An Integration of Practice and Theory:
A Practicum Experience in Primary Health Care

A MSW Field Practicum Report
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A PRACTICUM EXPERIENCE IN PRIMARY HEALTH CARE

Abstract

This practicum paper is an integration of self-reflection, current literature, research, and theory and knowledge, based on my experiences and field practicum placement in Primary Health Care (PHC) - Central Network within the Regina Qu'Appelle Health Region (RQHR). It will provide a summary of how I achieved my goals and objectives. This paper will focus on the organizational changes taking place and the adoption of the LEAN approach within the Regina Qu’Appelle Health Region and how the health regions are implementing new strategies to be more efficient in delivering services to clients. Additionally, I explain the assessments tool used during my practicum and how motivational interviewing and strength based approaches are utilized into completing assessments and client care. Next, the report explains how the Trauma Informed Care approach is being integrated into health care in order to understand long term health and wellness and the impact trauma has on the clients the health region serves. Finally, I provide information on how I used social work values and ethics to guide my practice.
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In 2006, I began working at Ranch Ehrlo Society in the position of a youth care worker. I quickly realized working in the social work field has a special place in my life. Shortly after, I enrolled in university and graduated with my Bachelor of Social Work in 2010. I continued to work at Ranch Ehrlo Society in a new role as Intake Coordinator and took on temporary roles as a Caseworker in various group homes. I continue to work in these roles to this day, which has exposed me to a diverse population. When deciding on a practicum placement, I wanted to gain a completely new experience in a field of which I had little knowledge, so I spoke with my professional associate and was intrigued by the dynamic organization that is the Regina Qu'Appelle Health Region. My professional associate informed me that the health region was heading in a new direction and making a great number of changes that I might find exciting. This news intrigued me and I knew it was going to be a unique opportunity with all new experiences in environments that were unfamiliar to me. I felt that this was the best fit for me and that I would gain valuable experience and a new outlook on the many aspects of social work.

Practicum Setting

My practicum was completed in the Regina Qu'Appelle Health Region (RQHR) in Primary Health Care- Central Network. RQHR is a dynamic, high-level organization that provides a wide variety of care for a diverse population including aging individuals and high risk clients who engage in substance abuse and have been exposed to trauma throughout their lives. Its vision is to deliver health services from the patients' perspective.

The vision, missions, values and beliefs of RQHR set a clear direction for the organizations and those who work and receive care within the setting. Its vision is to have healthy people, families, and communities. The Regina Qu'Appelle Health Region is provincially supported and
provides the community with a full range of safe, quality health services, education and research that inspires public confidence. RQHR achieves success in meeting the diverse needs of our communities through the strength of its people, partnerships and personal responsibility for health. Its values include compassion, respect, collaboration, knowledge, and stewardship.

My practicum began in September 2015 and ended in December 2015. I was fortunate enough to be afforded the opportunity to take an education leave from my position at Ranch Ehrlo Society in order to complete my practicum on a full time basis.

**Practicum Objectives**

Before I began my practicum in Primary Health Care (PHC), I identified several practicum objectives and learning goals to guide my journey. Once I began, I learned more about my placement and identified areas of interest and opportunities available to me that were not known previously. I successfully achieved my goals in one form or another and for this paper I will focus on the following four main areas of my learning:

1) *To gain knowledge and practical social work experience by conducting literature research about policies and development within the context of Primary Health Care Networks and RQHR.*

I came into my practicum during a time when RQHR was going through a massive transformation. I took advantage of many opportunities to sit in on development meetings, training sessions and learning opportunities. I took Kaizen Basics training, which was a three hour training session for new employees to gain insight into the history of LEAN and how RQHR has implemented new strategies for efficiency and improved care. LEAN is a patient-centered approach to health care. LEAN seeks to reconfigure organizational processes to reduce waste and enhance productivity while creating a culture of continuous improvement. It engages
employees and patients to find ways to improve processes so that every patient served receives reliable, safe and timely care. I gained valuable knowledge about how the LEAN program is being implemented in the health region and continued to do literature research in order to gain further understanding of how this will truly benefit clients and providers. Additionally, I took part in primary health care network development meetings in which the manager was able to explain changes that were occurring and how they will directly impact health care providers and how primary health care networks are being re-organized.

2) To gain knowledge about available services within the community to support greater independence and reduce reliance on the Emergency Departments within RQHR.

RQHR is made up of a large number of community services from adult day programs to long term care facilities. I was able to visit some programs, as well as learn about many programs by asking questions and reading about the function of resources available. Taking part in some Program Access Committee meetings gave me an excellent opportunity to learn about a variety of programs along with the criteria one needs to have their referral accepted.

3) To develop skills in working with a multi-disciplinary team in Primary Health Care and provide high quality assessments, referrals to community resources, and consultations with clients to assist them in achieving success within the health care system.

My involvement in assessments with clients was an essential part of my learning experience. I was fortunate enough to take part in multiple assessments and learned valuable skills about conducting interviews with families and discussing, sensitive topics, as well as using various assessment tools. Additionally, I was able to learn about documentation, planning, and a variety of services that are available as each client has unique needs and health issues.
4) To work with a diverse population and better understand the complex needs and health issues faced by individuals within the health care system.

The central primary healthcare network has a diverse population of clients with unique and complex health care needs. The clients within this network have lower incomes, serious and chronic health problems at younger ages, can be transient, and for the most part are not connected to a physician. Along with these dilemmas come some challenges for providers and Assessor Coordinators. Assessor Coordinators are the social workers involved in completing assessments and linking clients to the appropriate care. The work with patients can be difficult as services are not always mandated or designed for younger clients even though these services may be needed or most appropriate. Each client and situation is unique and does not always fit into the strict guidelines or mandates for services. In addition, clients sometimes minimize health issues as they may be dealing with larger problems in their life. As a result they seek emergency medical care as the illness becomes extremely serious.

I was able to research the impact of trauma and the benefits of trauma informed care and present it to two teams who provide assessments and care to high risk clients. Providing information and awareness about the importance of trauma as a factor in health outcomes helps health care providers to engage clients, develop rapport, and build trust over time. As a result, providers will be able to identify health care issues and make improvements to care and the environment.

Theory

During my practicum, I worked with a diverse group of clients who have unique health, social, and economic histories that shape their lives, experiences, and outcomes. The Assessor Coordinator role must take into account how the social, emotional, economic, and environmental
factors impact the health and well-being of the client. The social work professional has overarching theories that professionals draw upon to frame practice and intervention with clients. When complex situations arise, professionals can draw from theory and design appropriate solutions. In my practicum placement, strength based perspective and motivational interviewing are both tools that are widely used and beneficial when working with a diverse population.

Strength based perspective and motivational interviewing work well together as a large part of strength based perspective is linking resources and strengths to specific goals and tasks and motivational interviewing focuses on building confidence in individuals who may reluctant to pursue these goals or plans because of low confidence. Conversely, if a social worker is using motivational interviewing and a client becomes very motivated to change and is ready to develop an action plan, having that plan grounded in client strengths will increase confidence and success (Manthey, Knowles, Asher, & Wahab, 2011). Both theories support personal empowerment and hold the belief that the individuals already have the skills necessary to solve their problems and achieve success. Both place emphasis on relationships and hold the belief that hope is essential.

**Strength Based Perspective**

Strength based perspective is widely used by the Assessor Coordinators in RQHR’s central network as it gives them a framework to recognize the client as having an unlimited capacity for growth and resilience. The strengths perspective in social work was proposed by Saleebey (2006). The perspective is widely used in child welfare, substance abuse, family services and services for the elderly. It holds that all of our clients have their own strengths, despite their health concerns, problems, or disadvantages. The role of the social worker is to enable, support, stimulate, encourage, and nourish the strengths within people. The strength based perspective allows people to move beyond deficits and instead illuminate the strengths
available and explore aspects of their lives that are still intact despite the presenting problems. The strength based perspective transforms the professional relationship into an equal collaboration between client and provider which allows for effective problem solving (Guo & Tsui, 2010).

Rather than focusing on client deficits or health problems, strength based practice allows the Assessor Coordinators in my practicum setting to concentrate on the inherent strengths of individuals and families in order to establish personal strengths that will aid in recovery or long term management of chronic illnesses in order to maintain independence. In essence, the focus is on health and well-being to embrace an asset based approach where the goal is to promote the positive aspects of the client.

In primary healthcare, strength based approaches are instrumental in successfully shifting the balance of care, and develop services that are focused on prevention and independence. This approach aligns with the shift being made in RQHR to primary health care as it focuses on the personal characteristics and individual decisions of the client. Additionally, it promotes empowerment and allows the client to identify goals and resources that are available in order to achieve those goals. In other words, the question is not what kind of life one has had, but what kind of life one wants, and then use available resources to accomplish this goal.

Brun and Rapp (2015) describe strength based practice as combining a focus on client strengths and self-direction with three principles: promoting the informal networks, offering assertive community involvement by case managers, and emphasizing the relationship between client and case manager. During my practicum, I was able to observe and implement each of these principles. The clients, with whom I was involved, had informal resources such as family, friends or casual hired help that I was able to collaborate with to provide the necessary care or
completion of specific tasks in order to maintain independence while managing chronic or acute illnesses. For example, one client has a hired helper who takes her grocery shopping. It came to my attention that my client struggled to organize her groceries and meal plan appropriately. My client enjoys cooking her own meals and wants to maintain her independence in this area so a plan was made to take advantage of the informal resource and have her hired companion help her organize and put away her groceries. In addition, my client was offered community resources in order to manage her immediate need of medication management and she was reassured that case management will be an ongoing collaboration in order to meet any future needs.

Strengths perspective aligns with the values of social work. Uncovering the hidden strengths and framing them in an accessible and useful way becomes a core social work process. Weick, Rapp, Sullivan, and Kisthardt (1989) state that if anything, a strengths perspective is a strategy for seeing; a way to learn to recognize and use what is already available to them. The professional person thus becomes a translator who helps people see that they already possess much of what they need to proceed on their chosen path. Focusing on human strengths is one significant strategy for helping people reclaim a measure of personal power in their lives (p. 354).

Strength based perspective can be viewed as instrumental in successfully shifting the balance of care, and developing services that are focused on prevention and independence. It challenges and encourages service providers to focus on possibilities and solutions in order to highlight factors that create and support health and wellness rather than the cause of disease. It is important to recognize that strength based perspective is not simply about different tools or methods that are used with people who use services; it is about different concepts, structures and relationships that social workers build in their support services.
Motivational Interviewing

Motivational interviewing (MI) is a style of patient-centered care that fits into the direction of PHC in the Regina Qu'Appelle Health Region. This counselling technique was developed to facilitate change in health-related behaviors. The core principle is to negotiate and support rather than direct and create conflict (Treasure, 2004). Motivational interviewing is an evidenced-based approach that health care providers can use to help patients adhere to treatment recommendations and follow through on treatment plans.

MI is grounded in the trans-theoretical model which conceptualizes behavior change as a process with multiple stages. The stages represent distinct categories along a continuum of motivational readiness. The stages include pre-contemplation, preparation, action, maintenance, and relapse. According to Prochaska and Climente (1982), pre-contemplation is the state in which an individual is not yet considering the possibility of change. Pre-contemplation is the stage of ambivalence. Preparations are characterized by the intention to make changes in the immediate future. Action is the stage where the individual takes action in order to achieve change. Maintenance is where the individual strives to maintain the behavior that has been successfully changed. Relapse is the when an individual re-engages in the undesired behavior. The overall intention of motivational interviewing is to support individuals to move along the continuum of change by being supportive, non-judgmental, and facilitating exploration of the individual's motivations and readiness (Wahab, 2015). It is important to meet the client where “they are at” on the continuum of change.

What appears to be most important about motivational interviewing is the "spirit" of the approach. This refers to the style, intention, or way the practitioner interacts with the client. It is
said that the spirit of motivational interviewing cannot be taught but is found within the clinician. Rollick and Miller (1995) identify seven elements of the MI spirit:

1. Motivation to change is elicited from the client.
2. It is the client's task to articulate and resolve ambivalence.
3. Direct persuasion is not effective in resolving ambivalence.
4. The counselling style is generally a quiet and eliciting one.
5. The counsellor is directive in helping the client examine and resolve ambivalence.
6. Readiness to change is a product of interpersonal interaction.
7. The therapeutic relationship should be seen as a partnership or companionship rather than expert/recipient roles.

The spirit of MI requires willingness for the clinician to glimpse into inner world and experiences of the client. Additionally, MI is driven by four principles rather than a set of specific therapeutic techniques. There is no rigid formula or "cookie cutter" approach to teaching or practicing motivational interviewing, rather, clinicians facilitate a process where clients convince themselves to engage in behavior change. Clinicians do so through the following four principles: express empathy, develop discrepancy, roll with resistance, and support self-efficacy (Levensky, Forcehimes, O'Donohue, & Beitz, 2007).

The clinician can express empathy through reflective listening and demonstrating an understanding of what the client means. This will help the clinician to understand the clients underlying reasons for change. Developing the discrepancy between the client's values and goals and current behaviors helps the client to become aware of the inconsistencies between his/her unhealthy behaviors and personal goals. It is beneficial for the client to able to identify these discrepancies. Rolling with resistance means that the clinician does not directly oppose any
resistance, instead they respond with empathy and understanding. Finally, the provider will hold the client's confidence and will express to the client their belief in the possibility of change (Levensky et al., 2007).

The way in which health care providers speak to their clients about their health can substantially change the client's personal motivation for behavior change. No person is completely unmotivated. Everyone has goals and aspirations and health care providers can make a difference and have long term influence on the client's health. The service provider's communication skills are in and of themselves a toolbox. The tools of asking, informing, and listening can be combined in a manner that is effective and efficient in eliciting change and hope for the clients.

I gained knowledge in both strength based approach and motivational interviewing throughout my practicum. I was able to put into practice my new knowledge as well as observe others with experience with these theories.

**Primary Health Care**

Primary health care in Canada has entered a period of transformation and positive change. Limited resources due to declining federal support to fund health care have caused concerns about private delivery of health services. The development of a wholly private sector for health care, one that is both delivered and funded privately, is perceived as a far more serious potential threat to the publicly funded system.

The Government of Canada (2012) describes primary health care (PHC) as an approach to a spectrum of health services that go beyond the traditional health care system. It includes services that influence health, including income, housing, education, and environment. PHC has been driven in part by patient-centered practice (PCP) in that it is meant to focus on identifying,
understanding, and answering patient's needs and recognizing that the patient should be in the centre of the circle of care. Social workers or in the case of RQHR, Assessor Coordinators place greater emphasis on the dimensions and importance of patient autonomy and empowerment (Gachoud, Albert, Kuper, Stroud, & Reeves, 2012).

It is important to recognize that primary healthcare providers are now being increasingly asked to provide services that are more complex and extensive than in the past. There is a demand to provide in home post-operative care, community rehabilitation, and a variety of other intensive in home treatments and palliative care. These demands result in a greater emphasis on assessment and care planning, multidisciplinary teams, care collaboration, and extended hours of service along with the flexibility to respond to urgent care demands.

The function of primary health care is twofold: to provide direct provision of first contact services (family physicians, nurse practitioners, pharmacists etc.) and to ensure continuity and ease of movement across the system.

Hutchison, Levesque, Strumpf and Coyle (2011) state that each province and territory has its own goals and objectives but ultimately they each have common underlying themes:

- improved access to primary care services;
- better coordination and integration of care;
- expansions of team based approaches to clinical care;
- improved quality/appropriateness of care, with a focus on prevention and the management of chronic and complex illness; and
- greater emphasis on patient empowerment and self-management; and the implementation and use of electronic medical records and improved information systems.
One of the key features of primary health care reform is a transformation into teams of providers who are accountable for providing clients with comprehensive services and care. Having social workers, physicians, nurses, continuing care aids, and other professionals working together will result in better health outcomes, consistency and continuity, better use of resources, and better satisfaction for patients and providers. It is anticipated that primary health care will result in better experiences for patients and providers, improved responsiveness to patients' and communities' needs, greater health equity, efficiency and accountability (Hutchison, et al., 2011).

During my practicum I was involved in home care and home care assessments. Home care is a part of modern, integrated and patient-centered care. Improving access to home and community care services will improve the quality of life for many clients by allowing them to recover at home (Health Council of Canada, 2008). Home care is designed for clients who want the ability to remain independent in their own home or receive end of life care in their own home. Providing care at home allows clients the opportunity to remain comfortable and as independent as possible. These services involved nursing, continuing care, occupational therapists, and other personal care services. These services are most frequently used with vulnerable populations such as seniors and adults with chronic conditions. In turn, these services will alleviate some pressure that may be placed upon family members or support persons.

RQHR provides an extensive list of services. For the purposes of this paper I will touch on a few that were accessed or referred to during my practicum. Services include but are not limited to: Adult Day Support Program, Respite Care, Pharmacy and Nursing Services, Long-term Care, and Occupational Therapy.

The Adult Day Support Program is a program that offers opportunities for recreation, socialization and personal care to clients, and provides daytime respite for caregivers. This
program is offered for a daily fee and assessor coordinators must request approval from the Program Access Committee in order for clients to attend.

Respite care is offered as a means for caregivers to have the break they need in order to continue caring for their loved ones. Its aim is to maintain the client's level of functioning and scheduling while receiving respite care. Respite care is primarily provided at care facilities such as Regina Pioneer Village, William Booth Special Care Home, Wascana Rehabilitation Centre to name a few. Respite service is provided 24 hours a day, seven days a week. All potential candidates must be presented to the Program Access Committee by the Assessor Coordinator and approval will be based on the client's level of risk.

Pharmacy services can be accessed by clients in order to have medications blister packed for ease of administration and pharmacy services will also deliver medications for clients who are unable to transport themselves. Additionally, clinical nursing services are provided to accommodate acute, supportive, and palliative client care needs. Nurses provide services such as wound management, health education, IV therapy, medication management, injections, and symptom and pain control.

Long Term Care is sought when the client is no longer able to safely live on their own in the community. Long Term Care is primary accessed from the hospital and placement in a Long Term Care facility must be approved by the Program Access Committee.

Occupational Therapy is concerned with the functional capabilities of clients of all ages. Assessor coordinators refer clients to an Occupational Therapist who will visit the client in their home for the purpose of assessing the client's needs and level of functioning. For example, the therapist may recommend a walker or safety bar for the bathtub. Ultimately, this service provides
a comprehensive assessment of the client in home, they provide education to clients and family, and will assist in obtaining funding for home modifications or equipment as needed.

In addition, there are many other services that are offered throughout the health region to help individuals navigate the vast health care system and aid them in preventing further health care issues and to encourage individuals to access primary care providers before seeking care in emergency departments. RQHR continues to work to improve their systems and seeks to provide the best patient centered care possible.

**Interview Process**

The process of completing assessments can at times be stressful or produce anxiety for both the clinician and the client. Initial assessments can be most difficult as the assessor feels pressure to form a trusting relationship while explaining protocol, assessment details, and addressing the client's concerns. Cooper and Lesser (2005) describe an intake interview as the process of collecting information to gain a well-rounded understanding of client problems, and then using that information to form treatment goals to meet the needs of the client. In order to be effective when interviewing, both technical knowledge and interpersonal skills are required. Technical skills involve knowledge of what areas to cover and using the appropriate interview approach. According to Miller (2010), interviews can be divided into two categories: unstructured and structured approaches.

My practicum placement involved completing assessment tools while incorporating an unstructured interview approach. This allows the assessor to formulate their own questions in addition to the assessment tools being used. This approach allows the assessor to open up a dialogue in regards to the client's concerns and issues. Additionally, unstructured approaches allow the assessor to record client responses and presentation in an idiosyncratic way. The
assessor draws upon their knowledge base, clinical intuition, theoretical model, and interpersonal skills to guide their interview and assessment process (Miller, 2010).

The primary advantage of the unstructured approach is flexibility. It allows the assessor to use assessment tools as a guide while being able to engage clients in deeper conversation and spend more time on specific subjects regarding symptoms or concerns. This flexibility promotes relationship building and establishing rapport with clients. The client becomes the main focus of the interview and little time is wasted talking about information that is not relevant to the needs and concerns of the client.

The downside to unstructured approaches is reduced reliability and validity. Each assessor interviews and completes assessments in their own way and with their chosen theoretical model. As a result, semi structured interviews can provide a guideline along with flexibility in conducting assessments and interviews allowing the assessor to inquire about additional information and engage in conversation that will be helpful when developing treatment plans and determining which services are appropriate and most beneficial (Miller, 2010).

In addition to technical skills it is imperative for assessor to possess interpersonal skills. Johnston, Van Hasselt and Hersen (1998) call empathy and rapport the most inherently fundamental skills for successful intervention (as cited in Miller, 2010, p. 32). Rapport has been described as the alliance, collaboration, or working relationship an assessor establishes with a client. Both the assessor and client should be able to easily and openly express thoughts, feelings, and concerns. Morrison stated that rapport is best developed by the assessor by demonstrating a relaxed, interested, and non-judgmental attitude. The assessor should convey an open,
welcoming attitude while listening without judgment (Miller, 2010). Furthermore, the client should be treated with respect and understanding.

While completing assessments during my practicum, I was able to demonstrate rapport building with clients by discussing their expectations, goals and needs. The focus of assessment is to identify areas of concern in regards to health issues, demographic information, gather information about who is involved in care, what supports are available, and what supports and services would be beneficial to the client. Additionally, assessments provide an opportunity to identify programs and services that the client may not be aware exist. I used paraphrasing and clarified statements in order to ensure we are in agreement about treatment planning and services. I was also aware that the assessment and information being discussed can be personal, sensitive, and emotional for our clients and providing calm understanding statements helped clients to feel comfortable and part of a collaborative team.

Empathy is an important part of practice within RQHR. It has been defined by Cormier and Nurius (2003) as the ability to understand people from their frame of reference and trying to understand their view point (as cited in Miller, 2010, p.33). Empathy allows assessor to express that they are accepting and open to understanding the client’s world without being judgmental. During assessments with clients, discussion about personal health information took place in order to assess their service needs and at times extended family became involved and often had different viewpoints about their loved one. I found that being empathetic toward my client and validating their feelings would improve our relationship and possibly the relationship they have with their family members as I offered an understanding of the difficulties they may be facing and the complex emotions they experience in regards to their health needs. Clients are
encouraged to open up about the many difficulties they are navigating and helping them to identify and voice concerns they have in regards to their health and well-being.

Ultimately, I learned that effective interviewing not only involves that ability to ask the appropriate questions or the questions involved in the assessment but to be able to obtain the most informative and detailed response from the client. Technical knowledge and interpersonal skills go hand in hand in completing assessments and determining the necessary services and formulating an effective case plan.

**Assessment Tools**

I was given the opportunity to take part or sit in on a variety of meetings, services, and assessments. RQHR has an extensive list of services and as such there are many processes and procedures to navigate. Assessor Coordinators in the Central PHC Network use multiple tools to assess the needs of their clients. These tools include the Regina Risk Indicator Tool (RRIT), the Minimum Data Set Assessment - Home Care (MDS-HC), Mini-Mental State Examination, Montreal Cognitive Assessment. As I reflect on my practical experiences, I will focus on three tools that I had the opportunity to complete alongside an Assessor Coordinator: RRIT, MDS-HC, and Mini-Mental State Examination.

The Regina Risk Indicator Tool is designed to assess "risk" and gain objective information that can assist in predicting the client's potential "risk" of requiring placement in an institution. Assessor Coordinators in the Central Network complete this tool on their computer after their contact with clients. Additionally, this tool is required in order to present at the Program Access Committee meeting to seek approval for placement. The Regina Risk Indicator Tool (RRIT) has 23 client indicator categories. Categories range from socio-demographic factors
such as age, living situation, caregiver support, self-rated health, to functional attributes such as dressing and eating abilities. The tool is designed to give a total score indicating the client's degree of risk from minimal risk to high risk. Identifying the risk level of clients in the community, the coordinators can ensure that clients in need benefit from close monitoring, case management and appropriate program and service access.

The Minimum Data Set Assessment - Home Care (MDS-HC) is an internationally recognized assessment tool that allows the assessor to gather a large volume of information in order to identify the needs of clients and match them with the appropriate services. It is beneficial as it is designed to serve multiple functions including care planning, eligibility screening, and outcomes. The MDS-HC gathers a wide variety of information from finances, medical history, to the client's ability to complete daily tasks. This assessment aids in determining a person's care needs and goals, with the purpose of developing a holistic care plan to ensure their needs are addressed.

Assessors are provided with a tool called the Mini-Mental State Exam to use as cognitive screening tool. The "mini-mental" was developed by Folstein, Folstein, and McHugh (1975) as a rapid screening tool for cognitive function. It is a 30 point questionnaire and administration of the test takes between five to ten minutes and examines areas of orientation, attention, registration, calculation, recall, language, and visual construction. One advantage of the Mini-Mental State Exam is that it requires no specialized equipment or training for the administrator. This tool allows the assessor to complete this test easily during in-home consultations. It has both validity and reliability and due to its shorted ministration period and ease of use it can be done almost anywhere. Some weakness include its inability to detect mild changes, requires adjustment based on age and education, clients may be able to mask mild impairments, and
clients with hearing or vision impairment or low in English proficiency may struggle to complete the assessment.

Early on in my practicum, I was fortunate enough to sit in Program Access Committee (PAC) meetings. PAC is a committee of senior management for rural, continuing care, mental health, System Wide Admission and Discharge Department, and home care. Assessor Coordinators will complete the appropriate Program Access Committee Request Form with detailed assessment information about the required services and needs for their client. Client needs are assessed using standardized tools. Assessor Coordinators may be requesting a placement for their client at a long term care facility, adult day programs, palliative care, respite, assessment bed, or other services. PAC will either approve or deny the request.

Assessor Coordinators become familiar with all of the mentioned tools and used them on daily basis. Outcomes along with professional judgment and client’s wishes and requests are used to make informed decisions and provide individuals with the best care, services and supports possible.

**Kaizen/LEAN Overview**

As previously mentioned, RQHR has been going through a significant transition and moving toward patient and family centered care. In order to achieve this, RQHR has taken a Kaizen or LEAN approach and are working with staff, physicians, patients and their families to improve how they design and deliver services so that the needs of patients and their families come first. RQHR, along with the Government of Saskatchewan and all other provincial health regions and the Saskatchewan Cancer Agency, are partners in this undertaking. This has been an exciting time to complete my practicum as so many innovations and changes are happening
within RQHR. Having the opportunity to witness and be a part of this offered me a unique experience.

Hospitals today are made up of many departments, comprised of administrative departments and medical departments. The system can be complex and difficult to navigate. Physicians frequently receive hospital privileges but are not actually employed by the hospital. In many cases, the incentives for physicians are not aligned with efficient operations and creating a patient centered organization (Protzman, Mayzell, & Kerpchar, 2011). This section will describe how LEAN aims to make changes in these areas.

LEAN is a tool set, a management system, and a philosophy that can change the way RQHR is organized and delivers care. LEAN is a methodology that will help Saskatchewan healthcare system to improve the quality of care for patients by making the shift to have patients and family at the center of the circle of care, improving safety, reducing cost, reducing waiting times, and improving staff morale (Graban, 2012). Additionally, LEAN is not about fixing any one major problem within healthcare, rather it is about solving as many little problems as possible that may be a detriment to the healthcare system. It is not practical to use LEAN across the entire health region all at once. The resources and attention required to support these efforts properly would be too high. Therefore, RQHR identifies priority for LEAN and ongoing problems that need to be addressed.

LEAN originated in the manufacturing industry, but applying the LEAN philosophies does not mean that patients and healthcare providers are treated as assembly lines. LEAN recognizes that each patient has his or her own medical needs and each patient and situation is unique. LEAN aims to be defect-free by digging into a defect or anticipating defects and
determining how to prevent it. This would ultimately mean that the patient receives exactly what he or she needs in a timely manner (Cottington & Forst, 2010).

When I attended Kaizen Basics training to learn about LEAN, the presenter spoke about medical errors occurring on a regular basis. Medical errors cost patients emotional and physical harm, as well as cost patients and hospitals incredible amounts of money. Reducing errors by implementing and maintaining LEAN processes will have an effect on the bottom line and patient outcomes (Cottington & Forst, 2010). During this training session, it was emphasized many times that LEAN is designed to make it difficult or impossible for healthcare providers to make the wrong decision or follow the incorrect process.

In order to see LEAN processes in action, I attended a value stream mapping presentation. A value stream map involves steps that occur in a process, from the initial point of contact to delivery stage (Cottington & Forst, 2010). In healthcare, this is from the point of calling for an appointment or point of admission to being discharged. This is a tool used to help identify the value-added and non-value-added pieces of the process from a high level view.

Process maps are created on the wall as large posters with sticky notes that are color coordinated by actions. Each part of the process is represented with a sticky note and the length of time it takes to complete each process is also noted. An example of an identified problem, during the value stream mapping presentation I attended was the inefficient method in which clients are referred to community resources by social workers on hospital wards upon the client’s discharge. The current method of referral is through fax but it was identified that faxes were not always confirmed as received and is an inconsistent and unreliable way to send referrals. The ideal state is to have a standard form completed with a specific email address to send referrals that will allow a received ticket to be emailed back upon being read and received.
The value stream maps presented had both current state and the ideal future state. It is important to have goals and ideas of what would be an ideal state. Putting the ideal state down on paper helps to propel movement and ideas to reduce non-value-added time. Including this map is vital for improvement and will help establish an understanding of the current processes, as well as goals to achieve (Cottington & Forst, 2010). In addition, this creates a great opportunity to take advantage of the many great minds that are in attendance as someone may have new ideas for improvement.

Change management will determine the success of LEAN throughout RQHR. It began with the need for change and a clear vision and objectives have been identified. Communication is important as my experience has brought to light that providers did not fully understand the direction, benefits, and impact of the LEAN process and outcomes. Communication is important in addressing resistance to change. The most difficult part of LEAN is establishing a culture of continuous change and improvement (Protzman, Mayzell, & Kerpchar, 2011). Unlike other specific programs, LEAN has no finish line. Creating a culture of LEAN is to create an insatiable appetite for improvement. For LEAN to take hold in an organization and transform its culture to one of continuous improvement, senior management must relinquish the role of master problem solver to those who are closer to the problems to be solved to benefit from their knowledge of the focal process, to give them hands-on experience in using LEAN methods and to see first-hand the performance improvement and teamwork this can create, and to promote an attitude that what exists can be improved.

Many countries share an increasing concern that healthcare costs have exploded but with no evidence of an equivalent improvement in healthcare. Even with increases in healthcare spending, it seems there is a need to improve healthcare delivery and LEAN methods may be one
way to achieve this. As previously mentioned, LEAN is easily adaptable to healthcare settings and provides staff empowerment and concept of continuous improvement. It is believed that LEAN healthcare is gaining acceptance not because it is a “new movement” but because it is proven to lead to sustainable results such as creating a process or steps to create value for patients and service providers (Protzman, Mayzell, & Kerpchar, 2011). An example of sustainable results witnessed in a hospital was having supplies labeled and organized with a specific process for restocking. Nurses and other staff indicated that this makes their job more efficient as they spend less time tracking down the proper supplies. Service providers see the value in making changes that will benefit both themselves as well as the patient.

It should be noted that LEAN is not accepted by everyone and implementation comes with its challenges. A barrier for implementing this approach is to convince staff that LEAN can work in a healthcare setting. Training can be a challenge as educators need to be hired and a culture needs to be created in order for everyone to be using common language and tools.

There is a lack of rigorous research on the outcomes of LEAN in healthcare. However, Moraros, Lemstra, and Nwankwo (2016) recently completed a systematic literature review which identified that evidence does not support the claim that LEAN has made any major impact on the healthcare system. They found that that there is no statistically significant association with patient satisfaction and health outcomes, there is inconsistent benefits on process outcomes like patient flow and safety. Additionally, the article indicated that LEAN has an overall negative effect on worker satisfaction. It is also shown to have no impact on workplace engagement, inclusion and productivity. These outcomes are surprising as worker engagement, input, culture, and buy-in are essential LEAN principles.
RQHR identifies patient participation as the guiding force of evaluation outcomes and improvements with LEAN. Patients and families are fundamental in the improvement process as they ask questions about processes and encourage employees, service providers, and management to reflect and evaluate the tasks and changes being implemented. RQHR will continue to seek out patient input with the goal of having patient input entrenched in the health region’s continuous improvement work. Patient representatives are key members of Rapid Process Improvement Workshop Teams where small changes are trialed followed by a series of audits and fine tuning. Ultimately, the way in which patients access services and are satisfied with their health care along with a reduction in service provider errors, will determine if LEAN is successful.

The reality is that there are a multitude of internal and external variables that impact the complex workings of the healthcare system and the impact of LEAN may be minimal. It is important to continue with rigorous scientific research in order to definitely ascertain whether continuing to invest in LEAN will bring the health care system closer to long-term solutions for the problematic health care system that is currently in place.

**Trauma Informed Care**

My practicum took place in the central network which is a designated and mapped out area in the core of Regina. Many clients in this area live high risk lifestyles, have low incomes, and have experienced a variety of traumatic events throughout their lives. I focused some of my time on Trauma Informed Care (TIC) research and completed a presentation to help inform home care and primary care teams about the impact of trauma on the clients we serve. TIC will greatly improve the way in which healthcare providers in a variety of settings can better serve people with trauma histories.
Knowledge and research in this area is growing and it is extremely important for primary care providers to have an understanding of the impacts and lifelong effects trauma has on health and wellness. Studies have shown that exposure to trauma during childhood is related to increased incidence of impulse dysregulation, alterations in attention and consciousness, and interpersonal difficulties (D’Andrea, Ford, Stolbach, Spinazzola, & Van Der Kolk, 2012). Trauma exposed children may experience extended and comorbid difficulties into adulthood as they experience trauma differently than adults. The type of trauma, the age of exposure, the duration of experiences, and the developmental stage of the child all impact the manifestation and symptoms that arise. Children who have been exposed to trauma have been found to experience developmental regression, dysregulation of bodily functions such as sleep and appetite, separation anxiety, social constrictions, and limited awareness of danger and aggression. These behaviors will frequently present before the identification of trauma, therefore, delaying treatment. Research suggests that early intervention is most effective. If left unidentified and untreated, individuals have been found to experience psychiatric problems and more serious health issues (Racco & Vis, 2015).

Traumatic events are common and research has shown that these events impact mental health, physical health, and morbidity. The Adverse Childhood Experiences study provides compelling evidence that greater levels of trauma lead to poorer health outcomes through the lifespan (Felitti et al., 1998). Trauma is defined as an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects (Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015). Because many traumatic events involve a violation of an individual’s bodily integrity and can influence their reaction to the world around them, they frequently have adverse influences on
physical and mental health as well as attitudes toward medical care (Raja, Hasnain, Hoersch, Gove-Yin, & Rajagopalan, 2015).

Trauma informed care is used to describe ways in which providers in a variety of settings can better serve people who have experienced traumatic life events. TIC is an approach developed by Harris and Fallot (2001) to improve clinical practice and service delivery. To be trauma informed is to understand the ways in which violence, victimization, and other traumatic events may have impacted the lives of the individuals involved in seeking health care services and to apply that understanding to the design of systems and services so they can accommodate trauma survivors' needs and are consistent with healing and recovery. Every part of service is assessed and can be modified in order to include an understanding of how trauma impacts the life and health of those seeking our services (Raja et al., 2015).

Traumatic experiences, particularly recurrent trauma over the lifespan, can cause neurological, psychological, biological, and emotional difficulties. Hyper-arousal such as nervousness, jumpiness, and quickness to startle can occur as the nervous system is chronically activated. Additionally, individuals may re-experience trauma through memories, intrusive images, sensations, and dreams or they may avoid or withdraw by shutting down, pulling away or avoiding triggers. The neurological and biological changes can lead to many health issues such as damaged blood vessels, heart disease, long-term changes in the body's stress response and immune systems, and chronic illness (Raja et al., 2015). The damage to the body’s stress response system, coupled with negative coping behaviors to manage stress also contributes to the deterioration of health.

Trauma is a major public health issue and is prevalent with the clients within RQHR's central network neighborhood. It impacts families, individuals, and communities as a whole.
Many of the problems facing the people the workers serve may be related to traumatic life experiences. People who have experienced traumatic life events are often very sensitive to situations that remind them of the people, places or things involved in their trauma history.

Many traumatic experiences involve violating a person's body, as a result, attitudes toward physical and mental health are influenced. Although trauma survivors are high utilizes of emergency departments, it is common for them to actually avoid seeking preventative medical care. Medical settings can be particularly distressing as appointments may involve invasive procedures, removal of clothing, physical touch, power dynamics, or vulnerable physical positions (Raja et al., 2015).

Harris and Fallot (2001) identify five principles of trauma informed care that are fundamental in creating and sustaining trauma informed settings and services: safety, establishing trust, maximizing choice, prioritizing empowerment, and maximizing choice.

First and foremost, establishing a safe physical and emotional environment where the basic needs of clients are met is imperative. Safety measures should be in place and service provider responses should be consistent, predictable and respectful at all times. Clients should be encouraged to be open and honest in a non-judgmental environment that is patient centered.

Second, establishing trust with clients is important but can be difficult given their histories. Trauma survivors may have difficulties forming trusting relationships and as previously mentioned are often sensitive to issues of power and authority. As service providers, it is our job to support our clients to navigate through these interactions and difficult health care experiences.

Third, service providers should maximize collaboration with our clients. The relationship should have no hierarchy, rather, it should be seen as equals working together as a team.
Additionally, our clients are the 'expert' when it comes to their trauma history, coping, and resiliency. However, it should be noted that some clients may not understand or recognize their trauma histories and the impact it has had in their lives and health.

Next is prioritizing empowerment and building on the skills and strengths of our clients. Service providers should encourage clients to identify strengths and skills they possess and empower them to make changes in their lives. They are in control of their treatment, health, and wellbeing.

Lastly, clients deserve to be well informed in language that is easy to understand. All questions they may have should be addressed and choices should be explained thoroughly in order to maximize choice. Clients should be encouraged to be active in their health care and their opinions should be valued.

Raja et al. (2015) state that TIC can be implemented in primary health care by making trauma screening routine and asking every client what can be done to make them comfortable during appointments or assessments. Workers need to give patients options such as shifting an item of clothing instead of putting on a gown. Service providers should be well informed and understand maladaptive coping mechanisms such as smoking, substance abuse and so on. Furthermore, providers should have knowledge about how maladaptive coping behaviors impact health.

Other suggestions include maintaining a list of resources and services that are available, and how to contact services and encourage continuity of care. Physicians should work in collaboration with other services in order to provide comprehensive treatment and consistency.

Service providers should understand their own trauma histories if applicable and how that will influence their interactions with clients. They should learn the signs of burnout and vicarious
trauma which can occur as service providers hear the trauma stories and witness the pain and hardship clients have experienced. Service providers may be profoundly impacted by the trauma of their clients and in turn may experience nightmares, intrusive images, and preoccupation with their client’s stories. It is important to learn about self-care and establishing a supportive work environment.

Traumatic events have negative physical and emotional health consequences across the lifespan. It is important for anyone working within the health region to understand how trauma influences our client's experiences when seeking health care. Ultimately, at its core, trauma-informed care is good patient centered care. The goal is to help individuals heal from trauma and its consequences and create healing environments for children, families and communities (Machtinger et al., 2015).

I used the Adverse Childhood Experiences (ACE) study to guide my research in this area. The study determined that adverse childhood experiences are major risk factors for health issues. The ACE study is one of the largest investigations to link childhood maltreatment and later-life health and well-being. The ACE study is a collaborative effort between the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, California. It is critical that health care providers understand how trauma and early childhood experiences impact some of the worst health and social problems in our nation. Realizing the connection will likely improve efforts towards prevention and recovery. An ACE questionnaire was implemented that asked ten questions in the areas of physical, emotional and sexual abuse. Also included were neglect, both emotional and physical, and household dysfunction including domestic violence, household substance abuse, divorce and incarceration. Ultimately, the higher the ACE score leads to worse health outcomes across the lifespan (Felitti et al., 1998).
The outcomes largely center on behaviors such as smoking, alcohol or drug abuse, overeating, or sexual behavior that may be consciously or unconsciously used because they are coping mechanisms that result in psychological benefit to the individual. Additionally, high doses of exposure to adverse childhood experiences produce anxiety, anger, depression, and changes in the neurobiology of traumatized individuals.

Even if individuals do not engage in high risk behaviors they are still likely to develop health issues as a result of the stress put on the body’s response system: “fight or flight”. For individuals with a trauma history, the emotional brain becomes a survival brain. They may feel fearful and unsafe with their bodies, feelings, and thoughts as they try to make sense of a world they perceive to be chaotic and dangerous (Machtinger et al., 2015). They are guided by automatic response. Thoughts will be hijacked making it so they cannot access the thinking brain to make decisions. Alarm systems become distorted and will perceive danger everywhere. This can also make it difficult for individuals to make use of resources and relationships (D’Andrea et al., 2012).

The ACE study suggests that professionals need to support individuals and implement strategies to prevent the occurrence of adverse childhood experiences, prevent the adoption of health risk behaviors and improve the disease burden among individuals whose health problems are a consequence of long term adverse childhood experiences. Increased recognition and awareness as well as knowledge about how to implement routine screening and multi-disciplinary teams are needed to address issues that arise with the client (Felitti et al., 1998).

Values and Ethics

As a social worker I am guided by a set of values and ethics which are outlined by the Canadian Association of Social Workers Code of Ethics. These values and ethics aid in ensuring
that all social work professionals act in accordance with the overarching principles of practice. During my practicum I found it helpful to have a guideline of values and ethics to refer to when interacting with clients and families.

Value 1: Respect for the Inherent Dignity and Worth of Person

At times during my practicum, I spent time in the homes of the agency’s clients completing assessments and providing information about services that may be helpful. During these meetings with some of our clients who were older and experiencing difficulties in the home, they had family members present. Family members often had opinions and ideas of what they would like to see for their loved one that did not always align with what our client was planning. It was important to remember to promote client self-determination and informed consent. This involved clearly discussing with our clients their rights and responsibilities and providing honest and accurate information regarding our services, the purpose of our visits, risks and benefits, and explaining that we will provide services only after they have given consent (CASW, 2005). For example, when entering one clients home I explained the nature of why I was visiting, she thought I was involved as a result of her daughter’s belief that she was struggling to manage medications as well as some daily tasks. My client agreed somewhat but believed she was managing on her own and didn’t require any supports. During this time it was important for me to recognize the rights and desires of my client. I wanted make sure she felt like I was hearing her point of view and understood that independence was important to her. Before completing any formal assessments, I explained each assessment and asked for her permission and explained confidentiality.

Value 2: Pursuit of Social Justice
At the very core of my practicum was learning how to help clients to access resources and to advocate for fair and equitable access to services. Equally important is that clients have choices and it is my job to reduce barriers between them and service providers. Working with a wide variety of vulnerable individuals, this value became extremely important. I was able to challenge views and stereotypes by implementing the Trauma Informed Care approach. This was one way to help individuals working in our network to put aside any judgments toward our clients and become more informed about the marginalized and disadvantaged individuals.

For example, service providers should not judge or label clients who do not attend a scheduled medical appointment or follow treatment plans. It is imperative to remember that many of the clients have extensive trauma histories and seeking medical attention may be more difficult, stressful or triggering. It is important to continue to work with them to gain access to medical care as well as link them with services to help them work through their trauma. Every individual should have access to the same health care and resources no matter their circumstances. Primary Health Care network will work to achieve this as much as possible.

Value 3: Service to Humanity

During my placement I worked with a vulnerable population and wanted to ensure that I worked and advocated for services and resources that were in the best interest of my clients. I frequently returned to this value as I was aware that my position was often perceived as a position of power and authority. I maintained the interests of my clients above my own self-interest and was able to use it in a way that was supportive and empowering while helping with any conflicts that may arise.
Often times, the conflicts that arose were between family members and clients. They had disagreements or differing points of view on what was best for the client. I wanted to ensure I heard each client and to work collaboratively rather than overpowering their opinions or beliefs.

Value 4: Integrity in Professional Practice

It can be difficult to push aside one’s own thoughts, values, and opinions but as a social worker, this is of the utmost importance. When working with a vulnerable population who are experiencing health issues and are seeking the support of a social worker, it is important to promote the values of the professional and refrain from imposing one’s own personal values and opinions. Throughout the assessments I completed, I reminded myself that it is not what I personally believe is best for the client that is relevant. I focused on being open and transparent in my practice and remained respectful toward my clients. I strove for impartiality and focused on the needs and desires of my clients while offering them the best options and resources for their needs.

Value 5: Confidentiality in Professional Practice

A cornerstone of the professional social work relationship is confidentiality with respect all matters associated to our clients (CASW, 2005). I respect the importance of the trust and confidence placed in the professional relationship by clients and members of the public.

Given the nature of discussions that usually involved personal health information, it is important to protect the privacy and confidentiality of our clients. When making referrals to services I ensured the clients agree to a release of information and clearly explained procedures. Additionally, it is important to take into consideration the location where meetings and conversations are taking place. Confidential issues were never discussed in public areas and I asked the client if they feel comfortable with family members who may present.
Additionally, clients were informed of the limits to confidentiality and that social workers may break confidentiality and communicated information without permission when required or permitted by law. Along with this confidentiality came the responsibility for clients and service providers to be respectful of charts and information binders that may be transported or left in the home of the client. Clients were encouraged to keep their charts and binders safe and in a private area.

Value 6: Competence in Professional Practice

This is extremely important value as I feel it encompasses a social worker’s ethics and values in one. As a social worker, I wanted to bring the best services available to clients I served. They deserve a competent social worker who is able to be compassionate and empathetic, as well as analytical and knowledgeable. I continue to do research, complete ongoing training and am always learning and trying to be as effective as possible.

I was able to demonstrate this by reviewing literature and speaking with others in the field in order to provide new information, as well become informed about services that are best suited for each of the clients. This was very important for me as I was new to the area of health and did not have a clear understanding of criteria and services that can be offered. I think it was necessary for me to take the time engage others, take tours, and ask questions about different areas in health care in order to really get a sense of the wide variety of options for my clients.

The CASW Code of Ethics is an excellent guideline in order to maintain a high standard of service and care for the clients. The public should be assured that social workers are trained, skilled and are diligent in their work.
Conclusion

As I started my practicum I was unsure what to expect but I was excited to do something new and different. I knew it would be a challenge to balance a full time practicum, motherhood and family obligations. I made a commitment to myself that I would start my placement with an open mind and recognize that the knowledge and experience gained will be worth every challenge. Stepping outside of my comfort zone and working with a diverse group of clients in a health region that is in undergoing what seems to be, from and “outsider’s” perspective, positive changes, was a great learning experience.

I was able to achieve my goals and gain practical knowledge about a wide array of services that RQHR offers. In addition, gaining an understanding of how the health region functions is, in my opinion, invaluable for my future career regardless of where it takes me. The social workers, nurses, and continuing care aids that took the time to share their knowledge and experience taught me a wide variety of skills that can be used in my future practice. It was a unique experience to work as part of the Central Primary Health Care Network.

First, I was able to research and attend orientation to learn about RQHR. This initial orientation was invaluable and gave an excellent overview of the health region and its current state as well as future objectives. I spent a great deal of time reading and learning about primary health care, how its functions, and its benefits in order to achieve patient centered care. Ultimately, I learned that primary health care aims to increase accessibility, health promotion, and interdisciplinary collaboration, use of appropriate skills and technology, and public participation. Primary health care is an approach that encompasses all aspects of life including social, economic and physical environments.
Second, I believe it is important to learn about the wide variety of services available. As a professional, I believe it is important to know services that are available within the community and additionally what may be lacking. I found this aspect of my practicum to be very informative as my previous work experience did not involve much interaction with community resources, especially within the health region.

I was welcomed with open arms by the team at the Central Primary Health Care Network and because of this I was able to learn from their knowledge and experiences. My practicum experience was unique and a growing experience for me as a social worker. I feel more confident in my knowledge and abilities. I will carry the skills forward as I practice as a professional social worker and will be able to share my knowledge and learning experience with my co-workers.
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