - ✓ FNIH/Health Canada has long denied that funding a Foot Care Program is within their Mandate or that the policy does not exist to do so; where in fact their practice indicates otherwise. Instead it suggests that FNIH maintained some level of responsibility for the provision of Foot Care Services for First Nations on and off reserve:
 - 1st. FNIH acknowledged that delisting would create gaps in services and agreed to re-profile NIHB dollars into program dollars, currently managed by the Operations/Nursing Directorate;
 - 2nd. In response to limited service providers in northern and remote communities they trained and provided equipment for federally employed community health nurses to deliver basic foot care in their communities of employ/residence.
 - 3rd. By transitioning from Standing Offer Agreements (SOA's) to Contribution Agreements (CA's) and one Transfer Agreement (TA) a federal responsibility to provide foot care services has been affirmed.

INTRODUCTION

In January 2007, the Minister of Health announced the support to fund the Patient Wait Times Guarantee (PWTG) pilot project, which commenced April 2007 and is coming to an end September 2008. The partners working on this project are Saint Elizabeth Health Care (SEHC), a not-for-profit charitable health care organization, and the Assembly of Manitoba Chiefs (AMC), the political body representing 64 Manitoba First Nations. The goal of the project is to reduce the significant impacts of foot ulcers in First Nations individuals with diabetes by establishing and implementing a wait times guarantee for the prevention, treatment and care of diabetic foot ulcers in Manitoba First Nation communities.

To accomplish this goal, the PWTG pilot project has been divided into the following three phases and time frames:

Phase 1A: Documenting the current situation, with literature review and interviews. Phase 1B: Building a Model for Care by analyzing the current situation and developing the Best Practice Pathways, implementing a data collection mechanism, and understanding the options for client care.

Phase 2: Testing the Model. The pilot project will be implemented to test the options for client care. The results of the pilot, including the number of clients involved, the outcomes for clients, the types of care offered, the frequency of care used and its cost will be reported on.

Phase 3: Analyzing the data, developing recommendations, and completing final report including a comprehensive written evaluation of the new clinical model.

This independent policy review and analysis concentrates on completing one component within the third phase. It begins with a brief overview of the demographics of Manitoba First Nations and their experiences of diabetes and diabetes-related complications. The problem is identified and then contextualized within the national experience. Next, key players are introduced, followed by a review of their policy positions and practices.

The final sections identify and discuss the impacts of the major policy shifts as they relate to diabetic foot care for Manitoba First Nations. Finally, policy alternatives are suggested to improve equity, consistency, and efficiencies for foot care programming.

WHAT IS THE PROBLEM?

Diabetes, a serious chronic condition which affects significantly greater proportions of the population every year, is “the leading cause of death by age” (RNAO, 2004). Furthermore, prevalence rates are projected to increase from the 1.4 million Canadians with diabetes in 2000 to 2.4 million by 2016; a 72% increase versus a 12% projected population increase (Ohinmaa, Jacobs, Simpson, & Johnson, 2004). Diabetes is growing even more rapidly in First Nations populations. The overall age- and sex-adjusted diabetes prevalence for Manitobans is 45 per thousand, less than one quarter of the prevalence of on reserve Registered First Nations. The age- and sex-adjusted prevalence for on reserve Registered First Nations is 203 per thousand (Martens, Martin, O’Neil, & MacKinnon, 2007).

Three quarters of Canadians with diabetes also have other chronic health conditions, which without appropriate care can result in serious but avoidable complications (Ohinmaa, et al, 2004), such as cardiovascular disease, kidney disease, blindness, and lower extremity amputations. Unfortunately, Canadians with diabetes are not receiving appropriate care. The Health Council of Canada found that “less than half of Canadians with diabetes get all the lab tests and procedures that experts recommend to monitor blood sugar, blood pressure, cholesterol, kidney health, vision, and foot health” (2007, p. 13).

Access to prompt, appropriate care, treatment, and footwear reduce the incidence of foot ulceration and amputation.

(Rith-Najarian, et al, 1998)

Diabetes-related foot complications result in an enormous burden to both patients and the healthcare system. “Diabetic patients with foot ulcers are at risk for hospitalizations, lower extremity infections, and amputations. Both foot ulcers and amputations result in decreased function, lowered quality of life, and increased health care costs” (Wrobel, Charns, Diehr, Robbins, Reiber, Bonacker, et al 2003, p. 3042). The literature reports that 85% of lower extremity amputations are preceded by non-healing ulceration (Pecoraro, Reiber & Burgess, 1990; Lavery, Armstrong, Wunderlich, Mohler, Wendel, & Lipsky, 2006).

The prevention of diabetic foot complications is complex; requiring early identification of potential problems and access to prompt, appropriate care, treatment, and footwear. Such measures have been proven to reduce the incidence of foot ulceration and amputation.

The Registered Nurses Association of Ontario (RNAO, 2004) states that:

The sequence of events leading to lower extremity ulceration and amputation in diabetes is a complex process with many factors combining to increase the likelihood that a foot injury or infection will occur and healing will be delayed. In the presence of reduced circulation (peripheral vascular disease) and loss of protective sensation (neuropathy), even minor foot trauma or unusual pressures on the foot may be sufficient to cause ulceration and eventual amputation. (p. 22)

The Health Council of Canada identifies influences “outside of the traditional health care system – income and social and physical environments, for instance – that play a role in the complex challenge of preventing and curbing chronic health conditions” (2007, p. 9). Broader determinants of health are supported by studies conducted in Manitoba where lower diabetes rates were found to be associated with higher income and geography, where lower rates of diabetes were found in southern regions of the province (Martens, Martin, O’Neil, &

MacKinnon, 2007; Green, Blanchard, Young & Griffith, 2003). Martens, Martin, O’Neil, & MacKinnon however, also found that income and geography were not associated with amputation rates for First Nations. Instead, amputation rates were inversely associated with access to specialist care.

85% of lower extremity amputations are preceded by non-healing ulceration

(Pecoraro, Reiber & Burgess, 1990; Lavery, Armstrong, Wunderlich, Mohler, Wendel, & Lipsky, 2006).

Even though these serious conditions and complications are being experienced in Manitoba, foot care is not covered by the provincial health care plan; it is inconsistently and non-proportionately funded in select First Nation communities in Manitoba, and access to

foot care services for First Nations clients are not reimbursed through NIHB. Thus Manitoba First Nation Diabetic clients, with 4.2 greater prevalence of diabetes, have amputation rates 18 times higher than all other Manitobans creating a \$15 Million dollar annual expenditure on lower limb amputations for First Nations alone.

WHO IS THE PROBLEM AFFECTING?

The North American Indian population in Manitoba made up 8.9% of the Manitoban population according to the 2006 Census (Stats Canada), with 100,640 reporting North American Indian ancestry. Martens, et al (2002) report that in 1999 the 87,328 Registered First Nations made up 7.63% of the Manitoba population; a smaller percentage partially due to the fact that only those with Indian status, as defined in the Indian Act, were included.

A large percentage of Registered First Nations reside off-reserve; reportedly 43.35% in 1999. The 2006 Census (Stats Canada) reports that 33.6% of North American Indians in Manitoba are residing in the urban areas of Brandon, Portage la Prairie, Thompson, and Winnipeg.

The Manitoba Centre for Health Policy's linked database provides the on-reserve Registered First Nation populations by tribal council as of December 31, 1998. The most recent INAC figures, July 2008, are also listed in Table I on the next page. Both are included to demonstrate populations at the onset of foot care funding in the region as well as the population growth since that time.

Table I: On Reserve RFN Populations by Tribal Council, 1998 & 2008

Tribal Council	Total Population 1998	On-Reserve Population 2008
Keewatin Tribal Council	6,982	9,815
Island Lake Tribal Council	5,568	8,935
Interlake Reserves Tribal Council	4,155	8,032
Independent First Nations North	9,187	14,271
Independent First Nations South	4,262	7,027
Swampy Cree Tribal Council	6,285	10,621
West Region Tribal Council	2,724	5,229
Southeast Resource Development Council	3,646	7,834
Dakota Ojibway Tribal Council	5,227	8,867
Total	48,036	80,631

WHO ARE THE PLAYERS & WHO OFFERS WHAT?

KEY POLICY PLAYERS, POSITIONS/PRACTICES & FUNDING STRUCTURES

A variety of government policies influence the context of foot care services for Registered Manitoba First Nations. The key players in this policy arena include Manitoba Health; Family Services and Housing, Manitoba; Indian and Northern Affairs Canada; and Health Canada, First Nations and Inuit Health. It is a well-known and documented fact that this jurisdictional web of policy positions results in service delivery gaps for First Nations (Alex, 2005; Lavoie & Forget, 2006). The provision of foot care services is no exception as demonstrated in the following policy positions and funding structures.

Manitoba Health

Foot care is neither an insured health service through Manitoba Health, nor a Non-Insured Health Benefit for Registered First Nation individuals (with the possible exception of SK Region). Allied Health Services, such as podiatry and chiroprody, were de-listed from NIHB in 1998 as they were available through many provincial health insurance plans. Treatment provided by physicians is insured but there are very few general practitioners in Manitoba that will provide foot care or treatment such as wedge resections for ingrown toenails. Instead, clients are referred to podiatrists and are required to pay all costs associated with care and treatment.

Manitoba Health care insurance covers:

- ✓ Physicians services,
- ✓ Surgery / anaesthesia,
- ✓ X-ray and laboratory services in approved facilities when ordered by a physician,
- ✓ Some optometry services (exams for all ages will be covered if deemed medically necessary by a physician or optometrist),
- ✓ Chiropractic care up to a maximum of 12 visits per Manitoba resident per calendar year, and
- ✓ Dental Surgery (for some procedures when hospitalization is required).

Services performed by chiropodists and podiatrists are among those services not insured by Manitoba Health

The Act does provide for the provision of prosthetic and orthotic devices prescribed by a physician, certified prosthetist, or certified orthotist, including removable, molded-to-patient type foot inserts and non-removable, attached to shoe, arch supports. Manitoba Health does not, however, interpret this section of the Act as including foot orthotics. According to Cecelia Bergen, Ancillary Programs Supervisor, Manitoba Health (personal communication September 23, 2008), the criteria for insured orthotics is limited to those prescribed:

- ✓ post amputation,
- ✓ to support fractures, and those
- ✓ attached to or used with an ankle foot brace

Preventative devices of any kind are not covered. The practice, therefore, is that clients pay out of pocket for prescribed preventative orthotics unless covered through private health insurance plans.

The Winnipeg Regional Health Authority has recognized the need to incorporate foot care into their primary health care clinics, however, the costs associated with accessing the services of the certified foot care nurses must be covered by the client. It remains unclear why Manitoba Health chooses to not to insure preventative measures rather than incur the exponentially greater costs associated with amputations. One would assume that tax-payers in this province would appreciate some clarification and justification on this matter.

NATIONAL PROVINCIAL INSURANCE HIGHLIGHTS

As Table 3, on the next page, indicates Podiatry services are covered to some extent in British Columbia, Alberta, Saskatchewan, and Ontario. Coverage is not provided in Manitoba, Quebec, the Maritime Provinces or the Territories. In BC, surgical podiatry services are fully insured. For those residents receiving premium assistance, 10 visits per year for non-surgical podiatry services are covered at a rate of \$23 per visit. Saskatchewan and Ontario partially cover the costs of podiatry, while Alberta covers services to a maximum of \$250 per year.

Table 3: Provincial Health Insurance Coverage for Podiatry Services

Province	Service (Coverage)
B.C.	Surgical podiatry covered. Allied health services including non-surgical podiatry are covered @ \$23/visit for max 10 visits /year
Alberta	Max \$250/person/year
Saskatchewan	Partial Coverage
Manitoba	None
Ontario	Partial Coverage

Quebec	None
Nova Scotia	None
P.E.I.	None
New Brunswick	None
Nfld/Lab	None
Yukon	None
GNWT	None
Nunavut	Specialized services are covered but not defined

FAMILY SERVICES AND HOUSING, MANITOBA

Off-Reserve Manitoba Registered First Nations (RFNs) receiving Employment and Income Assistance (EIA) through the province are eligible for podiatry, chiropody, and foot care services when deemed essential by the clients health practitioner or staff member based upon information provided by the health practitioner. Nine visits per fiscal year are covered at a rate of \$32 per visit for a total of \$288 per person per year.

The EIA Administrative Manual states that,

Participants in hospitals are not covered through EIA for podiatry or chiropody services, as it is the responsibility of the facility to cover these costs. Individuals residing in Personal Care Homes, Chronic Care Facilities and Mental Health Centres are to access their personal resources available in their liquid assets first, before EIA approval. (section 22.4.3)

The EIA Administrative Manual also states that prosthetic and orthotic devices are not covered because they “are normally covered as an insured service under The Health Services Insurance Act and its Regulations” (section 22.4.1). It is interesting that the two provincial departments, Manitoba Health and Family Services and Housing, interpret the same legislation differently. Unfortunately for clients, these medically prescribed treatments are not considered entitlements for any Manitoban.

Off-reserve Registered First Nations residing in provincial Personal Care Homes are required to pay for foot care services. Once their personal assets have been exhausted EIA will cover associated costs up to the maximum 9 visits per year.

INDIAN AND NORTHERN AFFAIRS CANADA

INAC does not have policies related to foot care services as these are considered a health related provision under Health Canada's NIHB program. INAC remains unaware of the changes to these policies and has not resourced the implementation of benefits to fill the gap created by the delisting of non-insured health benefits.

The Terms and Conditions for Assisted Living do not make provision for foot care, podiatry or chiropody either. There are, however, a few personal care homes on-reserve that do provide foot care services, but these facilities are not funded by INAC to do so. (personal communication, B. A. Scott, INAC representative, June 26, 2008). Residents of Dakota Oyate Lodge in Sioux Valley, for example, access the services of their FNIH funded, community-based foot care nurse.

The discrepancies between Federal and Provincial entitlements result in Manitoba First Nation Social Assistance recipients receiving inequitable access to foot care services based upon place of residence. Those living off-reserve are entitled to medically prescribed podiatry, whereas those living on-reserve are ineligible.

FIRST NATIONS AND INUIT HEALTH (FNIH)

FNIH MANDATE:

According to their website, the mandate of First Nations and Inuit Branch is to:

- ✓ ensure the availability of, or access to, health services for First Nations and Inuit communities;
- ✓ assist First Nations and Inuit communities address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and
- ✓ build strong partnerships with First Nations and Inuit to improve the health system.

In describing their Primary Care Services, FNIH has adopted the WHO definition of primary health care. The FNIH's program compendium states that,

Community primary care services are provided to remote and/or isolated First Nations and Inuit communities where such services are not provided by provincial or regional health authorities. The first point of contact is the community health nurse (CHN), who functions in an expanded scope of practice, or the community health representative (CHR). Community primary care services encompass a spectrum of sectors and activities that influence health, including illness and injury prevention, health promotion, cure and rehabilitation (WHO, 1998). Primary Care is the first client contact with the health care system at the community level where resources are mobilized to diagnose and treat minor illnesses, manage chronic diseases, identify cases requiring complex care and coordinate care needs. It is the delivery of a comprehensive range of Community Primary Care services by a multi-disciplinary team of service providers including nursing services. (Section 3.3).

FNH – NIHB PROGRAM (PODIATRY, FOOT PRODUCTS & TRAVEL)

In 1998 NIHB de-listed Allied Health Services from the benefit list since provincial health plans were insuring many of these services. Allied Health Services include podiatry as well as other services such as chiropractic care, dentistry, physiotherapy, occupational therapy, speech therapy, acupuncture, etc. This national decision implied that these services were available through provincial health plans nation wide; however this is not the case. Only four (4) jurisdictions insure foot care services to any degree. Inequities and service gaps have become the result.

NIHB, however, continues to cover the cost of custom made footwear, custom made internal footwear devices, and modifications to stock footwear that have been prescribed by a general practitioner or medical specialist and provided by a certified orthotist, prosthetist, podiatrist, or pedorthist. Foot products manufactured only from laser or optical scanning or computerized gait and pressure analysis systems are excluded. According to Brian Scharfstein, Certified Pedorthist and NIHB Consultant, this is based upon his recommendations, as these methods cannot adequately assess the diabetic foot (personal communication July 16, 2008). Footwear, although considered therapy and/or medicine for the diabetic foot, is not covered nor are the travel costs associated with shoe fittings. It is interesting to note that while neither Manitoba Health

Self-care education,
routine foot care,
protective footwear, and
implementation of
clinical guidelines
reduced lower limb
amputations by 48%

(Rith-Najarian, et al, 1998)

nor NIHB cover the costs of therapeutic shoes, Blue Cross Health Insurance, recognizing the savings associated with preventative care, does.

Furthermore, therapeutic footwear is not covered by NIHB despite the fact that research conducted on their behalf demonstrates that the provision of appropriate footwear dramatically reduces the incidence of ulceration, re-ulceration, and callus formation (B. Scharfstein, personal communication July 16, 2008). These results are supported in the literature (Armstrong & Lavery, 1998, 2002; Bild, et al, 1999; Frykberg, 2002; Lavery, et al, 2006; Pecoraro, Reiber, & Burgess, 1990; Wrobel, et al, 2003) but most noteworthy is the study by Rith-Najarian, et al who documented the outcomes of 3 phases of foot care programming amongst the Chippewa Indians of northern Minnesota. Each of the phases (baseline, prevention services, and implementation of practice guidelines) showed incremental reductions in LEAs. The provision of self-care education, routine foot care, and protective footwear resulted in a reduction rate of 29/1000 to 21/1000 LEAs per year and with the implementation of practice guidelines to 15/1000. This represents a 48% reduction; a reduction occurring when the rate of diabetic LEAs was increasing nationally.

The release of the Medical Transportation Policy Framework, July 2005 resulted in the cessation of travel benefits for podiatry and pedorthist visits. Currently, podiatry and pedorthist appointments must be coordinated with other medical appointments for clients to have their travel costs covered, which eliminates the possibility of coverage for urgently required services.

For those clients choosing to access First Nation Healers in their care and treatment, NIHB does cover the associated travel costs. The policy provides transportation costs within the clients' region/territory of residence once the client's medical condition has been confirmed by a licensed physician, or if a licensed physician is not routinely available in the community, a community health professional or FNIHB representative. Preauthorization from an authorized FNIHB or First Nation Health Authority/ Organization representative is also required. The costs are reimbursed at the rate of the most economical form of transportation, regardless of the condition of the client travelling. For example, elderly clients with chronic medical conditions are reimbursed to travel by bus from their community to the nearest healer; trips that could easily exceed 10 hours. Furthermore, accommodation and meal expenses are covered for the duration of their trip when accessing medical service

providers; however, clients travelling to see traditional healers are not provided accommodation and meal allowances during their stay.

Transferred communities who have taken on the responsibility of providing medical transportation for their community members and received funding through transfer agreements have more flexibility. Their more vulnerable community members can often be provided with more suitable modes of transportation and supports.

OTHER FEDERAL BENEFITS (CANADA HEALTH ACT EXEMPTIONS)

The federal government is responsible for providing health benefits not only to Registered First Nations, but also to the following groups designated exempt from the Canada Health Act: RCMP, Veterans, and individuals incarcerated in federal Correctional Facilities. Table 4 illustrates the provision of podiatry services to these groups.

Table 4: Podiatry Coverage Under Federal Plans

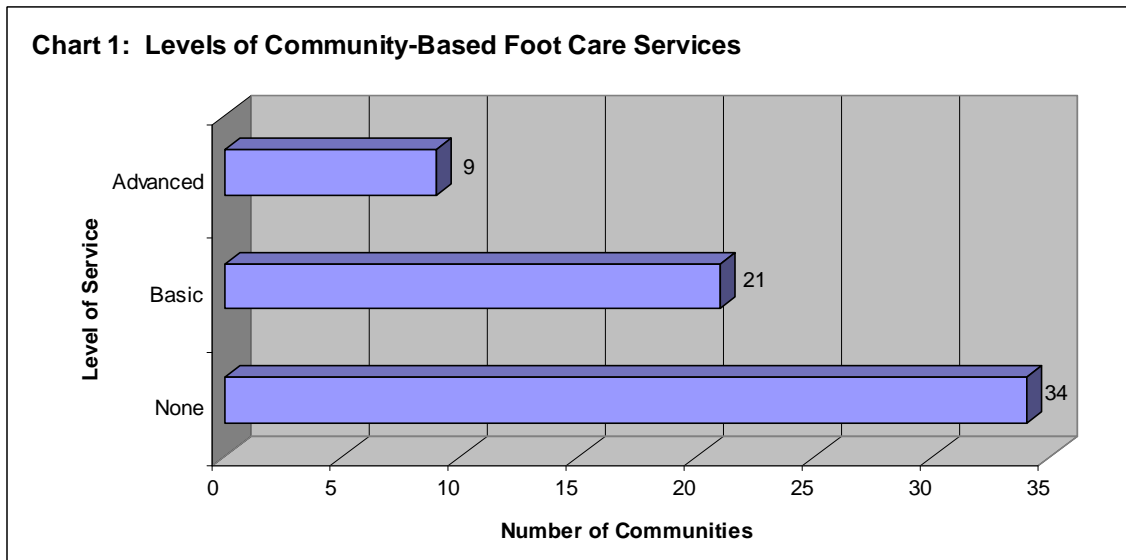
Services	Veteran’s Affairs*	RCMP Benefits	Inmate Benefits	NIHB
Podiatry	√	√	√	
Orthotics	√	√	√	√
Therapeutic Shoes	√	√	√	
Custom Shoes	√	√	√	√
Travel	√	√	N/A as available in institution	

* The benefits for Veterans are program specific; therefore not all benefits apply to all Veterans. However, those receiving a disability pension or able to demonstrate a financial or rehabilitation need are covered. Medical prescription and prior approval are required in some instances. Some programs, such as the New Veterans Charter, offer group health insurance, where the Veteran is responsible for paying premiums (personal communication September 23, 2008, Kristin, Veterans Affairs Canada, Winnipeg).

The RCMP Blue Cross benefit for podiatry does not limit the number of visits per year, however, RCMP members requiring frequent visits would not be stationed outside an urban environment where services would not be readily accessible; although infrequent travel to the nearest practitioner is provided. RCMP members also receive a kit and clothing allowance, which covers the costs of shoes. Individuals requiring therapeutic shoes, priced over and above their coverage would be assessed on an individual basis. The benefit for orthotics provides for 2 pair initially with 1 replacement pair every 2 years. The maximum benefit is \$800 initially, and \$400 for replacements.

FNH FUNDED FOOT CARE SERVICES

Currently, First Nations and Inuit Health funds community-based foot care services through Contribution Agreements with those communities or tribal councils where services were established. One tribal council representing 7 communities and 14 additional communities receive funding, 43 communities do not; however the Northern Medical Unit receives funding to provide advanced services in 9 communities. Chart 1 clearly depicts a 3 tiered system of community-based foot care services for Manitoba First Nations.



The Contribution Agreements specify what services are to be provided. Basic foot care services are defined as including:

- ✓ Basic foot and lower limb assessment
- ✓ Basic wound assessment and management
- ✓ Basic footwear assessment
- ✓ Corn and callus reduction
- ✓ Nail care
- ✓ Health education and health promotion related to care of the feet

The resource allocation for community-based foot care services total \$130,962, with the Northern Medical Unit receiving an additional \$258,000 for services delivered in the four fly-in communities of Island Lake, the 4 fly-in South East communities, and Norway House. The funding levels for each tribal council area differ significantly. Table 4 on the following page illustrates the disproportionate levels of foot care funding received by Tribal Council and their comparative populations.

It is important to note that while this table breaks down funding by Tribal Council areas, some communities within these Tribal Councils do not receive funding or services. Furthermore, other communities are responding to community needs and offering foot care programs in the absence of foot care funding, such as Peguis and Cross Lake.

With current off reserve podiatry expenditures almost eliminated (personal communication Joe Tyson, June 9, 2008), it is unclear where the remainder of the \$176,000 foot care budget is being spent.

Table 4: Foot Care Funding by Tribal Council

Tribal Council	Total On-Reserve Population 1998	Foot Care Funding Received 2002	Total On-Reserve Population 2008	Foot Care Funding Received 2008	Per Capita Funding 2008
Keewatin Tribal Council	6,982	\$0	9,815	\$0	\$0
Island Lake Tribal Council (ILTC)	5,568	(NMU) *\$150,000	8,935	(NMU) **\$258,000	\$12.83
Interlake Reserves Tribal Council	4,155	\$0	8,032	\$0	\$0
Independent First Nations North	9,187	\$0*	14,271	\$0**	\$0*
Independent First Nations South	4,262		7,027	\$30,520	\$4.34
Swampy Cree Tribal Council	6,285	\$0***	10,621	\$0	\$0
West Region Tribal Council	2,724		5,229	\$31,000	\$5.93
Southeast Resource Dev't Council	3,646		2,359 <i>road</i>	\$15,600	\$6.61
			5,475 <i>fly-in</i>	(NMU)	\$12.83
Dakota Ojibway Tribal Council	5,227		8,867	\$53,842	\$6.07
Total	48,036		80,631		

*The NMU received \$150,000 in 2004/05 to re-establish services in ILTC and Norway House

** The NMU contract was enhanced to \$258,000 in 2007/08 to expand services into the SERDC fly-in communities, for a total population of 20,114.

*** The majority of communities affiliated with SCTC receive health services from the province, through the 1964 agreement.

WHAT WERE THE POLICY & PRACTICE SHIFTS?

The delivery of FNIH funded foot care services in Manitoba Region began in 1998 when allied health services were de-listed from the national Non-Insured Health Benefits (NIHB) list. At that time, expenditures for Allied Health Services, including podiatry, were reallocated to regional envelopes under community-based health programs. Each region independently decided whether to allocate the monies to existing programs or to develop allied health service programs. Manitoba Region made the decision to offer a foot care service with the \$176,000 reallocated NIHB expenditures for allied health services. The program budget was, however, fixed.

By 1999 the program consisted of several southern communities receiving foot care nursing services on reserve. Other southern communities were contracting with nearby podiatrists to provide services within the community or referring community members to podiatrists off reserve. No services had been established in the north, and not all southern communities were accessing services. This is not dissimilar to the situation today.

In 2000, in an attempt to ensure **all** First Nations communities received quality, community-based, cost effective foot care services, a request for proposals (RFP) for Certified Foot Care Nurses (CFCNs) was issued and Standing Offer Agreements (SOAs) were initiated. Mandatory educational and experience requirements were established in addition to mechanisms for referral. The intent was to secure a sufficient number of CFCNs to deliver services in all FNIH MB Region communities, excluding those under provincial jurisdiction through the 1964 Agreement. However, despite repeated RFPs, FNIH was unable to secure adequate numbers of service providers for all communities. Nurses were particularly unwilling to travel to the northern, fly-in communities to provide foot care services. Due to this human resource shortage, FNIH MB Region supported interested Community Health Nurses (CHNs) working in the north to attain foot care certification. Thus, with the purchase of foot care equipment and training support, limited services were established in a few northern communities.

Community leaders, health directors, and nurses were apprised of the changes through written correspondence as well as through area health meetings and NIC conferences. Once program parameters were developed the program manager was notified that services were to be offered to off-reserve Manitoba Registered First Nations. A significant proportion of the

available funding therefore went to provide services to off-reserve clients. The budget of \$176,000, however, remained fixed.

In keeping with the organizational mandate, once the service was established the resources available for basic foot care services via SOAs were made available to communities. Between 2000 and 2004 negotiations with interested community leaders took place. Funding allocations were established based upon current expenditures, demonstrated need for enhancement, and administrative costs. Communities entered into Contribution Agreements (CAs) to receive funding and West Region Tribal Council included the funding in their Transfer Agreement.

Sometime after 2004, the SOA's were discontinued; those communities still utilizing the services of SOA providers, wishing to continue to receive foot care services, were required to enter into Contribution Agreements with the Region. They were reportedly made a one time, non-negotiable offer. Therefore, all 14 communities who had SOA providers, as well as West Region Tribal Council (representing 7 communities), have entered into Contribution and Transfer Agreements for the delivery of community-based basic foot care services.

The shift from SOA providers to Contribution Agreement funding allowed communities to hire their own providers, and while the CAs maintained the educational requirements outlined in the SOAs, linkages with the Infectious Diseases Clinic and other medical specialists were lost.

In addition to these community based services, the Northern Medical Unit (NMU) managed a University funded Diabetic Foot Nurse Clinician Outreach Program pilot beginning in May 2000, offering community-based diabetic foot clinics in 5 communities. The visiting advance practice Diabetic Foot Nurse Clinician (DFNC) "facilitated and made accessible at a community-based level, the delivery of care usually associated with the tertiary care system" (Everhardus & Martin, 2002). A program evaluation was conducted in September 2002, which culminated in a cost-benefit analysis prepared by NMU for FNIH in January 2003. A region-wide Diabetic Foot Nurse Clinician program, with a regional coordinator/part time service provider, one advance practice clinician affiliated with each Tribal Council, and an estimated total annual cost of \$914,000 was proposed.

Despite the estimated travel cost savings to the Regional NIHB program of \$635,000, the identified need, and the disparity of service provision in the region, the proposal was not accepted. The Manitoba First Nations Diabetes Committee were in favour of a regional foot care program, however, they opposed re-profiling NIHB dollars. This suggests that they did not have the autonomy or authority to support changes to the NIHB program and budget. The Region never discussed the issue with the Chiefs, and, although FNIH often made unilateral decisions regarding NIHB, they did not go ahead and use NIHB dollars to fund a regional foot care program.

In 2004/05, however, the NMU was contracted to re-establish DFNC services in 5 communities in their program areas with an annual allocation of \$150,000 from the nursing operational budget. Thus, the Island Lake fly-in communities and Norway House were provided access to community-based advanced foot care with both routine and urgent (within 24 hours) referral mechanisms to specialist care.

<u>2004/05 Expenditures</u>	
Budget:	\$176,000
NMU:	\$150,000
<u>NIHB:</u>	<u>\$635,000</u>
Total:	\$961,000
Proposed annual program costs:	\$914,000

In 2005 the ongoing disparity in service delivery across the region led a FNIH Nurse Manager to develop a foot care business plan. The plan outlines how Home and Community Care or Community Health programs (such as the Aboriginal Diabetes Initiative) were delivering some foot care services, although not resourced or mandated to do so. The foot care services delivered were therefore limited and mandated programs suffered. For these reasons an increase in the foot care budget was proposed to allow “equal access to all First Nations” on reserve to a “proactive, cost-efficient, and proven... preventative [foot care] program” (Tyson, 2005). The proposed annual projected expenditures, including salaries, travel, meals, podiatry, one time equipment costs, and medical consultation for continuing education & program evaluation, totaled just over one million dollars. Again, the upstream investments proposed were not made and the program never implemented.

Instead, in July 2005 NIHB implemented the Medical Transportation Policy Framework, which eliminated the payment of travel costs for podiatry services. Clients accessing podiatry must now coordinate these appointments with those that are covered or pay the costs themselves. The NIHB Medical Transportation Policy Framework, July 2005 stipulates that:

Medical transportation benefits may be provided for clients to access the following types of medically required health services:

- ✓ medical services defined as insured services by provincial/territorial health plans (e.g., appointments with physician, hospital care);
- ✓ diagnostic tests and medical treatments covered by provincial/territorial health plans;
- ✓ alcohol, solvent, drug abuse and detox treatment;
- ✓ traditional healers; and
- ✓ Non-Insured Health Benefits (vision, dental, mental health). (p. 3)

FNIH updated its Foot Care Policy November 28, 2005. This version states that to access podiatry “a certified foot care nurse referral is required” and goes on to say “MD referrals are be [sic] accepted” (p. 3). For those communities without foot care nurse programs and where the CHNs responsibilities do not include treatment, the need for either a foot care nurse or MD referral prevents clients from accessing necessary service. The budget attached to the Updated Foot Care Policy, November 28, 2005 indicates an allocation of \$170,000, and projects a surplus of \$20,338, when in the south, Long Plain, Dakota Tipi, and none of the 7 Interlake communities receive any funding for foot care services.

In 2006 FNIH did invest in the Manitoba First Nations Diabetes Committee’s proposed upstream initiative and funded the Diabetes Integration Project (DIP). The project, however, is currently in the planning and development phase, with some early implementation beginning. The DIP model proposes to offer itinerant, advanced practice foot nurse clinicians to support community-based programming. Given that the majority of Manitoba First Nations communities are not funded to provide community-based foot care services, the implementation of an advanced foot care program is problematic.

In the 2007-08 fiscal year, the nursing directorate enhanced NMUs resources to fund a second nurse. The NMU’s 2008/09 Public Works contract for foot care services totals \$258,000, inclusive of salaries, equipment/supplies, and travel costs. As of September 2008 a second nurse has been hired and is completing her training, expected to begin independent practice mid-month. By the end of September an additional 4 communities will have access to advanced levels of foot care service provision from the NMU.

To summarize the Manitoba context, foot care and preventative devices are not covered by the provincial health care plan. Instead MB health paid an estimated \$15 Million of downstream costs associated with amputations in 2005. Community-based foot care services are inconsistently and non-proportionately funded in select First Nation communities in Manitoba, creating a 3 tiered system, and access to foot care services for First Nations clients are not reimbursed through NIHB. Thus Manitoba First Nation Diabetic clients, with 4.2 greater prevalence of diabetes, have amputation rates 18 times higher than all other Manitobans.

Figure 1: Chronology of Foot Care Related Events

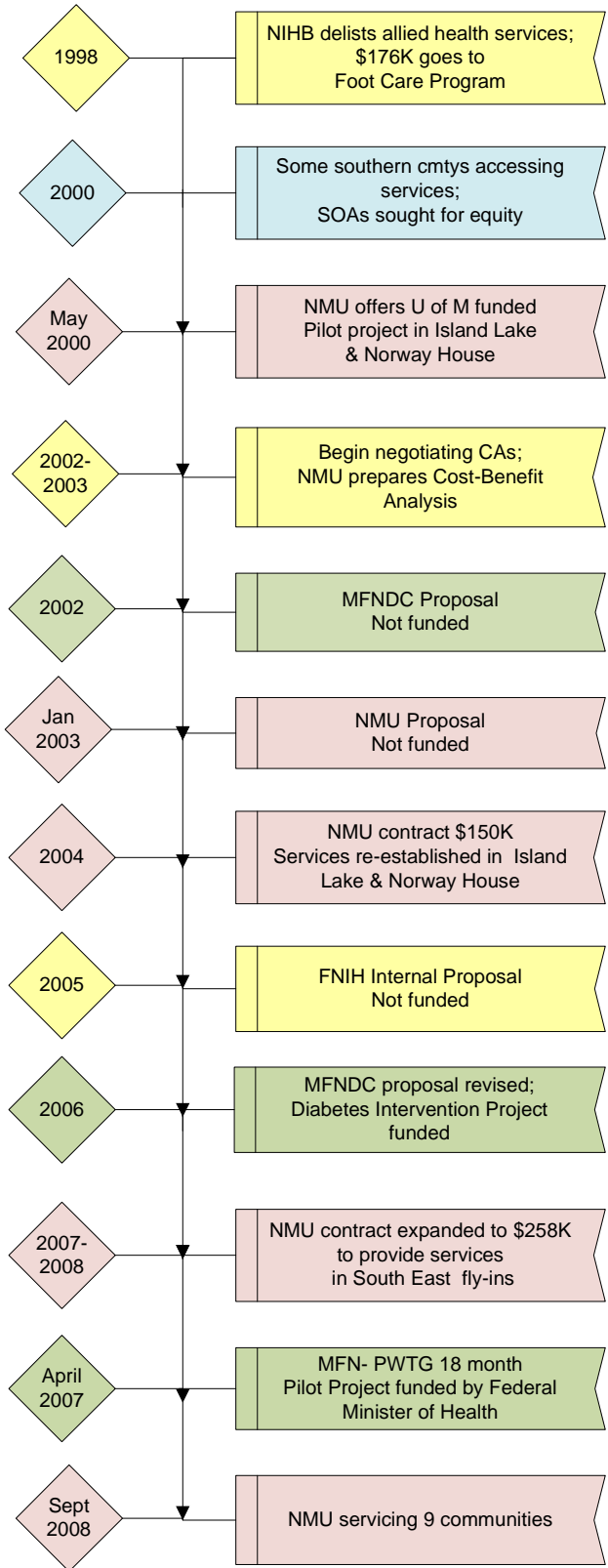
MFN Amputation rates 18% higher than other Manitobans

Estimated costs of NMU's 2003 proposal \$914,000

2004/05 Expenditures total \$961,000

Estimated costs of the 2005 proposed program just over \$1 Million.

MB Health spending \$15 Million in 2005 on MFN amputations



HOW CONCERNED SHOULD WE BE?

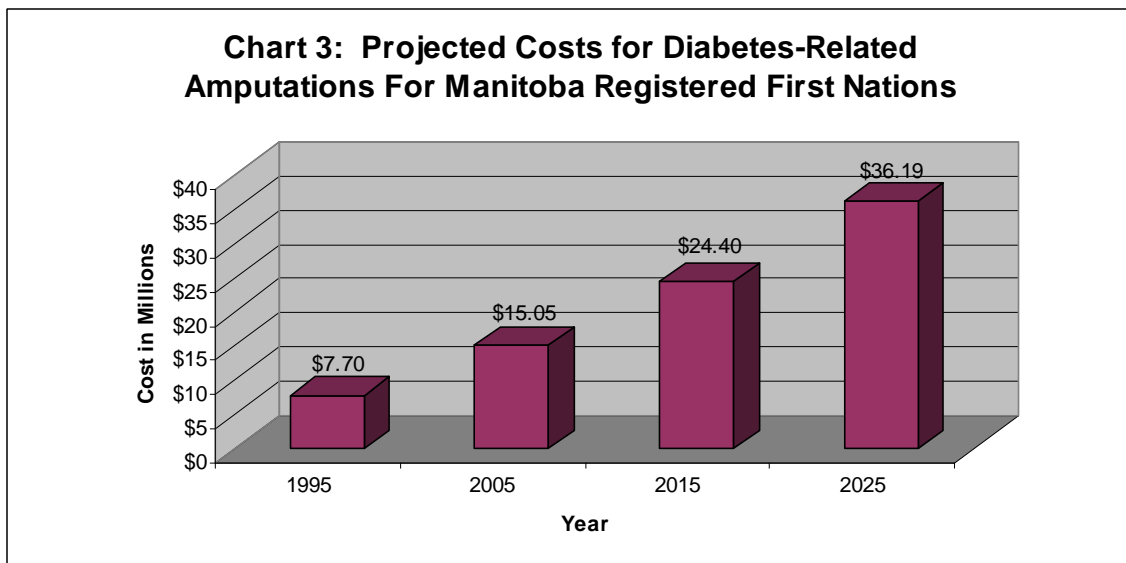
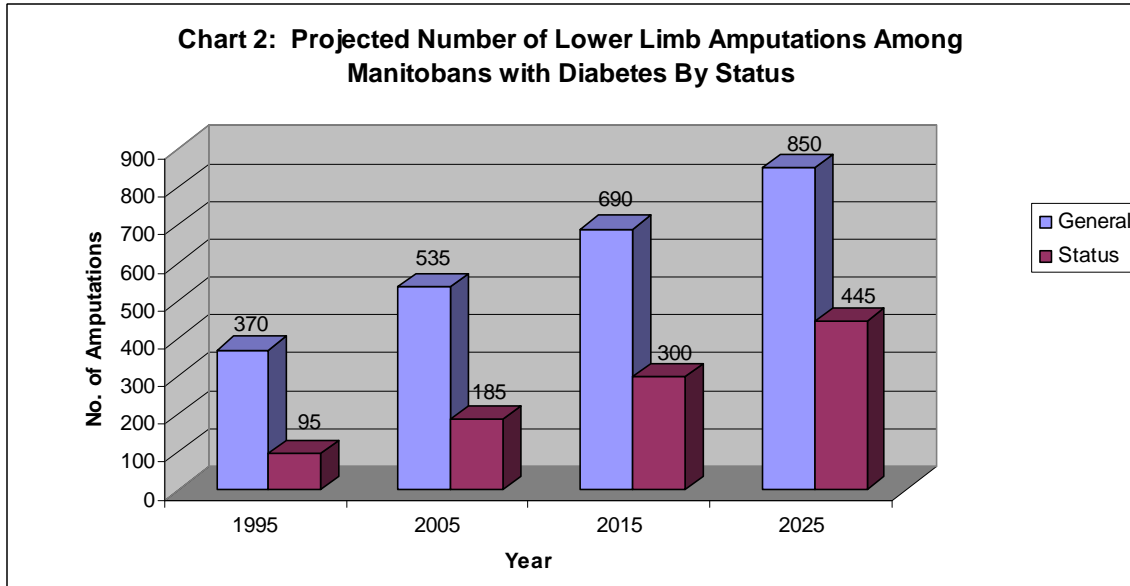
The Canadian health care system expends considerable resources on the care and treatment of diabetes and diabetes-related complications. The Canadian Diabetes Association states:

Canada's federal and provincial governments spend more than \$5.6 billion annually to treat people with diabetes and its complications within our acute care system. This amount includes the cost of hospitalization for surgical and emergency care, in-hospital medications, devices and supplies as well as physician and specialist visits. It equals 10% of the annual cost of our health care system and does not include the costs of rehabilitation after major surgery or amputation, or the personal costs to the individual and family (CDA, 2008, p. 4).

In Manitoba, the estimated 1995 expenditures on diabetes and diabetes-related complications represented 18% of the province's total health care budget (Lavoie & Forget, 2006). These costs are "estimated to increase by 130% for all Manitobans and by 330% for Registered First Nation people by 2025" (Lavoie & Forget, p. 30). The costs associated with specific diabetes-related complications, such as amputations, have not been previously reported.

However, at the First Nations Patient Wait Times Guarantee Project's Partnerships in First Nations Diabetes Foot Care Conference, Winnipeg, Manitoba (March 2007), Dr. Arneja, Director, Amputee Program, Physical Medicine & Rehabilitation, Health Sciences Centre, reported that in Manitoba lower extremity amputations (LEA) cost a total of \$81,334 each. This includes the costs of surgical intervention, general hospital ward stay, rehab hospital ward stay, and prosthetic fitting. Using this figure, the costs associated with the projected number of LEAs for RFNs in Manitoba will increase from \$7.7 million in 1995 to \$24.4 million in 2015 and \$36.2 million in 2025, all in 2008 dollars. This does not take into consideration inflationary influences and other cost drivers.

Chart 2 on the following page depicts the diabetes related amputation rates, projected by Blanchard, Wadja, and Green(2003) while Chart 3 shows the corresponding cost projections.



Additionally, a cost-benefit analysis was completed by the Northern Medical Unit in 2003 based upon actual service delivery expenditures between January and June 2002 and the associated cost savings had clients been referred out of the community for care. The outreach Diabetic Foot Nurse Clinician in this pilot project provided 457 assessments/procedures to over 700 clients in 11 fly-in communities, which would have required referral out of the community, in addition to the “596 routine nail care procedures

and 13 partial nail resections” (Everhardus & Martin, 2003). These services had previously been unavailable on reserve. Avoided client transportation costs, estimated at \$1000 per trip as per FNIHB Manitoba Region’s average, total \$457,000 whereas actual program costs equalled \$51,608 for the 6 month period. The potential travel **cost savings per year** was therefore estimated at **\$634,784** with immeasurable savings to First Nation clients and the health care system.

Because cost estimates were not available at the time, the fiscal analysis conducted by Lavoie and Forget (2006) states, “It would be useful to know by how much the costs of avoidable lower limb amputations would exceed the costs of funding an adequate foot care program” (p. 30). The cost estimate for the proposed comprehensive, region wide program in 2003 was \$914,000. FNIH Manitoba Region at that time would have saved \$635,000 on NIHB travel if a program was implemented, their budget for foot care was \$176,000, and the NMU was subsequently funded \$258,000 to provide services in 9 communities. These expenditures total \$1,069,000. The cost estimate for the program proposed in 2005 was \$1,027,272. This suggests that program costs would neither exceed federal expenditures nor come close to the estimated \$15 million dollars required to fund Manitoba First Nations amputations.

Unfortunately, the ability of FNIH, Manitoba Region to re-profile the \$635,000 from the NIHB Medical Transportation budget to a regional foot care program expired with the de-listing of the NIHB travel benefit for podiatry in 2005. Manitoba First Nations experienced a ‘double’ loss with the de-listing of the NIHB travel benefit and these potential cost savings are no longer available for community-based foot care services.

WHAT NEEDS TO CHANGE?

POLICY ALTERNATIVES

An analysis of the impacts of the various policy positions of all those players affecting foot care service delivery for Manitoba First Nations indicate a need for several changes. To lower the number of foot amputation and complications, to decrease patient wait times and to provide consistent and equitable foot care services that are cost efficient the following policy alternatives are suggested for each of the players. These broad based policy recommendations are intended to commence discussions and develop a move forward plan between relevant government departments, health care agencies and regional First Nation organizations.

First Nations and Inuit Health

- 1st. Recognize existing program provisions, accept mandate for foot care programming and develop policies to support consistent and equitable programming region-wide.
- 2nd. With NIHB expenditures on podiatry and travel no longer available, Health Canada must work with regional First Nations to develop foot care program frameworks to propose and secure program funding from the Treasury Board Secretariat (TBS) in addition to their regional budgets.
- 3rd. FNIH must implement their original plan to establish foot care services in 64 First Nation communities to ensure 'equity' is offered and **all** communities have access to basic foot care.
- 4th. FNIH should work with their appropriate regional First Nation organizations to develop a funding formula that ensures programs are adequately and consistently resourced.
- 5th. The original foot care funding envelope of \$176,000 has not been based on need or service utilization, this budget allocation can be rolled up into the larger foot care budget for the region once community-based programming has been established.
- 6th. NIHB, FNIH should revisit the efficiency and efficacy of their policy decision to delist medical transportation for urgent podiatry visits and shoe fittings. The costs for re-introducing the travel benefit, limited to urgent care and shoe

fittings, is considerably less than the down stream costs of foot complications from improper foot wear.

Indian and Northern Affairs

- 7th. Although therapeutic shoes were never covered by any federal or provincial insurance plans, INAC must consider the overall health and financial benefits for diabetic clients on social assistance. At a minimum, INAC should provide an annual allowance for clients on social assistance for therapeutic shoes, similar to the increase benefits for clients on diabetic diets.
- 8th. INAC must also increase PCH institutional funding to include foot care programming or client specific re-imbursements, similar to provincial EIA provisions of 9 visits per year upon physician/foot care nurse referral.
- 9th. This additional benefit from INAC should also be extended to cover the foot care costs for clients in off-reserve personal care homes that are not covered under provincial EIA plans and have limited personal resources.

Manitoba Health

- 10th. Must consider improved client outcomes and financial efficacies for providing basic/preventative foot care by certified providers as an insured health service. Manitoba Health is encouraged to follow suit behind Alberta and British Columbia and insure foot care services for all Manitobans.

Family Services and Housing

- 11th. Amend their policy regarding provision of orthotics for EIA recipients based upon Manitoba Health's interpretation of the legislation, i.e., provide pre-surgical orthotics to diabetic clients on EIA.
- 12th. To be in line with their federal counterpart, offer therapeutic foot wear to First Nation EIA clients living off-reserve.

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