Conseil Cri de la santé et des services sociaux de la Baie James
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Cree Board of Health and Social Services of James Bay

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NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES
RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX NUNAVIK

CANCER PROJECT IN NUNAVIK AND EEYOU ISTCHEE

2014-2017

GOAL 1:
ENSURE PATIENTS AND FAMILIES FEEL AT HOME WHEN INVOLVED WITH SERVICES

The patient experience is documented and known within services
- **Patients have a voice in services**
- **Services have greatly improved ways of communicating with patients and their families**

GOAL 2:
ENSURE PATIENTS AND FAMILIES ARE INVOLVED AND RESPECTED BY BUILDING IN THE INUIT AND EEYOU CULTURAL DIMENSION IN THE DELIVERY OF THE SERVICES

1. Each region has a network for cancer services and supports.
   - Has a mandated governance structure in each region for setting overall direction of the cancer file.
   - Links to the Direction québécoise de cancérologie.
2. In each region, the regional cancer plan supports the cultural adaptation of services.
3. The regions offer training programs on intercultural approaches in services for professionals newly arrived in the region.
   - These are built from needs assessments, training curricula, tool kits, training modules and platforms, etc.
4. The regions and their corridor of services operate with guidelines for announcing a cancer diagnosis in a culturally appropriate way.
   - The regions hold workshops to develop and implement these guidelines.
5. Each region has developed a training program for interpreters based on needs assessments, terminology development and training curricula.

GOAL 3:
IMPROVE THE COORDINATION OF SERVICES THROUGHOUT THE CORRIDOR OF SERVICES

1. The process for referring patients between levels of care is based on formal processes built on signed agreements, with management follow-up and tracking etc.
2. The regions work with those organising the corridor of services to set up a system to refer patients to a single window of access.
3. The medical information which follows the patient through the various levels of care is standardised and formalised in referral processes.
4. The mandate of the nurse pivot is assessed and the role of the nurse pivot is made widely known throughout the networks.
5. The regions collaborate through the cancer project team and through larger workshops involving those governing cancer services from each region, along with those organising the corridor of services.

GOAL 4:
STRUCTURE AND DEVELOP THE LOCAL SERVICE OFFER FOR FOLLOW-UP, REHABILITATION AND PALLIATIVE CARE

1. The regions along with those organising the corridor of services work to stream-line care and offer it as much as possible close to the patients' homes.
2. The regions define potential uses for telemedicine and work to implement them whenever feasible.
3. The regions keep an updated inventory of community and psychosocial resources available for patients and their families and ensure these are well known and linked to services.
4. In Nunavik, palliative care services are available for patients and their families.
   - In Eeyou Istchee, palliative care services are documented.
5. In Eeyou Istchee, a plan and pilot project for an integrated women's clinic for screening breast, cervical and colorectal cancers is organised.

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