Sioux Lookout First Nations Health Authority
(SLFNHA)

The Anishinabe Health Plan

July 31, 2006

Table of Contents

Figures & Tables

Acknowledgements

This report would not have been possible without the participation and dedication of the members of the Primary Health Care Working Group (PHCWG), the Physician Services Working Group and other stakeholders. Stakeholder input and participation was instrumental in the development of the Anishinabe Primary Health Care Model. Thank you to all who gave your time and energy to this project.

This report is a product of the collaboration of the working groups, community based health directors and the Sioux Lookout First Nations Health Authority (SLFNHA). We also wish to thank our funders: the Ministry of Health & Long Term Care, Province of Ontario for access to funds through the Primary Health care Transition Fund (PHCTF); and, First Nations & Inuit Health Branch, Health Canada for funds received through the Health Integration Initiative (HII).

Meequetch

Prologue

The Gifts of Amik (Beaver) and the Anishinabe Health Plan

Many voices said we need a story that speaks to how the Anishinabe Health Plan can help us — individually and together — improve the health of our people. Some of those voices suggested Amik could offer such a story and a way forward. The story that follows is a humble offering about bringing the journey to health alive.

When the Great Spirit created the lands, animals and man, each were given a gift and responsibility while living on Mother Earth. For Amik, the gift and responsibility was as engineer or builder. Amik was to construct ponds which would become rivers, and where they flowed would become lakes. When this was done, flowers, trees and plants blossomed and smaller creatures flourished and enjoyed a good home. Once this was done, the larger animals came, including those who took flight. All lived in an eco-system generously and cleverly built by Amik.

Just as Amik builds strong, secure dams of wood held together by mud and leaves, the foundation of the Anishinabe Health Plan is rooted in community and strengthened by our culture, traditions and language. Our ways of knowing are included: in teaching our youth; using our language more often; inviting our healers to be an integral part of our health system; and most of all, work at communicating (including translation) and understanding what is necessary to manifest health. This helps bring strength to each family, community, and Nation. Amik reminds us to be patient and persistent in bringing our traditions forward, and teaching our youth, as this heals the spirit.

> ***"Elders need to play a very important role in guiding and steering us on this road. [We] have to find ways that our teachings are passed on and practiced in the home. The more you say it, the greater the likelihood you will do it."***

Amik is resourceful and industrious working in teams to build a healthy home and community. Similarly, the Anishinawbe Health Plan has all staff working in teams across programs/departments and levels of service (promotive, preventive, curative, rehabilitative and supportive) to better coordinate and provide a holistic approach. Roles and responsibilities are clear, and case management helps community members access information (including translation), and receive services in a coordinated manner. More emphasis is placed on promotive and preventive services, and on finding holistic solutions. For example, to address asthma we also address the mould in our homes and the dust on our land. We call on the gifts of Amik to help us gnaw through the problems to help us provide the same standard of care across all communities, and that those standards reflect the best knowledge from both worlds.

Amik, the engineer, is clear in directing the building/repairing of the dam. So too, the Anishinabe Health Plan is now governed by First Nations. The Sioux Lookout Zone Chiefs provide direction and assure transparency and accountability. They call on the Chiefs Committee on Health to oversee the work, and they charge the Sioux Lookout First Nations Health Authority (SLFNHA) with implementing the plan.

The Chiefs also ask that SLFNHA work in collaborative leadership to assure:

- Our services are community driven, reflective of those needs and delivered as close to home as possible;
- Our communities do what they can and with others' support;
- We work together where we can, while respecting First Nations autonomy; and
- We are accountable to each other throughout the system and continuously find ways to strengthen how we work, the services we deliver, and the health of our people.

As we build from inside out, we stay *"…humble, tak[ing] our time to seek guidance and support to have an understanding." (Elder) "We … remember this is for our future generations." (Chief) And, "[we] go back to the people and grassroots level in order for the system to work and be strong. [We continuously] identify ways to include things from our communities."* We draw on Amik to get the job done. Amiks' gifts of engineering, industriousness, resourcefulness, teamwork, patience, persistence and adaptability remind us to:

- Gnaw through the details;
- Stay rooted in community, bringing our culture, traditions, language and healing practices to life;
- Find ways to balance the needs and autonomy of each community with the common good;
- Protect the treaty rights of First Nations while working with federal and provincial partners;
- Take the best from both cultures, creating a new harmony; and
- Reflect and learn along the way so that all of us gain strength and health.

We are not going back; we are adapting our form, but never our essence. Our spirit sustains the balance. (Adapted from Awiakta, 287) "We are the stor[y]. We speak in the present and bring the past forward, so we can have a future." (Awiakta, 208)

We call on the wisdom of our Elders to help us individually and together bring back our spirit, our health.

EXECUTIVE SUMMARY

In Resolution 04/44 the Sioux Lookout District Chiefs mandated the Sioux Lookout First Nations Health Authority to prepare a Sioux Lookout Anishinabe Health Plan. The Health Planning Project, led by the Sioux Lookout First Nations Health Authority, is jointly funded by Health Canada through its Health Integration Initiative and the Ontario Ministry of Health and Long Term Care through its Primary Health Care Transition Fund. This Health Plan covers our 31 First Nations in the Sioux Lookout area.

Carrying out the Chiefs mandate to develop the Anishinabe Health Plan, the Health Authority set up the Health Planning Project. Our Project has worked cooperatively with First Nations and Tribal Councils to:

- Update the Participatory Research Project (PRP) conducted in 1995 to assess current health status, issues and priorities for the District.
- Undertake a comprehensive review of primary health care service delivery and possible gaps.
- Incorporate the evidence within the primary health care service delivery model and Health Plan.

Overall, the project intends to:

- Develop a comprehensive integrated primary health care model and implementation plan.
- Create a District physicians plan within the integrated primary health care framework.
- Develop a nursing services plan.
- Develop an allied health services plan.
- Establish a mechanism for the governance and management of the primary health care model by First Nations.

For First Nations people in Canada there have been improvements in health, particularly in infant death rates since 1979, and increasing life expectancy.[1] Despite these gains, "…the health status and conditions of First Nations on-reserve remained worse than that of the general Canadian population…" [2] The potential years of life lost to injury is 3.5 times greater.[3] "First Nations People continue to have a disproportionate burden of infectious and sexually transmitted diseases in comparison to the overall Canadian population." [4] Diabetes rates among First Nations people are higher with 22.7% of adults having Type 2 Diabetes compared with 5.7% for Canada.[5]

[1] Health Canada. (2003)
[2] National Aboriginal Health Organization. (2003). Pg. 2
[3] First Nations Regional Longitudinal Health Survey 2002/03
[4] National Aboriginal Health Organization. (2003). Pg. 2
[5] National Aboriginal Health Organization. (2005)

Suicides in the Sioux Lookout area are between 5 and 50 times more common than in the Canadian population.[6] Oral health problems are widespread among children, who have more than five times the rate of decayed, extracted or filled teeth compared with Ontario children.[7] Addictions are becoming more common, and are ranked as the third major health problem among Sioux Lookout First Nations. As well, many suffer from the effects of residential schools. Families are breaking down. People's health is at risk from living in crowded and mouldy housing, being inactive, eating non-traditional food, drinking alcohol or using drugs, smoking, gossiping, and not supporting each other except in times of crisis.

The Chiefs and the First Nations people of the Sioux Lookout area want and need change to improve health. A new approach was needed. In 1990, the Nishnawbe-Aski-Nation Chiefs moved to improve health by adopting the Primary Health Care (PHC) concept and creating the NAN Chiefs PHC Model. In approving PHC, the Chiefs recognized that the concept was close to the original Anishinabe ways. It enabled First Nations to work toward changes that were consistent with Anishinabe ways. Using PHC language made these ideas understandable to mainstream society including funders and those who operate current health services and systems.

While the Chiefs recognized that both Canada and Anishinabe First Nations have responsibilities for the health of the people, they also stated strongly that respect for the Treaties is essential. Canada, and Ontario for Treaty 9, must carry out the responsibilities of the Crown.

One important addition of the Anishinabe Primary Health Care Model is founding health care work on Anishinabe ways. Not only would the system include ooweechiwaywin, it would reflect a holistic view of health, encourage the use of Anishinabe traditions and language, ways of knowing, showing respect and caring. We also want a system that offers the best of both worlds in ways of helping people get healthy and live well. Only by focusing on health in a holistic manner, can we hope to regain the level of health that characterized the Anishinabe for centuries.

The new Anishinabe health system is:

- Based on Primary Health Care concepts;
- Governed and managed by Anishinabe and their organizations, and accountable to the people and First Nations it serves, as well as the Governments that fund it; and
- Funded by Canada and Ontario in partial fulfilment of their treaty obligations and to ensure equity in health care access with other residents of Ontario.

Our Anishinabe Health Plan describes the PHC Model vision, mission, and principles, community Primary Health Care team, core services and access, and provides an example of the PHC Team at work.

Using Anishinabe culture and ways to guide all our actions and decisions means that health care is consistent with our culture and traditions. We weave it through all our work. Our elders participate as part of our health committees, as advisors and wise guides in working with people in crisis and healing, as educators of the PHC Team and the community. This reflects our use of culture and Anishinabe ways. Traditional specialists, herbalists and midwives assist people with healing and provide guidance to other health practitioners from outside the community. By using our culture as the base for our work, we also strengthen it and build health for all.

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[6] Dougherty, J. (2005)
[7] Hamilton, M., (2005) A review of the Sioux Lookout Zone Dental Program

To determine the health needs of the population, community consultations composed of key informant interviews and focus group sessions were conducted in twenty-six (26) communities. In addition to community members, consultations included high school students from those same communities who were living in Thunder Bay and Sioux Lookout and attending the Dennis Franklin Cromarty (DFC) and Pelican Falls Schools.

Across the twenty-six (26) communities and the two (2) high schools, a total of two hundred ninety-eight (298) key informant interviews and twenty (20) focus group sessions comprising an additional seventy-seven (77) informants were conducted. In total, three hundred eighty-five (385) informants participated in the consultation process.

We asked key informants about the major health problems in their community and found the following responses:

- Diabetes was named by 265 respondents as the number-one health problem.
- Diseases of the respiratory system, such as asthma, were identified as the second major health problem;
- A variety of addictions such as alcohol, drugs, solvents and gambling was named as the third major health problem;
- Following addictions, mental health issues ranging from suicidal ideation to psychiatric disorders were identified as the next most serious health problem; and,
- Heart disease was the fifth most commonly identified health problem.

Many factors contribute to the poor health status of the Sioux Lookout population, among them the effects of colonization, the residential school syndrome and the lack of even the most basic health services. We asked key informants what they thought caused the health problems they had identified. Respondents overwhelmingly attributed the poor health of their community and/or health problems to lifestyle factors. Other leading causes of poor health were described as environmental issues, insufficient prevention programs and poor access to services, and destructive behaviour such as excessive alcohol intake, prescription drug abuse, illegal drug use, etc.

We asked key informants for comment on the vision for a health care system for themselves and their community. The majority of respondents said they wanted to see an increase in the number of providers and the level of services provided at the community level. Other responses included the need for improvements in capital equipment and infrastructure such as facilities, the need for more integrated/improved health services at the community level, the need for health promotion and disease prevention programming, the need for qualified human resources and the desire for more local control of the health system. Other responses included the desire for more aboriginal health professionals; 24/7 emergency care services; a hospital/urgent care facility; long-term care services; dialysis services; and the necessity for a needs-based system with adequate resources more comparable to the Canadian system.

The NAN Chief's Model has been used in a consultative and collaborative process to build the Anishinabe Health Plan. The Individual, Family, and Community are at the centre. The spiritual, cultural, environmental, and political context surrounds and guides the health system. There are five main Areas for Action which are; support, promotion, prevention, curative treatment and rehabilitation. By balancing work in the five areas of the NAN Chiefs' Model, we automatically

emphasize the profile of – and action in – public health, health promotion, risk and illness prevention, community development, rehabilitation, and support.

In the existing model, the emphasis is on the urgent/emergent care services with episodic illness and the demand for treatment consuming the majority of the health care resources. Nurses and community-based workers who should be delivering public and population health programs have become the core providers of primary care. Nurses have been cast in the role of physician replacements due to the lack of physician services at the community level.

Presently, no formal mechanisms are in place to ensure that public and population health programming get delivered. There are also no mechanisms in place for workers employed by multiple employers to communicate and work with each other for the benefit of the individual patient, family and/or community. There are no formal mechanisms to ensure that First Nations have input into how these services are delivered in and for their communities.

We propose a new primary health care model for the communities of the Sioux Lookout area, First Nations shifting from the current model that is focused on acute care, to a model that will ensure services are delivered to meet the communities' needs in all five areas of action. Within these five areas of action, communities continue to receive urgent/emergent/acute care services, non-urgent illness care, mandatory public health programs and public and population health programs (health promotion and disease prevention).

We recognize that there are some communities within the Sioux Lookout area that are unique in terms of location and others that are very small in size. At the present time we propose a model framework for service delivery in communities of four distinct sizes. The rationale for this is to set some minimum standards for service delivery across the whole range of communities within the district. We expect that in the implementation phase each community will be assessed individually in terms of its requirement for services and resources. At the same time community specific gap analyses will also be carried out.

Shortages of health care providers are more likely to affect rural and remote communities than their urban counterparts. One approach to addressing this issue is the "home grown" strategy whereby Anishinabe communities are proactive in recruiting young people into health careers. A second strategy is career laddering, whereby existing community-based workers are provided with educational/developmental opportunities to expand their skill and knowledge base in the health care sector. As these workers develop over time they are better prepared to take on higher level positions and may even want to seek further education such as nursing, pharmacy etc.

A third strategy involves addressing the issue of the right provider delivering the right service. In the current system nurses are providing many non-nursing services such as laboratory, x-ray and medication-dispensing, to name a few. This new approach would identify the services that are traditionally provided by nurses that can be provided by other personnel such as pharmacy technicians, phlebotomists (laboratory) and basic radiography workers. Community-based personnel can be trained to provide these services thereby creating a group of ancillary health care providers to support the services delivered by professional nurses, physicians and other allied health providers. This will allow professionals to focus on delivering more advanced care.

The feedback from the Primary Health Care Working Group, other key stakeholders and informants is that recruitment and retention should be a centralized service carried out by one agency to support all communities. This will avoid issues such as competition for nurses, variations in compensation packages and the burden on the community to recruit its own nurses. It will provide more support

and flexibility for relief staffing. Recruitment of local community-based employees will still occur at the community level. However, support in the assessment and selection processes for these employees may be provided by the central agency to that community upon request.

The capacity to manage and deliver both community-based and regional services is essential within the primary health care framework. There are certain supportive types of services that cannot be provided at the individual community level due to the lack of suitable economies of scale. In addition, there are programs and services which require standardization across the whole system. These types of services are often classified as those that fall within the realm of professional supervision and second-level support services.

At the District Chiefs Meeting in February 2006, the leadership indicated that capacity building has to be a major component within the Anishinabe Health System. The Chiefs said that:

- All workers are qualified and receive continuing education for their jobs;
- Workers have the necessary supports to do their jobs;
- There are adequate resources to support learning (e.g., orientation, mentoring, continuing education, education of youth in math and sciences, etc.); and
- Capacity is built and sustained in communities so that we do not become dependent on others.

The feedback from the Primary Health Care Working Group and other key stakeholders and informants is that capacity building is crucial to the successful implementation of the Anishinabe Health Plan.

To better develop health and encourage needed healing, we as Anishinabe First Nations have a rightful capacity to act on behalf of our people as well as the knowledge and skill to act wisely. We draw on Anishinabe governance and management traditions as well as governance and management ways that have worked elsewhere.

In accepting the AHP and approving it for implementation, the Chiefs have made the following decision for the Anishinabe health system. Use a working together approach for district-wide work while respecting First Nations autonomy. Responsibilities will be different at the First Nations' level, the Tribal Council, the SLFNHA, and NAN. The Anishinabe Health Plan has different roles and responsibilities for each type of organization to increase effective and efficient use of services; to reduce overlap and confusion about destinations; and to accommodate the development and change currently affecting First Nations' health services.

First Nations are the fundamental or primary service and support. All other organizations support First Nations in improving health of our people. It is understood that First Nation Chiefs and Councils will continue to exercise political governance over their health care organizations, while typically delegating organizational governance to a health committee or board.

The SLFNHA was established by the Sioux Lookout Chiefs-in-Assembly following the Scott-McKay-Bain Report of 1988, with the understanding that it would take on the work that communities could not do themselves. The SLNFHA has a Board of Directors, appointed by each member Tribal Council and with seats for independent First Nations. The Board of Directors is responsible for setting SLFNHA's direction, ensuring its adherence to policy and its program achievements and

outcomes. The Board is accountable to the Sioux Lookout Chiefs-in-Assembly, and through the Chiefs to First Nation members.

The AHP increases SLFNHA's program responsibilities. These changes will occur over time. In some cases, such as the direct employment of nurses, SLFNHA will pass these responsibilities to First Nations or their Tribal Councils as they become ready and wish to take control. SLFNHA will use a collaborative approach to recruiting health professionals, involving community representatives wherever possible.

The role of the SLFNHA is to support tribal councils, independents and other First Nations with program consulting and specialized services. The Health Authority shares its expertise in best practices, planning, training and program design using Anishinabe frameworks.

In research and information management, the SLFNHA plans and operates a health information system for First Nations, Independents and tribal councils. The Health Authority also has expertise in research and evaluation using Anishinabe culture and values.

Physician services, allied health professional services, and public health services are managed by the SLFNHA, along with nursing service management where requested. It is responsible for recruiting and retention strategies for all Sioux Lookout First Nations. It also provides program consultation services in Primary Health Care development (traditional health, mental health, health promotion, health education resources, human resources, best practices).

In policy analysis and development, the SLFNHA has expertise to share with First Nations and Tribal Councils. It concentrates on system-wide issues, coordinating its work with NAN. Through regular contact with Chiefs, the Chiefs Committee on Health and Chiefs Meetings, it keeps political leadership informed about system issues.

To undertake new responsibility, growth in governance and management capacity is needed for the SLNFHA Board and staff. Early in AHP implementation, the SLFNHA will have a governance and management review.

Functional plans have not been sufficiently developed at this point to prepare detailed budgets for the new AHP. As the 'value' enhancing activities are identified from the functional plans, then the attendant costs will be developed. Zero-based budgets will then be developed in two broad categories: the Operating Budget, sometimes referred to as the "expense" budget, and the Capital Budget (infrastructure requirements).

The working group has identified the types of health care providers and professionals needed for the new AHP and the numbers required, dependent on community size by population categories. This data has then been extrapolated by population numbers for all communities to be served by the new AHP to provide the total numbers of health care numbers required at the community level.

Using the numbers and types of health care providers as established by the AHP working group and extrapolating based on the community population numbers (total 20,491) results in a total of 719.51 FTE health care providers required for the new AHP in the communities. Detailed calculations of FTE's by community can be found in Appendix A, Table I.

In the implementation phase of the new AHP, each community will be assessed individually in terms of the makeup of their primary health care teams based on their unique requirement for services and resources.

Budgets will have to be established in the following areas once human resource and capital infrastructure requirements are in place at each community:

a) office/administrative staffing numbers and costs;

b) travel costs for PHC team members and admin staff;

c) general administrative costs (i.e., office supplies, telephone, fax, etc.); and

d) general operating budgets (would include utility costs for capital facilities, repairs, etc.)

Attached Appendix A, Tables II and III, provides some of these additional cost details for the cost components. Other Operating Costs for the new AHP are at a preliminary stage of development and are not presented as part of this report.

During the first five (5) years of implementation, work on the AHP will concentrate on building capacity throughout the primary health care system in order that both SLFNHA and the communities can assume the responsibility for governance, and also management and service delivery of the new health care system at their pace.

A preliminary survey of capital infrastructure completed during 2005 for the Northern communities indicates that present facilities in most communities are insufficient to meet the program needs of the new Primary Health Care program. The lack of facility space at the communities is very evident when the proposed increases in staffing from the new AHP is combined with the existing administrative staffing. The capital outlay planning and budgeting process will be linked to program needs, goals and objectives and be connected to the organization's strategic planning efforts. Capital assets will be planned for, acquired, and managed in light of their ability to contribute to the desired program outputs and outcomes.

The functional plan to be developed for capital will therefore encompass the entire scope of the new health care system. The information compiled in the functional plan on capital infrastructure requirements will have several uses:

- the information will be used in assessing whether or not there are adequate resources to institute the proposed new health care system;
- the information will be used in developing budgets; and
- the information will indicate when capital assets are required.

A key theme will be to ensure that adequate infrastructure exists at all locations to proceed with the new health care system. The functional steps of the capital plan will include concrete, specific actions and also the time frame for when they are to be performed.

The facilities of the Meno-Ya-Win Health Clinic where Northern physicians 'share' space to provide outpatient care to northern residents are badly outdated, overcrowded and spread over multiple sites. Physicians require the necessary clinical and office space to better service the needs of people from the northern communities. A new primary health care facility built in close proximity to Meno-Ya-Win and the new hostel is an option for providing the necessary space to support the northern community service.

SLFNHA will require additional office space to accommodate the significant staffing increases that will result from the impact of the new Primary Health program. A detailed space analysis will be conducted to determine actual space and equipment requirements. A capital strategy is required that

will provide the necessary infrastructure capacity to meet the anticipated program demands of the new health care program.

Conversion to an integrated Primary Health Care system requires several supports. We are committed to keeping what already works well *and* adapting to new ways in the transition to the Anishinabe Health Plan. We *must* have a useful health information management system. This is an *urgent* need. It is very difficult to plan or achieve accountability without proper information. First Nations need to work with others in the larger system to create a joint, useful, user-friendly, networked, electronic health record.

Public Health is dependent on an integrated information system (see above). Monitoring and fast response to disease outbreaks are an essential component of any public health system. A detailed design for public health services, as part of the Anishinabe health system, will require additional resources and involve many different organizations in planning discussions. It is anticipated that this planning work will occur in the early months of AHP implementation.

A key part of the AHP is including ooweechiwaywin or traditional specialists services as a core part of community primary health care. At present, there is no organized funding for ooweechiwaywin services.

To establish stability in the health system, we need to negotiate multi-year funding agreements with all funders. One and two-year funding agreements mean that long-range planning is not possible.[8] Similarly, flexible funding agreements and arrangements mean that managers can move or combine funds that allow them to achieve their communities' health plan goals and objectives. First Nations' health organizations would still need to be accountable to the funders to demonstrate that the funds are being spent in a responsible manner and that funding program goals are being achieved.

The basis for the Anishinabe Health Plan (AHP) is to set a pathway for improving the health of our people. This means improving access to primary health care in our communities; incorporating Anishinabe ways within the fabric of the system; and delivering those services as close to home as possible. We do this work while respecting First Nations autonomy and strengthening our accountability to each other.

The Sioux Lookout Zone Chiefs, on February 23, 2006 in Thunder Bay, Ontario, accepted the AHP, and mandated SLFNHA to proceed with implementation. They mandated the Chiefs' Committee on Health (CCOH) be tasked with the responsibility for providing oversight and monitoring of SLFNHA activities (Resolution 06/08), and directed SLFNHA to develop a negotiations framework for the additional resources required for implementation (Resolution 06/07).

Implementing the AHP requires a reminder that we can't do everything at once if we are to do anything well. The implementation plan addresses the need for progress and change in primary health care by setting out the goals with objectives and activities designed to build a strong foundation in communities and in SLFNHA by honouring Anishinabe ways including Elder guidance, fostering collaboration, supporting leadership and skills training, documenting the need for increased infrastructure to improve service delivery and recognizing the need for continuous quality improvement through evaluation.

To help focus efforts in restructuring the primary health care system for the Sioux Lookout area in a systematic way, some foundational work needs to be done in the first six months of the fiscal year

[8] Ibid

2006/07. This work will enable the implementation plan to proceed. This Phase One work for fiscal year 2006/07 will be accomplished in the time period of April to September 2006. Phase One emphasizes:

- Completing the detailed implementation plan, including a governance and management review framework;
- Hiring managerial, clinical and quality managers-in-training to build organizational capacity;
- Identifying data/information requirements;
- Initiating a capital needs assessment and plan;
- Developing team-based clusters for mental health and addictions;
- Using communication strategies to build consensus for implementation;
- Constructing a negotiations framework that addresses physicians' services, nursing programs, allied health and infrastructure requirements; and
- Building the evaluation program and mechanisms.

The second half of the fiscal year (October 2006 - March 2007) emphasizes initiation of the implementation plan using the seven themes. Effort is placed on essential first steps that are necessary to ensure successful implementation. This includes initiating:

- a governance and management review;
- skills development;
- using communication strategies to support implementation (e.g., translation, stories, etc.); and
- monitoring and refining implementation activities.

In initiating the Implementation Plan, it is important to build on the experience of those who participated in the successful development of the AHP. Therefore, the Implementation Plan continues doing the work in the same way as we developed the AHP. This means implementation activities are accomplished through collaboration with the Primary Health Care Working Group (PHCWG) and the Health Directors, with guidance from the CCOH and direction from the Sioux Lookout Zone Chiefs. An Elder and Youth Council is added to assure Anishinabe ways are incorporated within the fabric of the primary health care system.

Implementation of the Sioux Lookout Anishinabe Health Plan (AHP) requires an Evaluation Framework that offers a strategy and on-going mechanisms enabling the Sioux Lookout Zone Chiefs and SLFNHA to monitor and improve its performance toward the implementation of a First Nations-governed holistic, integrated, primary health care service delivery system for the region. The framework works within the Health Canada, FNIHB, the Province of Ontario, Ministry of Health and Long-Term Care and the Treasury Board Secretariat of Canada evaluation requirements.

Evaluation provides a periodic look at progress toward outcomes. At this early stage, the focus is on the effectiveness of management issues:

- Program planning and implementation;
- Outputs;

- Resource allocation in accordance with plan; and
- Progress toward achievement of outcomes.

The strategy employed for conducting the periodic look also considers how evaluation capacity can be built through this exercise and on-going monitoring.

As the performance measurement plan relies heavily on process evaluation, it is expected the independent evaluation include: a documentation review of work plan and management reporting; a financial review; key informant interviews; and a case study(s). The questionnaire and case study design should relate to the evaluation questions, the related short-term outcomes, and associated indicators. Information from this evaluation component supports and explains findings of the impact assessment and provides program management and partners with tools for continuous improvement. SLFNHA is responsible for evaluation of the initiatives.

CHAPTER 1 – Background

Key Ideas

- The District Health Planning Project was created by Chiefs Resolution 04/44 to prepare an Anishinabe District Health Plan.
- Today, Anishinabe people in the Sioux Lookout area have poorer health than the mainstream.
- The NAN Chiefs adopted a Primary Health Care Mode to improve the situation.
- Traditional Anishinabe health practices need to be integrated into the foundation of plan.
- The Treaties must be respected and the Crown must meet and maintain its responsibilities. Respect for the Treaties is needed and the responsibilities of the Crown must be maintained. Both Canada and Anishinabe First Nations have responsibilities for the health of the people.
- All parties are responsible for improving First Nations health.

Introduction

In Resolution 04/44 the Sioux Lookout District Chiefs mandated the Sioux Lookout First Nations Health Authority to prepare a Sioux Lookout Anishinabe Health Plan.

The Health Planning Project, led by the Sioux Lookout First Nations Health Authority, is jointly funded by Health Canada through its Health Integration Initiative and the Ontario Ministry of Health and Long Term Care through its Primary Health Care Transition Fund.

This Health Plan covers our 31 First Nations in the Sioux Lookout area. Some are allied with Tribal Councils; others are independent.

- The Independent First Nations Alliance: Kitchenuhmaykoosib Inninuwug, Muskrat Dam, Pikangikum.
- Matawa First Nations Council: Eabametoong, Neskantaga, Nibinamik, Webequie.
- Keewaytinook Okimakanak Council: Deer Lake, Fort Severn, McDowell Lake, North Spirit Lake, Poplar Hill, Keewaywin.
- Shibogama First Nations Council: Kingfisher Lake, Wunnumun, Kasabonika, Wapekeka, Wawakapewin.
- Windigo First Nations Council: Michikan Lake, North Caribou, Cat Lake, Sachigo Lake, Koocheeching, Slate Falls.
- Pawiidigong Tribal Council: Migisi Sahgaigan, Wabigoon, Wabauskang.

- The Independent First Nations of: Mishkeegogamang, Sandy Lake, Saugeen, Obishikokaang (Lac Seul).

This area in northwestern Ontario serves approximately 25,000[9] individuals and includes Sioux Lookout, which is the primary service area and town of about 5,165. It also includes 31 First Nations communities; most communities are accessible only by air.

Carrying out the Chiefs mandate to develop the Anishinabe Health Plan, the Health Authority set up the Health Planning Project. Our Project has worked cooperatively with First Nations and Tribal Councils to:

- Update the Participatory Research Project (PRP) conducted in 1995 to assess current health status, issues and priorities for the District.
- Undertake a comprehensive review of primary health care service delivery and possible gaps.
- Incorporate the evidence within the primary health care service delivery model and Health Plan.

Health Canada has provided funding through its Health Integration Initiative established in 2003. This Initiative is designed to address the "gap in health status between Aboriginal and Non-Aboriginal peoples through better integration of federally funded health systems within First Nations and Inuit communities and those funded through Provincial and Territorial governments".[10] The Ontario Ministry of Health and Long Term Care has also funded the project through its Primary Health Care Transition Fund. Our project has benefited from combining funding from both sources, and having support from both Governments.

Overall, the project intends to:

- Develop a comprehensive integrated primary health care model and implementation plan.
- Create a District physicians plan within the integrated primary health care framework.
- Develop a nursing services plan.
- Develop an allied health services plan.
- Establish a mechanism for the governance and management of the primary health care model by First Nations.

Our project was completed by March 2006. Our plan for a holistic primary health care systems model better coordinates and prepares for the integration of all services under First Nation governance.

[9] Gordon, Janet. (N. d.)
[10] Centre for Policy Management, Inc. (March 31, 2005)., p. 1

Figure 1.1 – Map

Using Our Health Traditions

While living by our traditional ways, our Anishinabe people in the Sioux Lookout area were mainly healthy. Two Oji-Cree words describe important basic ideas.

> *"Puh-mi-ee-ti-si-win" is looking after yourself in all your aspects. You can tell how Puh-mi-ee-ti-si-win a person is* by how clean they've kept their person and their clothing; for instance even if they become ill they look after themselves. *The water is already there and the food is already there. Basically you can apply this to anything – their house, how they look after their tools, look after their marriage to preserve it – talking out problems, celebrating your marriage, recognizing that there will be problems that will come along."* [11]

These Anishinabe ideas are larger than the mainstream ideas of individual 'healthy lifestyle' where it is easy to 'blame the victims' for not looking after themselves. The Anishinabe ideas include the family, clan and community. They reflect peoples being well in the four aspects of life: spiritually, mentally, emotionally and physically. What is now called the 'determinants of health' has always been part of being healthy to Anishinabe.

Another important Anishinabe idea is the role of the person(s) who knows about the helper's way. "Ooweechiwaywin" means the traditional practice and culture of helping within the community. In different situations, the responsibility for individuals and families to become and stay well lies with the people that have these helpers' gifts. As well, people needing help are supported by family, clan, and others. The helper has a humble role. This is a *fundamental* difference. In the medical model typically, the doctor or nurse is the one with the ability to diagnose and treat, and the role of the patient is to follow advice.

Only by building on a strong base of culture and tradition can the Anishinabe again become truly healthy. The Anishinabe Health Plan is grounded in Anishinabe ways of health, such as re-balancing the health care system, and 're-powering' the culture.

The Current System and Its Services and Funding

Most Sioux Lookout area First Nation communities have the following health services in community:

- Primary care including regular physician visits, community-based nursing services (except for the communities of Koocheeching, McDowell Lake and Wawakapewin).
- Community health education usually done by Community Health Representatives, some staff funded by targeted at-risk programs, and primary care staff.
- At-risk client work and community education on key priorities through a variety of targeted funding programs: pre-natal nutrition (Canadian Pre-natal Nutrition Program), healthy pregnancies and early childhood (Healthy Babies, Early Years), reduction of FASD risks (FASD Prevention), community mental health (Brighter Futures Initiative & Building Healthy Communities).

[11] Key Knowledge Interviews (2005) Governance Background Discussion Paper

- Addiction treatment referrals, some following up counselling and some community awareness education through the National Native Alcohol and Drug Abuse Program.
- Mental health services: crisis work and mental health counselling services either by a community worker or a visiting mental health professional.
- Some in-community allied health services (dental care, optometry and physiotherapy; limited chiropody service through NAN contract).
- Home Care including home support and homemaking services, home care nursing, service coordination.
- Patient transportation and referral services funded largely by Non-Insured Health Benefits Program.
- Administrative, translation, clerical, security, and janitorial services.

A few First Nations have additional services funded through several programs:

- Community healing work with staff supported through the Aboriginal Healing and Wellness Program.
- Tobacco reduction (special funding in a few First Nations).
- Transitional support services for special needs persons.

Some services, such as nursing, optometry and dental care, are provided exclusively at the community level and others, such as physician, physiotherapy and other specialized services, are provided either at the community level, in Sioux Lookout, or in larger centres like Thunder Bay or Winnipeg.

The First Nations and Inuit Health Branch of Health Canada provides funding directly to First Nations or to their tribal councils for additional programs such as:

- Aboriginal Diabetes Initiative (ADI)
- Aboriginal Head Start
- Health promotion
- HIV/AIDS
- Home and Community Care (HCC)

As well, FNIH provides primary care nursing, either directly or through other funding arrangements. Some limited public health nursing is provided. Other public health services include environmental health hazard review and reduction (through Environmental Health Officers and new Water Quality Standards). In Sioux Lookout Zone only, FNIH pays for doctors' services, with limited reimbursement from Ontario.

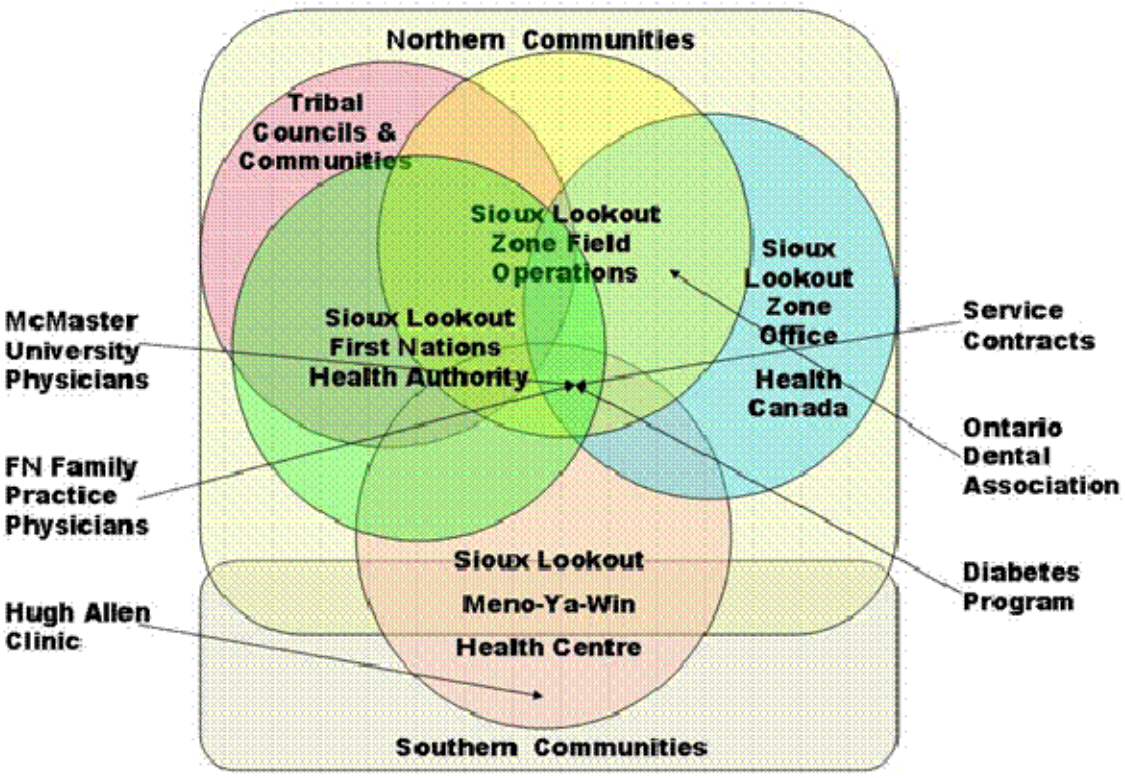
The Ontario Ministry of Health and Long Term Care also provides funding for or otherwise ensures access to the following services, not all of which are equally accessed by First Nations:

- Hospital services including diagnostic services
- Physician services including specialists, including diagnostic services

- Ambulance services including air ambulance/medical evacuation
- Some allied health professionals (e.g., physiotherapists, dieticians)
- Addictions services
- Children's health programs
- Public health services
- Mental health services including in-patient treatment
- Home, community and residential care services for seniors and disabled persons
- Aboriginal Healing and Wellness Strategy

The current system involves many different service agencies as well as funding organizations. The biggest ones are in the figure below, which shows the complexity of the system at present. It is difficult for community people, and even staff at times, to navigate the system. Communication and coordination is uneven.

Figure 1.2 – Current Health Care System



Continued Poor Health Creates Need for Change

For First Nations people in Canada there have been improvements in health, particularly in infant death rates since 1979, and increasing life expectancy.[12] Despite these gains, "…the health status and conditions of First Nations on-reserve remained worse than that of the general Canadian population…" [13] The potential years of life lost to injury is 3.5 times greater.[14] "First Nations People continue to have a disproportionate burden of infectious and sexually transmitted diseases in comparison to the overall Canadian population." [15] Diabetes rates among First Nations people are higher with 22.7% of adults having Type 2 Diabetes compared with 5.7% for Canada.[16] Suicides in the Sioux Lookout area are between 5 and 50 times more common than in the Canadian population.[17] Oral health problems are widespread among children, who have more than five times the rate of decayed, extracted or filled teeth compared with Ontario children.[18] Addictions are becoming more common, and are ranked as the third major health problem among Sioux Lookout First Nations. (See more information in Chapter 3.) There are fewer people living on the land, as families must be in town for children to go to school. New ways are introduced through television and now the Internet. Many people are not working in the wage economy, and families have limited funds coming in.

As well, many suffer from the effects of residential schools. Families are breaking down. People's health is at risk from living in crowded and mouldy housing, being inactive, eating non-traditional food, drinking alcohol or using drugs, smoking, gossiping, and not supporting each other except in times of crisis. (See more information in Chapter 3.)

The Chiefs and the First Nations people of the Sioux Lookout area want and need change to improve health. A new approach was needed.

The NAN Chiefs Model

In 1990, the Nishnawbe-Aski-Nation Chiefs moved to improve health by adopting the Primary Health Care (PHC) concept and creating the NAN Chiefs PHC Model. In approving PHC, the Chiefs recognized that the concept was close to the original Anishinabe ways. It enabled First Nations to work toward changes that were consistent with Anishinabe ways. Using PHC language made these ideas understandable to mainstream society including funders and those who operate current health services and systems.

While the Chiefs recognized that both Canada and Anishinabe First Nations have responsibilities for the health of the people, they also stated strongly that respect for the Treaties is essential. Canada, and Ontario for Treaty 9, must carry out the responsibilities of the Crown.

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12 Health Canada. (2003)
13 National Aboriginal Health Organization. (2003). Pg. 2
14 First Nations Regional Longitudinal Health Survey 2002/03
15 National Aboriginal Health Organization. (2003). Pg. 2
16 National Aboriginal Health Organization. (2005)
17 Dougherty, J. (2005)
18 Hamilton, M., (2005) A review of the Sioux Lookout Zone Dental Program

Primary Health Care

Primary Health Care (PHC) is a framework of ideas adopted at a United Nations World Health Organization conference in Alma Alta in 1978.

There are several fundamental ideas in PHC.

- It is "essential health care", the "first level of contact" of health care, and the "first element of a continuing health care process".
- Primary Health Care should be provided as close to the community as possible.
- Communities are to be involved through "their full participation … in the spirit of self-reliance and self-determination".
- Care is based on ways that are "practical, scientifically sound and socially acceptable".
- Services have a cost that the community and country can afford to maintain at every stage of their development.
- Primary Health Care is the "central function and main focus" of the country's health care system.
- It is "an integral part … of the overall social and economic development of the community".
- Teams of health care workers combine their knowledge and skills to help people recover their health to the greatest extent possible.

Building On (Our) Culture

One important addition of the Anishinabe Primary Health Care Model is founding health care work on Anishinabe ways. Not only would the system include ooweechiwaywin, it would reflect a holistic view of health, encourage the use of Anishinabe traditions and language, ways of knowing, showing respect and caring. We also want a system that offers the best of both worlds in ways of helping people get healthy and live well.

Only by focusing on health in a holistic manner, can we hope to regain the level of health that characterized the Anishinabe for centuries.

Protecting (Our) Treaties

First Nations signed treaties with the Crown that laid out relationships and responsibilities. The Treaties were based on the Royal Proclamation that set out the fundamentals for relationships between the Crown and First Nations.

Canada has often not lived up to its responsibilities with First Nations, either laid out in treaties or in land agreements. The result has been over a century of bad feelings and broken trust. Powerlessness of First Nations people was institutionalized through the Indian Act. It is clear from research that

powerlessness is harmful to health.[19] Relationships between Canada and First Nations must be changed as part of the responsibility all parties have to improving health.

Protection of treaty rights to health is a top priority for Chiefs and First Nations. This means making a new chapter in relations between First Nations and Canadian governments. Ontario government, as signatory to Treaty 9, also has treaty responsibilities. (As well, Ontario has obligations to ensure that First Nations people in Ontario have equitable access to health services and health generating resources.)

From the Scott-McKay-Bain Report[20], *Steps Along the Way*, the Chiefs accepted only one recommendation – to establish an aboriginal health authority. They did so because it was the only recommendation that spoke to self-determination and self-government, a precursor to re-empowerment.

Establishing First Nation control over health services is only one part of self-determination and self-government and the return to health of the Anishinabe. This Anishinabe Health Plan is designed to move First Nations in this direction as part of self-determination. It is also part of many efforts by First Nations, Tribal Councils, the Sioux Lookout First Nations Health Authority, the Nishnawbe-Aski-Nation to improve the health of their people.

Our Anishinabe Health Plan

In the next chapters, we outline how we intend to create a renewed Anishinabe Primary Health Care System. This is our Anishinabe Health Plan for regaining health.

The new Anishinabe health system is:

- Based on Primary Health Care concepts;
- Governed and managed by Anishinabe and their organizations, and accountable to the people and First Nations it serves, as well as the Governments that fund it; and
- Funded by Canada and Ontario in partial fulfilment of their treaty obligations and to ensure equity in health care access with other residents of Ontario.

Our Anishinabe Health Plan describes the PHC Model vision, mission, and principles, community Primary Health Care team, core services and access, and provides an example of the PHC Team at work.

[19] Wallerstein, N. (1992)
[20] Scott, McKay Bain (1989)

CHAPTER 2 – How We Did Our Work

Key Ideas

- The Sioux Lookout Zone Chiefs directed the Sioux Lookout First Nations Health Authority to lead a participatory process for planning.
- An assessment of community needs was done with 26 communities.
- A Project Management group was formed by representatives from SLFNHA, NAN, FNIH, MOHLTC, and the project team.
- Two representative Working Groups were set up: the Primary Health Care Working Group and the Physician Services Working Group.
- Two Communications Coordinators, plus First Nation and Tribal Council representatives and SLFNHA senior staff kept communities informed during the planning process.
- The Chiefs Committee on Health continued to provide political review, and the project reported regularly to all the Chiefs-in-Assembly.

A Large and Varied Contribution

The work of many people went into the Anishinabe Health Plan we have today. The Sioux Lookout Chiefs-in-Assembly provided direction, political review and eventual approval. Resolution 04/44 states that "the leadership, the health providers and the community members must continue to be involved in the design and development of primary health care services at the community level [and] the community members and health workers must be an integral part of the design, development and delivery of primary health care services".

The Anishinabe Health Planning Project (AHP) began in September 2004. The AHP reported regularly to the Chiefs Committee on Health (CCOH). As well, initial sections of the AHP were presented to the Sioux Lookout Chiefs-in-Assembly in June 2005 and given approval in principle. The Chiefs-in-Assembly accepted the AHP's report in February 2006 via Resolution 06/04, and directed the SLFNHA to develop an implementation plan.

Representatives of the SLFNHA, NAN, FNIH and MOHLTC, along with the project team, participated in the Project Management group.

Communities were involved in the Community Needs Assessment, described further in Chapter 3. Researchers fluent in Oji-Cree travelled through (26) communities, and in the process enlisted help from elders, youth, health staff and health committees.

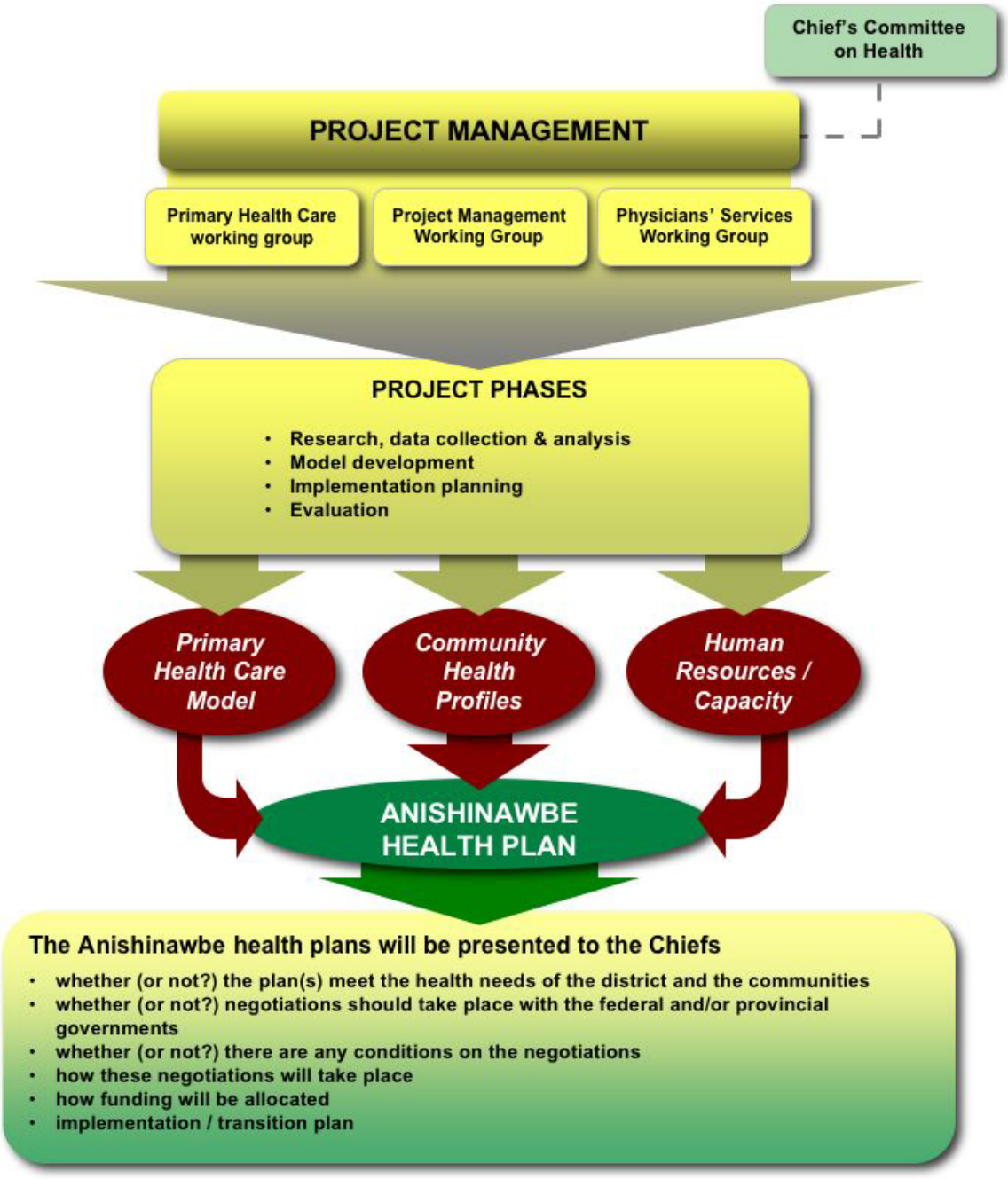
Two Working Groups were set up, one on physician services and another on the more generalized Primary Health Care. Both Working Groups included First Nations Health Directors (one from each Tribal Council group and the independent First Nations); the Tribal Council Health Directors; physicians from both northern practices; Meno-Ya-Win Health Centre (the area hospital); the Sioux Lookout First Nations Health Authority; Health Canada and the Ontario Ministry of Health and Long Term Care. By the middle of the project, participation was growing, peaking by the end.

Working Group members played a hands-on role in designing elements of the Anishinawbe Health Plan. In the Primary Health Care Working Group, members set out the vision, mission, and principles. They decided on Primary Health Care's most essential activities as well as the division of responsibilities within the team. They reviewed every draft of the Primary Health Care Model and various backgrounds papers.

The Physicians Working Group met during the first half of the project to discuss issues specific to physicians. They agreed on key elements in their plan, including the suggestion that their services should be offered under First Nation direction. The remaining work, concerning the whole PHC Team and doctors' roles and responsibilities in that team, was folded into the Primary Health Care Working Group.

In this way, we planned more holistically, using an integrated team approach. Figure 2.1 (following) shows the Anishinabe Health Planning Process.

Figure 2.1 – Anishinabe Health Planning Process



Help from the Project Team

Researchers and experts in northern Canadian First Nations health services and health systems formed a Project Team at the SLFNHA. Team members did background research on all major issues, such as other northern physician practices or Primary Health Care. They reviewed published literature; interviewed key knowledge people in the Sioux Lookout area and its First Nations and elsewhere; gathered statistics and other information; learned about service models from First Nations and elsewhere. Papers summarized the findings for the Working Groups, who usually gave a presentation on the highlights. These issues were discussed by the Working Groups, typically in small gatherings to maximize participation. Decisions were based on consensus, or referred to the CCOH.

Communities Staying in Touch

A key part of developing the Anishinabe Health Plan was initiating and maintaining continuous contact with our communities.

A region-wide community-needs assessment, meant our communities gathered information and identified health priorities. A researcher on the project team conducted the community-needs assessment with 26 communities. Assistant researchers fluent in the languages visited each community, talked with focus groups, elders, and other key people. Health staff self-administered a questionnaire to be mailed to the researcher. Additional information on community infrastructure, determinants of health and other data was gathered and together with the needs assessment results formed the basis of the community profiles. An overview of the health of the Anishinabe in the Sioux Lookout area was written and shared with First Nations leaders and health staff. The results of the assessment are reported on in Chapter 3 of this report.

Two Working Groups (which eventually merged into one) were established with First Nation and Tribal Council representatives, as well as other service providers and stakeholders.

Two Communications Co-ordinators travelled to our communities and made some ‘virtual visits’ by telehealth to present detailed information on the AHP, as it was being developed in Working Group meetings. In this two-way communication process, the Co-ordinators also listened and took careful notes during discussion with leadership; health staff; health committees; elders and other community members. Often, the Communications Co-ordinators visited community radio shows; there were opportunities for home visits. The Project Team regularly reviewed notes from community visits. Summaries both written and verbal were given to the Primary Health Care Working Group. This feedback was productive in reflecting community concerns and in meeting its needs while developing the AHP. It is being used in the evaluation of our planning process, as well.

Region-wide communications also included:

- Phone radio shows on parts of the AHP as it was developing;
- News stories about primary health care, feedback from community visits, and the developing AHP were written and included in *Wawatay* Newspaper; and
- Information ads were published in *Wawatay* Newspaper, *Wasaya* and *Bearskin* travel magazines in both Oji-Cree and English.

Working Group members developing the AHP benefited from steady community guidance. As well, communications work helped keep communities informed about the AHP as it developed. Working Group members, First Nations Health Directors and Chiefs have stressed the importance of maintaining this communication during implementation of health system changes from the AHP.

Three meetings were held with the First Nations and Tribal Council Health Directors to:

- Review the community-needs assessment process, and build capacity around population health ideas;
- Develop the framework for the reinvestment plan and a process for developing community-specific reinvestment plans; develop knowledge and skills in program planning; and
- Review the draft Anishinabe Health Plan and the draft Reinvestment Plan with the Primary Health Care Working Group.

Project Phases

In this way, the Project worked through each of its ten planning phases.

- Background research, literature review Primary Health Care theory and models (March 2005)
- Service Responsibilities in the system (May 2005)
- PHC Team Functions and Supports (September 2005)
- Defining Roles and Responsibilities (October 2005)
- Needed Relationships and Agreements (November 2005)
- Government and Management (December 2005-March 2006)
- Financial Plan (June 2005-March 2006)
- Develop Human Resources Plan (July 2005-February 2006)
- Implementation Plan (February 2006)
- Negotiations Strategy and Plan (February 2006-March 2006)

Anishinabe Health Plan is Approved

By the time the AHP was presented to the Sioux Lookout Chiefs-in-Assembly, it had received endorsement by First Nation Health Directors as well as members of the Primary Health Care Working Group. At the end of the January 2006 meeting, 84.4% said they believed the AHP reflects community needs. When asked whether the Plan included our language, culture and traditions, 84.4% said yes. Fewer felt we had included ways to respect our different worldviews (78.1%) or that the Plan included ways to work with other departments to ensure we address the whole problem and not just the symptoms (59.4%). More – 97% – said the AHP will help improve the health of our communities.

The Sioux Lookout Chiefs-in-Assembly accepted the report of the AHP with Resolution 06/04, and mandated the SLFNHA to proceed with implementation planning. The CCOH was mandated with political oversight and monitoring of the SLFNHA activities in Resolution 06/08. The SLFNHA was directed to develop a negotiations framework under the direction of the CCOH, and use the framework to guide negotiations for further resources (Resolution 06/07).

Creating the Reinvestment Plan

The Health Authority was mandated by the Chiefs to develop an evidence-based Reinvestment Plan and present it to the Chiefs for review as part of the AHP process. Reinvestment funds of more than $3.14 million are to flow to Sioux Lookout region First Nations starting at the end of September 2006. Funding is to be ongoing and exclusive of other FNIHB funding in the region. These reinvestment funds come from the agreement to amalgamate the two hospitals in the region, the FNIHB Zone "Indian" Hospital (funded largely by the province with top-up funding by FNIHB), and the District Health Centre (provincially funded). The agreements on amalgamation are contained in the Four Party Agreement on Hospital Services and in the Bi-lateral Agreement on First Nations Health Services.

To ensure the Reinvestment Plan was built from the ground up, all First Nation and Tribal Council Health Directors met in October. Working with the community assessment results, each Health Director set reinvestment priorities for his or her community. Priorities were then grouped: they are mental health, addictions, diabetes, behaviours, and capacity-building. All participants worked to understand obstacles that lay ahead and their root causes, which were all very similar: loss of culture, identity, colonialization, residential schools, and economic change. Working on root causes will simultaneously effect change in several areas. Looking hard at the root causes, as well as the 'symptoms' of the challenges, each Health Director created a draft Action Plan for change. The Directors took these plans back to communities, where more people could help finalize the plans.

In February 2006, the Chiefs reviewed the proposed Reinvestment Plan and its objectives. They passed Resolution 06/05 that stated "the Sioux Lookout First Nations communities proceed with the development of a detailed implementation plan for the Reinvestment Plan" with "all funds flowing directly to the communities for community based health programs." Reinvestment funds will start to flow to the communities at the end of September 2006, provided that the Reinvestment Plan has been created and approved by FNIHB.

CHAPTER 3 – Community Health Needs Assessment

Key Ideas

- The health status of the Anishinabe of the Sioux Lookout District is poorer than that enjoyed by mainstream Canadians
- There are many reasons for this lower health status
- Current analysis shows that their health status has, instead, deteriorated since the last needs assessment of 1994

Introduction

Canadian health data have long indicated the gap betweens First Nations peoples' health status and outcomes of mainstream Canadians.[21] In his 1995 Health Needs Assessment report for the Sioux Lookout communities Dr. Kue Young indicates that infant mortality rates, accidental deaths, suicide rates and diabetes are much higher for this population.[22]

This chapter looks at:

- the poor health status of the Sioux Lookout First Nations;
- their major health problems;
- some causes; and,
- some solutions designed to improve health outcomes.

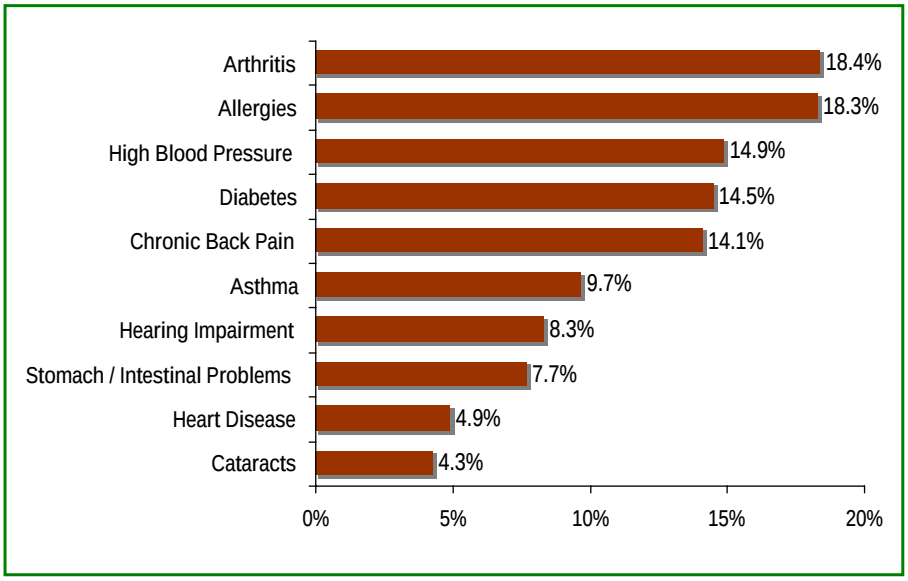
Health Status

The First Nations Regional Longitudinal Health Survey (RHS) of 2002/03 is an excellent source of health status data on the First Nations population in Canada. The RHS identifies the top ten medical conditions affecting First Nations adults, which we see in Figure 3.1.[23]

The RHS reveals arthritis as the number one self-reported medical condition affecting First Nations adults, followed by allergies, high blood pressure, diabetes and chronic back pain.

[21] SSCSAST, Kirby Report 2002
[22] PRP Report, 1995
[23] RHS at a glance, p.13

Figure 3.1 – RHS Top 10 Medical Conditions



Other sources of First Nations data are the Northern Health Information Partnership (NHIP) reports, particularly the Northern Ontario Child and Youth Health Report 2003[24], the Ontario Women's Health Report[25], the Diabetes in Ontario Report[26] and the ICES[27] report on health status by health region. Data on the prevalence of Mental Health issues in the Sioux Lookout area was provided by the Nodin/CFI Program.

While the RHS indicates a self-reported rate of 14.5% for diabetes the prevalent diabetes rate is 19.7% and these rates increase with age.[28] In First Nations females aged 55-64 the rate of diabetes is at 36.7% compared to the Canadian rate of 7.3% for this age group.[29] While specific diabetes rates are not available for the entire Sioux Lookout population, estimates indicate that as many as one in four (25%) adults are diabetic, in some communities. Ontario data for diabetes in both the First Nations and Non-First Nations population show rates for First Nations that are nearly three times that of the average population.

[24] NHIP 2003 Report
[25] Ontario Women's Health 2000 Report
[26] Diabetes in Ontario 1999 Report
[27] Institute of Clinical Evaluative Sciences, 2006
[28] First Nations Regional Longitudinal Health Survey (RHS) 2002/03
[29] Ibid p. 78

Figure 3.2 – Ontario Prevalence of DM in First Nations and Non-First Nations People, 1994 and 1998

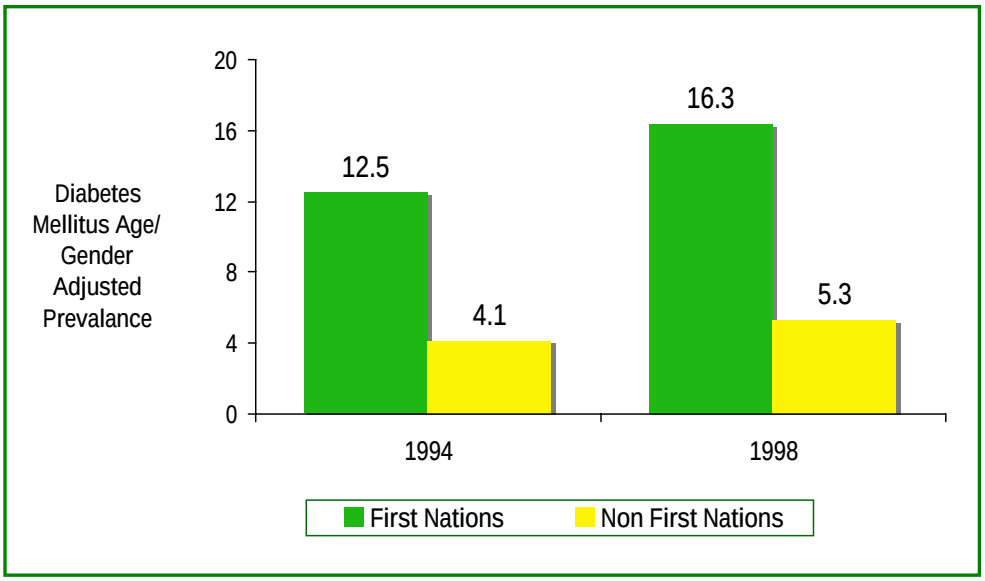
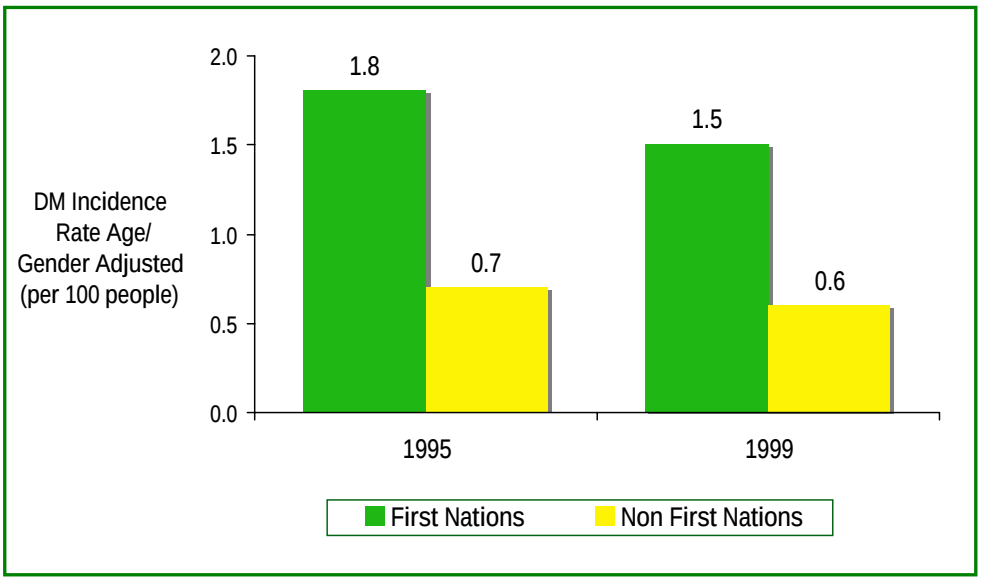


Figure 3.3 – Ontario Incidence of DM in First Nations and Non-First Nations People, 1995 and 1999



Health care providers commonly perceive the Sioux Lookout area as one with much higher incidences of diabetic complications. While this data is not available for the Sioux Lookout population it is available for Ontario First Nations. Overall, First Nations with diabetes have much higher morbidity and mortality rates than the non-First Nations population in Ontario. This is

evidenced in the Ontario data on annual hospitalization rates. The data compares hospitalization rates for acute myocardial infarction, congestive heart failure, unstable angina and infectious diseases for both First Nations and non-First Nations with and without diabetes.

Figure 3.4 – Annual Hospitalization of Acute Myocardial Infarction for First Nations and Non-First Nations People in Ontario with/out DM, 1994 and 1999

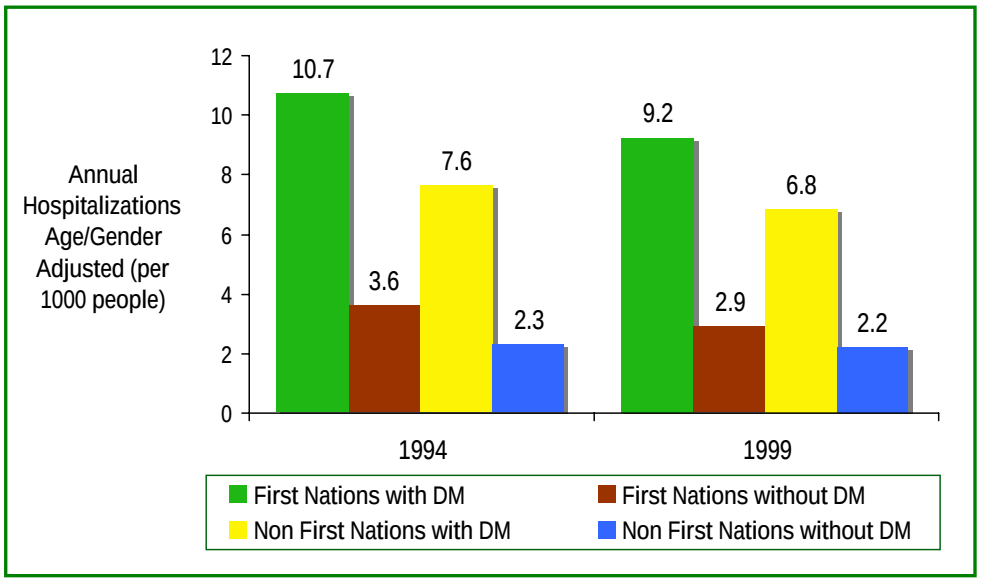


Figure 3.5 – Annual Hospitalizations of Congestive Heart Failure for First Nations and Non-First Nations People in Ontario with/out DM, 1994 and 1999

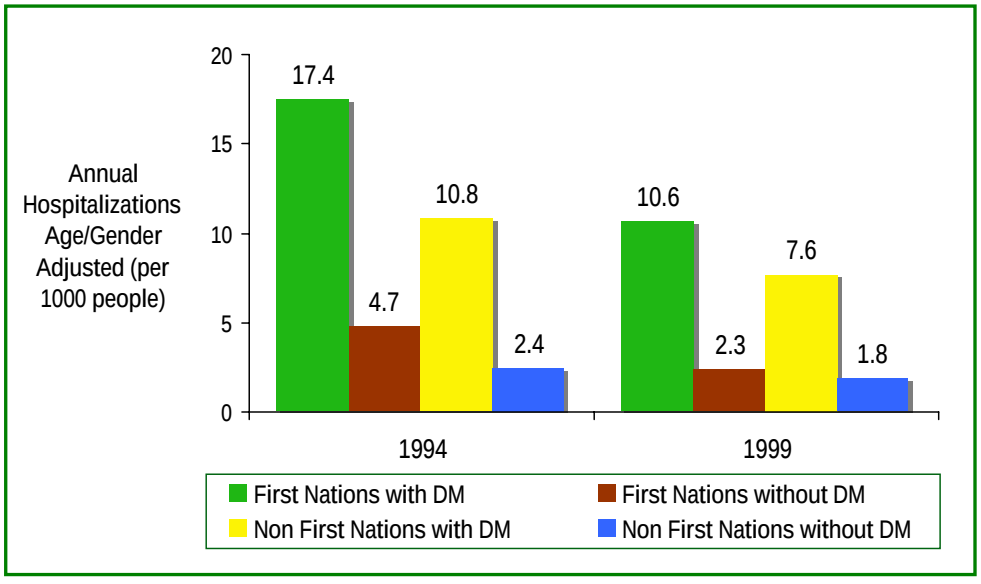


Figure 3.6 – Annual Hospitalizations of Unstable Angina for First Nations and Non-First Nations People in Ontario with/out DM, 1994 and 1999

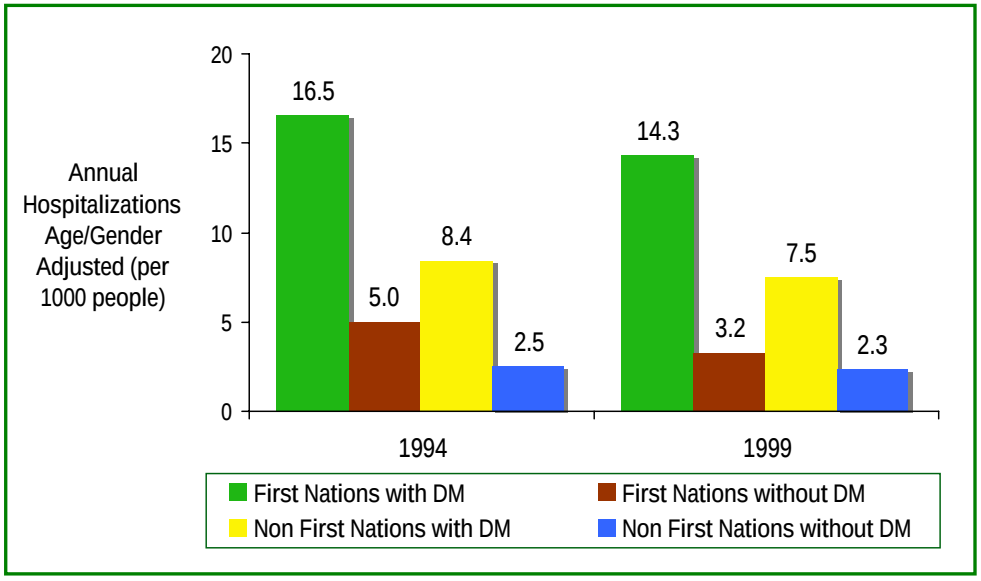
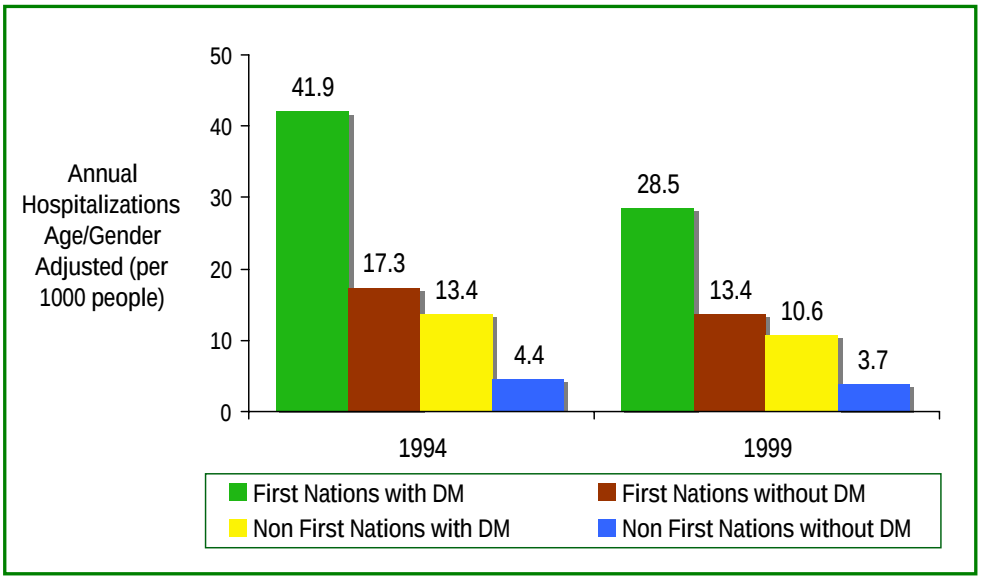


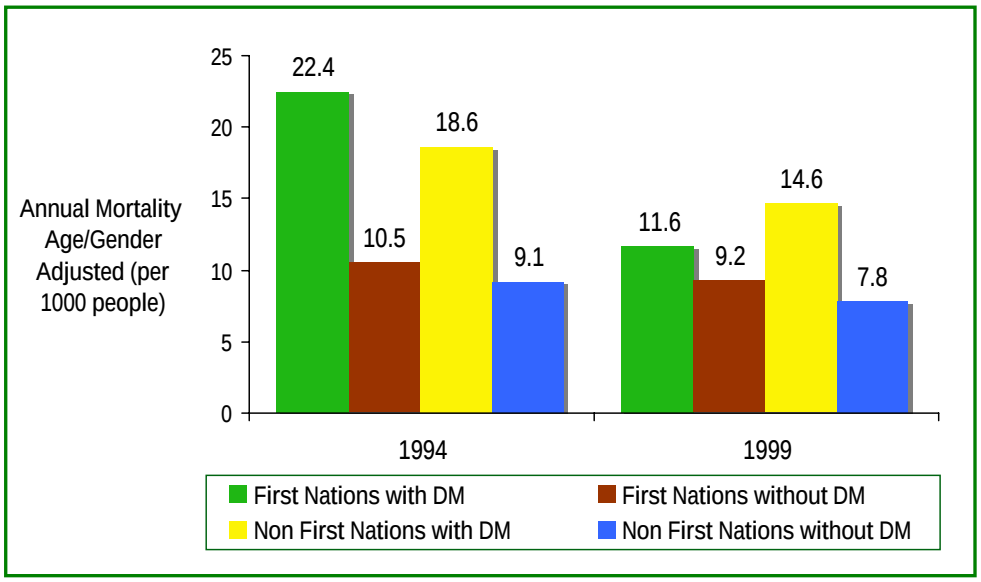
Figure 3.7 – Annual Hospitalizations of Infectious Diseases for First Nations and Non-First Nations People in Ontario with/out DM, 1994 and 1999



The overall mortality rate for First Nations in general is greater than in the non-First Nations population. In 1994 data we see that the mortality rate for First Nations with diabetes is significantly higher than the other categories. The 1999 data shows a change in this trend as mortality for First Nations with diabetes is less than the non-First Nations mortality rate. The author is sceptical about

the accuracy of this data and offers that there maybe errors due to First Nations not being identified separately from the general population in the data. The RHS supports that the prevalence of diabetes is increasing, not decreasing, and the data reports increasing morbidity associated with diabetes for First Nations; therefore it is unlikely that the mortality rate associated with diabetes is declining.

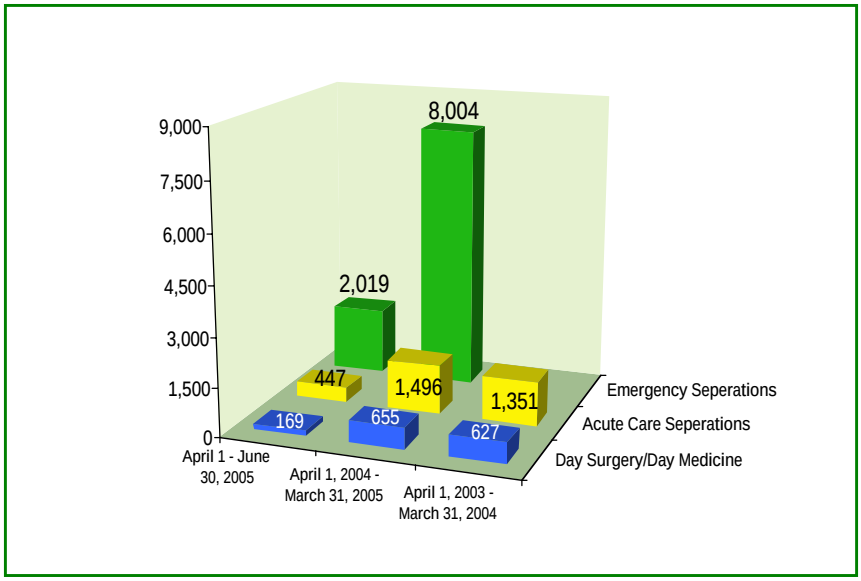
Figure 3.8 – Annual Mortality Rates of First Nations and Non-First Nations People with/out DM, 1994 and 1999



While actual morbidity and mortality data is unavailable for the Sioux Lookout population there is much evidence that the incidence of illness is not only burdensome, but is also increasing. Hospital separation data from the Sioux Lookout Meno-Ya-Win Health Centre showing acute care, emergency and day surgery/day medicine separations for the northern communities demonstrates high – and annually increasing – use.

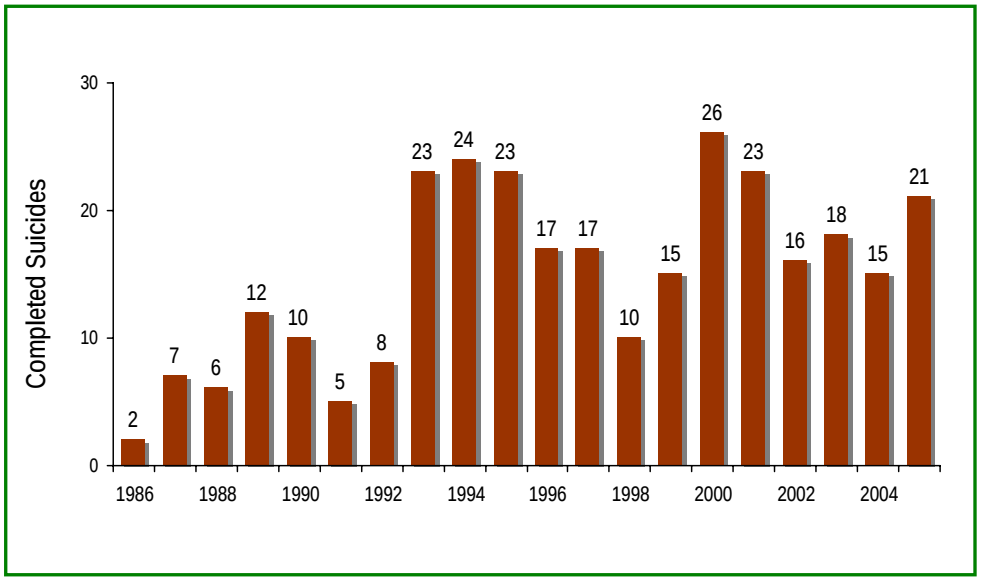
Figure 3.9 shows data for fiscal year 2003/04 (3), 2004/05 (2) and for 2005/06 (1) until end of June. This data does not include separations for residents of the town of Sioux Lookout or surrounding non-reserve communities.

Figure 3.9 – Hospital Separation Data



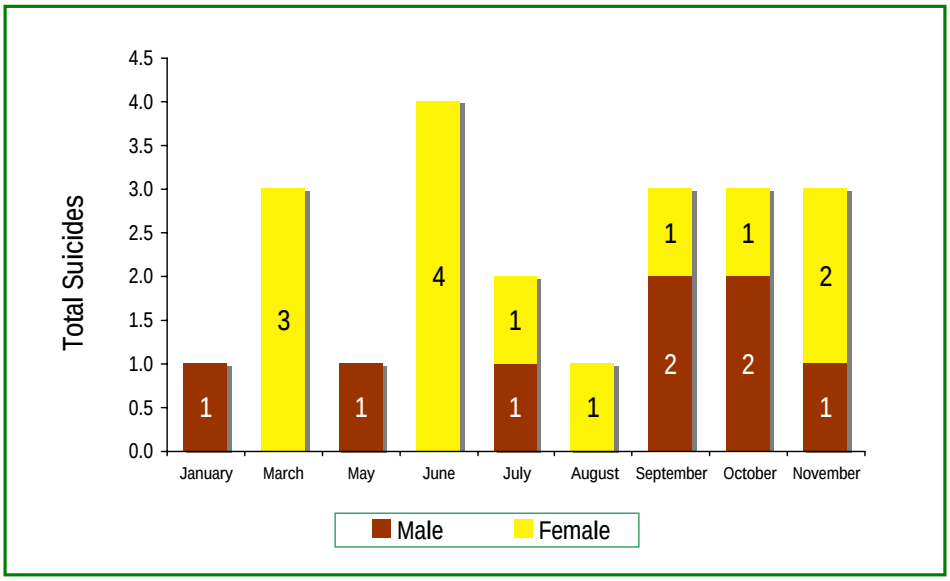
Data provided by Nodin/CFI services shows the number of completed suicides dating from 1986 to 2005. For the calendar year 2005 there were 21 completed suicides in 11 months, the majority of which were young males. A recent Nodin/CFI Services Review describes the population as "both economically depressed and mentally distressed….The suicide rate in the Sioux Lookout area ranges from 50 times higher for children under the age of 15 than the national average, to 5 times higher for those between the ages of 25-44.[30] "

Figure 3.10 – Completed Suicides in Sioux Lookout Region, 1986 to 2005



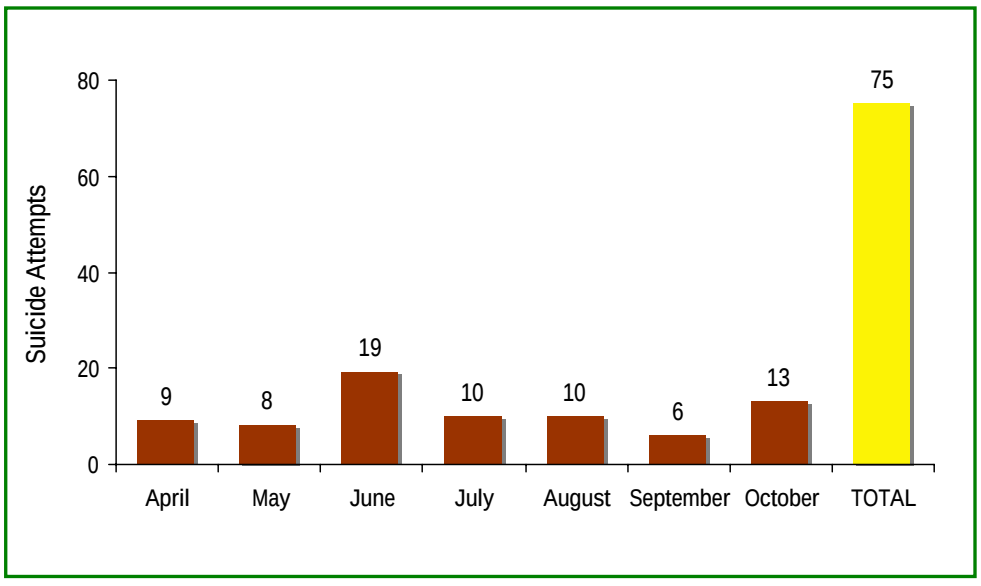
[30] Dougherty, J. (2006). Pg. 5

Figure 3.11 – Sioux Lookout First Nations Health Authority
Suicides for the Calendar Year January-November 2005



The data also shows suicide attempt numbers for the year 2005 from April through October. An average of 10 attempts per month warrant admission to and/or intervention by the Nodin/CFI program. Attempts handled and followed up in the community are not included here.

Figure 3.12 – Sioux Lookout First Nations Health Authority
Total Suicide Attempts, 2005

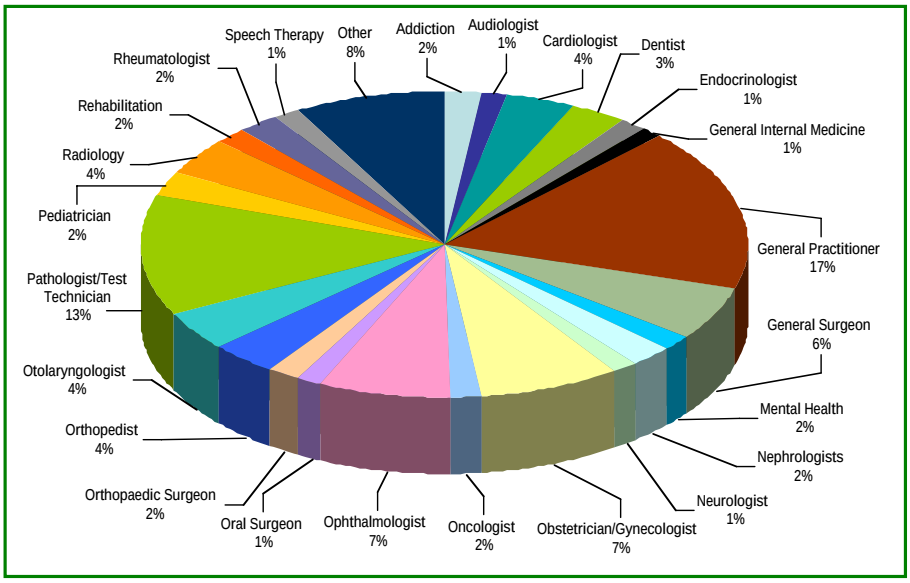


Another indicator of poor health status is the number of episodic care visits to community-based nursing stations. In 2004 this accounted for nearly 118,000 client visits at the community level for a population of approximately 19,000. The nursing department describes these numbers as underreported due to the use of a manual reporting system and high turnover in staff. Using these numbers it can be estimated that each person averages six encounters with the health care system per year.

Another indicator of health status within the Sioux Lookout population is the number of referrals for health care services outside the community.

For the years 2002-2004 the total referrals for services numbered 57,396 for 22 communities. Of this 9,887 were for general practitioner services. Figure 3.13 shows a sampling of the requirements for services for this population.

Figure 3.13 – NIHB Medical Transportation Program Claimants Reasons of Travel



This data does not represent the service needs of this population group. Access to Allied Health Services, for example, is very limited and as such these needs are not accurately reflected in the NIHB referral data. The statistical Report on the Health of Canadians[31] identifies disability and injury rates for First Nations children and youth as compared to the general Canadian rates. ICES[32] also identifies injury rates for Ontario and northwestern Ontario that require emergency room care and hospitalization by age grouping.

The statistical Report on the Health of Canadians[33] also indicates the dental needs as well as obesity and emotional distress rates for First Nations as compared to the Canadian population.

[31] Statistical Report on the Health of Canadians, 1999
[32] ICES, 2006
[33] Statistical Report on the Health of Canadians, 1999

Figure 3.14 – Prevalence of Injury and Disability as a Percent Compared in First Nations and Canada

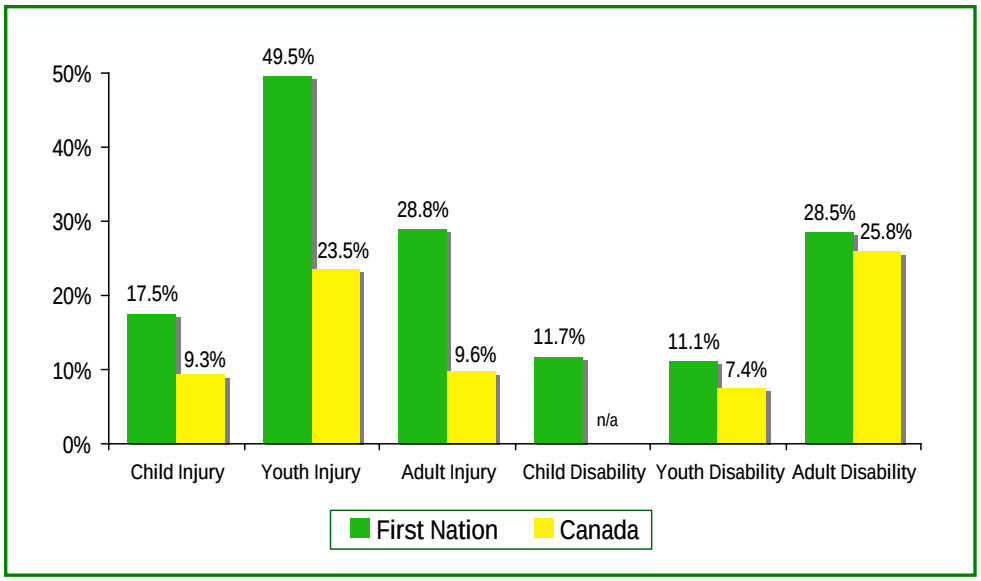


Figure 3.15 – Emergency Room Rates for Children and Youth of Ontario and Northern Ontario

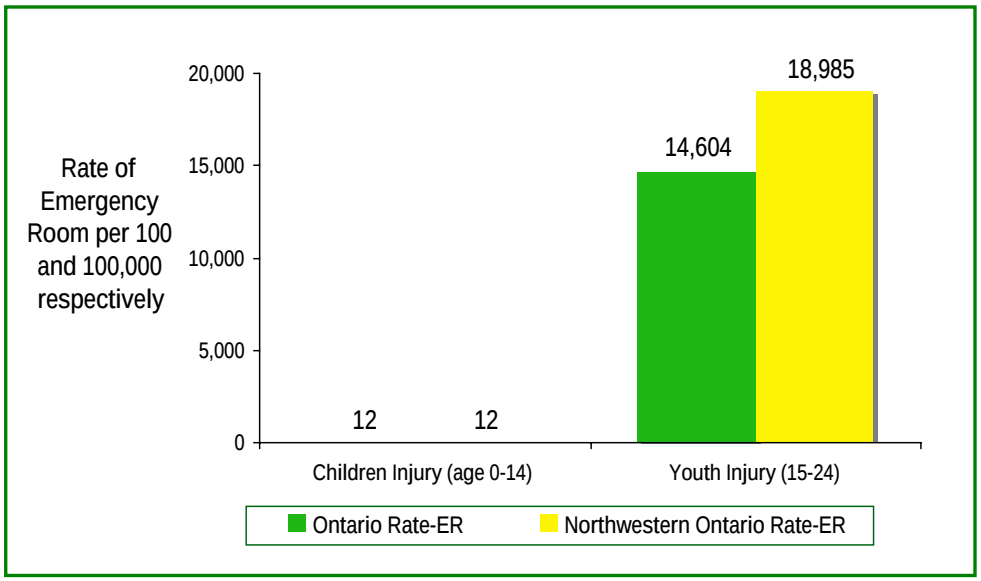


Figure 3.16 – Hospitalization Rates for Children and Youth of Ontario and Northern Ontario

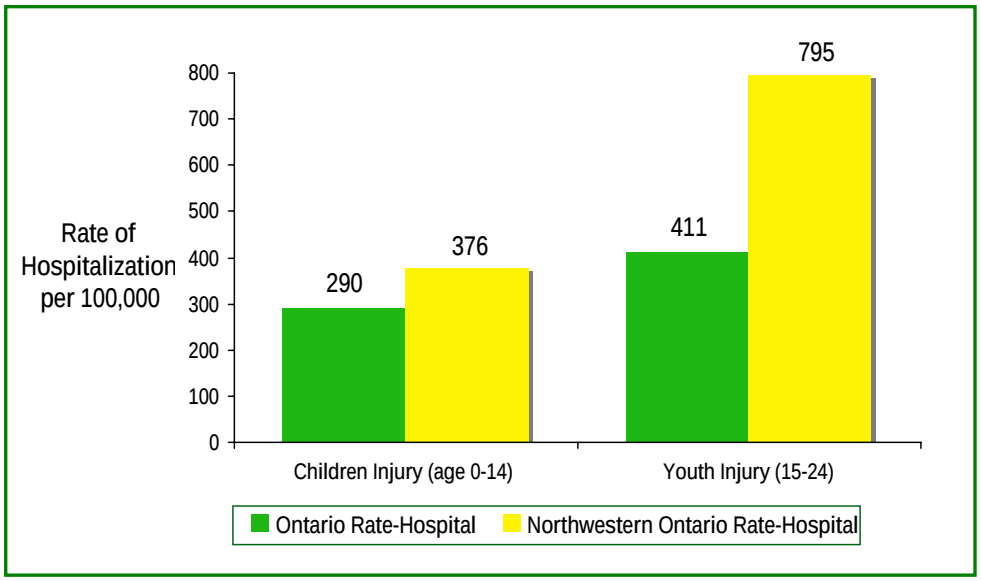


Figure 3.17 – Emergency Room and Hospitalization Rates for Adults and Elders of Ontario and Northern Ontario

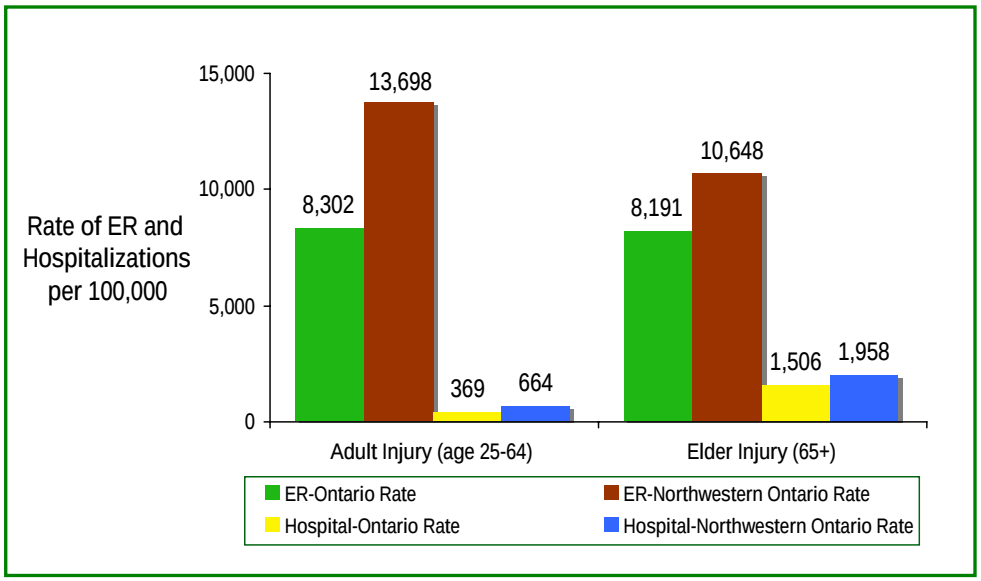


Figure 3.18 – Prevalence of Dental Needs as a Percent Compared in First Nations and Canada

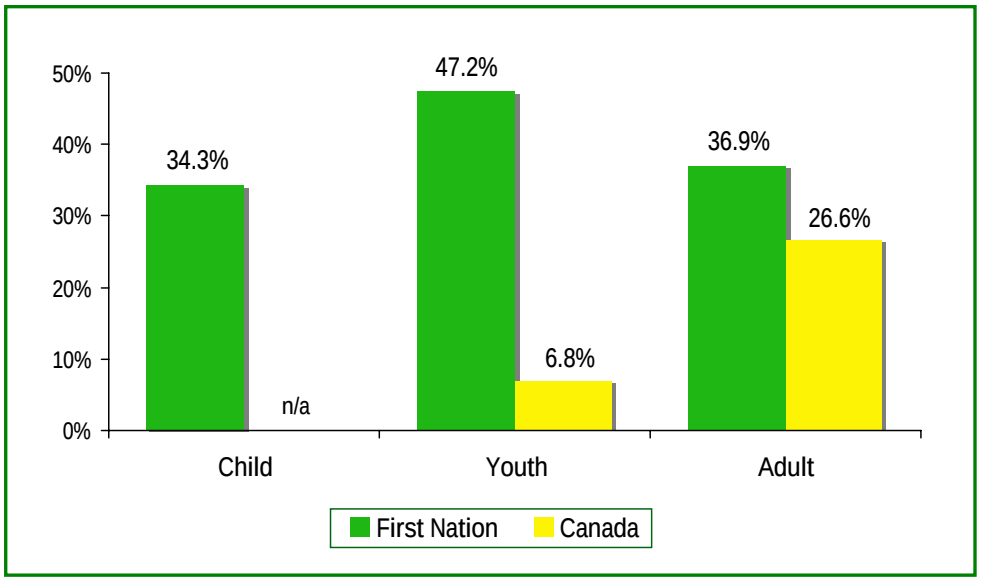


Figure 3.19 – Prevalence of Obesity as a Percent Compared in First Nations and Canada

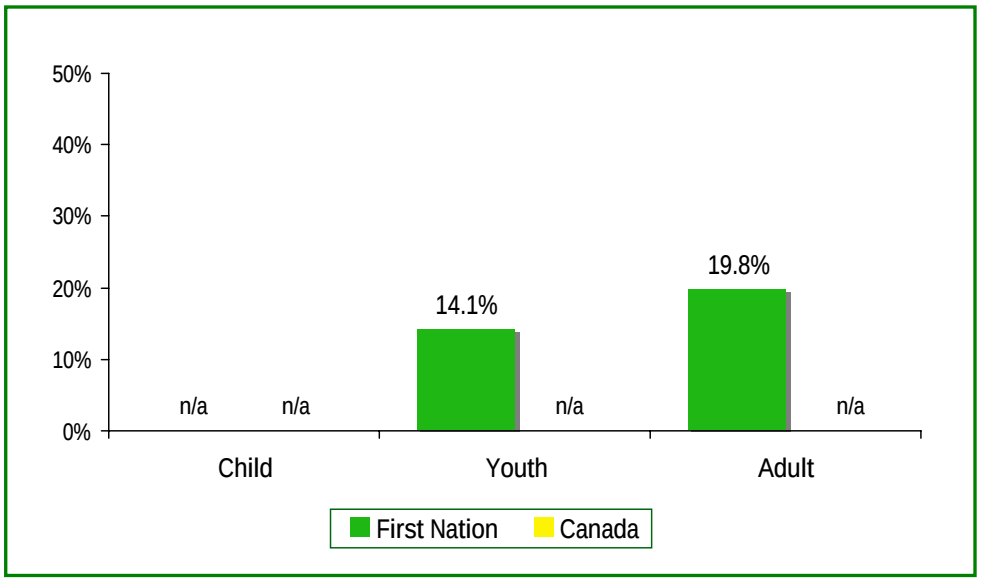
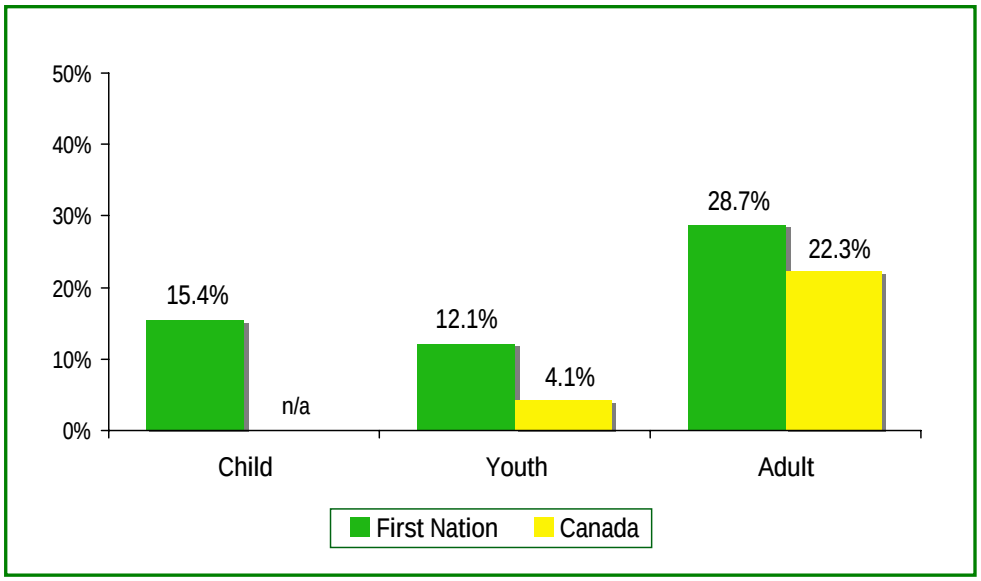


Figure 3.20 – Prevalence of Emotional Distress as a Percent Compared in First Nations and Canada



Needs Assessment Methodology

To determine the health needs of the population, community consultations composed of key informant interview and focus group sessions were conducted in twenty-six (26) communities. In addition to community members, consultations included high school students from those same communities who were living in Thunder Bay and Sioux Lookout and attending the Dennis Franklin Cromarty (DFC) and Pelican Falls Schools.

Across the twenty-six (26) communities and the two (2) high schools, a total of two hundred ninety-eight (298) key informant interviews and twenty (20) focus group sessions comprising an additional seventy-seven (77) informants were conducted. In total, three hundred eighty-five (385) informants participated in the consultation process.

For several reasons, inadequate data was obtained in the Needs Assessment to determine the actual need for allied health services. Focused on allied health services, a separate assessment was completed. It included a thorough literature search about allied health best practices and staffing numbers, key knowledge interviews, and analysis of hospital utilization of data from Meno-Ya-Win Health Centre as well as statistics from the First Nation Inuit Health Survey[34], and the Institute of Clinical Evaluative Sciences[35]. We present further discussion on the results of this search in a section at the end of this document.

[34] First Nations Inuit Regional Health Survey, 2003
[35] Institute of Clinical Evaluative Sciences, 2006

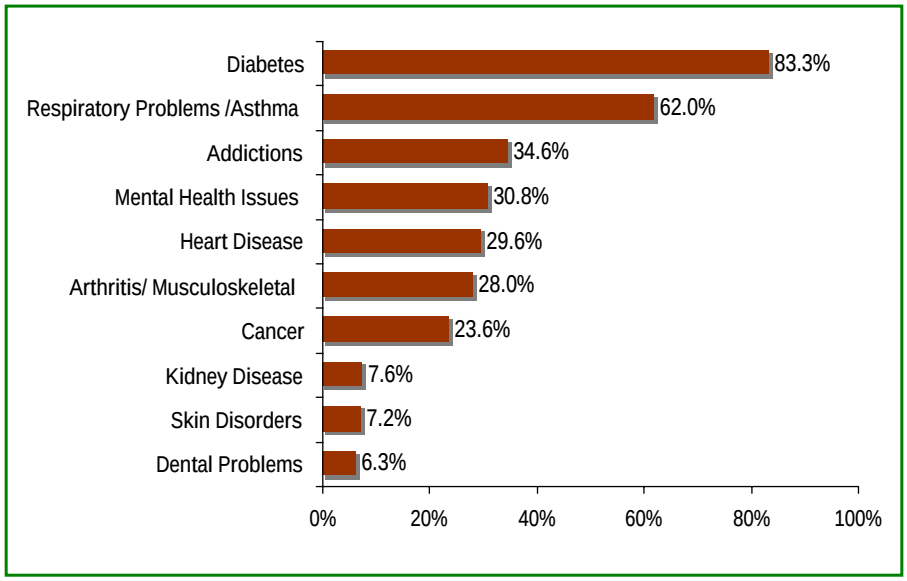
Major Health Problems

We asked key informants about the major health problems in their community and found the following responses:

- Diabetes was named by 265 respondents as the number-one health problem. Of special interest is that only 40 respondents who identified three or more major health problems did not identify diabetes as the first major health problem;
- Diseases of the respiratory system such as asthma were identified as the second major health problem by 197 respondents;
- A variety of addictions such as alcohol, drugs, solvents and gambling was named as the third major health problem for a total of 110 respondents;
- Following addictions, mental health issues ranging from suicidal ideation to psychiatric disorders were identified by 98 respondents as the next most serious health problem;
- Heart disease was the fifth most common health problem with 94 respondents identifying it as a serious problem; and
- The next five major health problems identified were arthritis and musculoskeletal disease (89), cancer (75), kidney disease (24), skin disorders (23) and dental problems by (20) respondents respectively.

The data collected by the RHS shows that a majority of the medical conditions identified by the Sioux Lookout population are also identified in the RHS. What the RHS does not reflect is the identification of high levels of addictions and mental health issues, as found in the Sioux Lookout population. The RHS data is reflected in Figure 3.1 while the Sioux Lookout data is reflected in Figure 3.21.

Figure 3.21 – Major Health Problems



Causes of Poor Health

Many factors contribute to the poor health status of the Sioux Lookout population, among them the effects of colonization, the residential school syndrome and the lack of even the most basic health services. We asked key informants what they thought caused the health problems they had identified.

Respondents overwhelmingly attributed the poor health of their community and/or health problems to lifestyle factors:

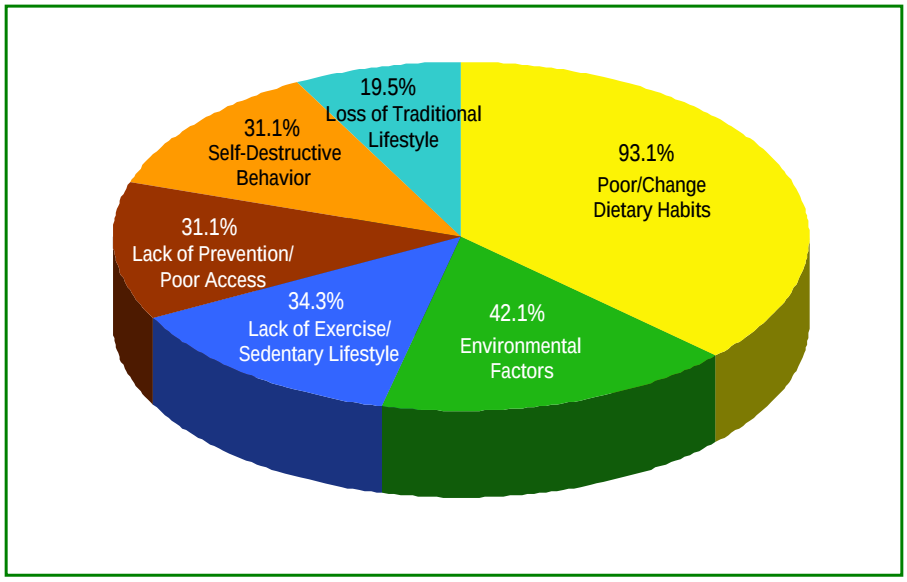
- Poor dietary habits and/or a change in diet was identified by 296 respondents to be the leading cause of poor health;
- An additional 109 respondents identified lack of exercise and sedentary lifestyle as contributing to their poor health; and
- Along with change in activity and diet 62 respondents stated that loss of their traditional lifestyle was a key factor in their poor health status.

The second leading cause (134 respondents) was described as environmental issues ranging from pollutants to poor air quality, mould, housing conditions, etc.

The third leading cause (102 respondents) included issues such as insufficient prevention programs and poor access to services.

The fourth leading cause was categorized as destructive behaviour and included behaviours such as excessive alcohol intake, prescription drug abuse, illegal drug use, etc. (99 respondents). This data can be seen in Figure 3.22.

Figure 3.22 – Causes of Poor Health

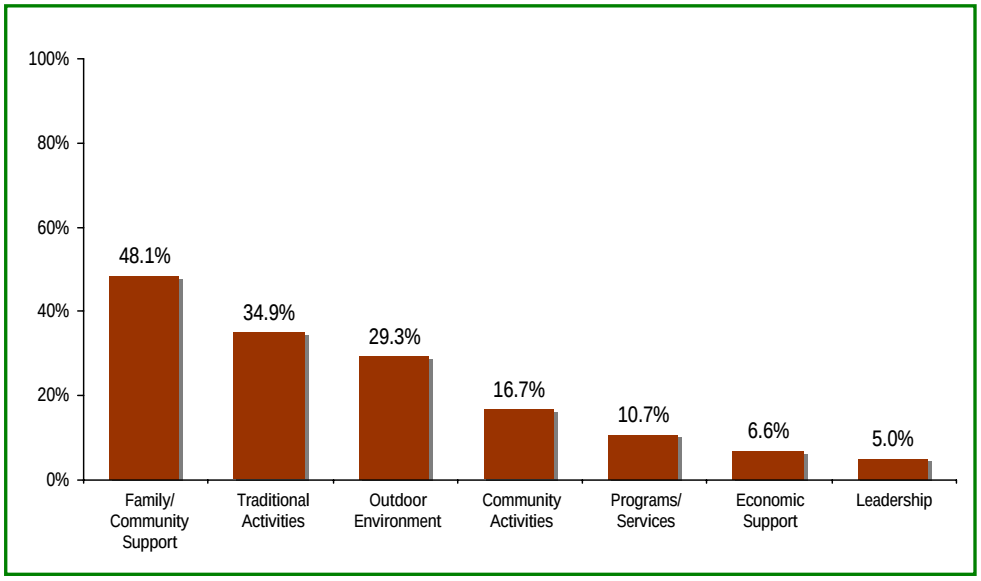


Community Strengths

We asked informants to identify what makes their community a good place to live despite the health problems. Their responses could be categorized into seven distinct themes, as follows:

- The presence of community and/or family supports was the most predominant community strength;
- The second most commonly-identified community strength was the presence of traditional activities;
- Additional respondents cited the outdoor environment and clean air as a positive factor;
- The availability of community activities was identified as a community strength; and
- Other themes that emerged as community strengths were the availability of programs and services, economic opportunities and supportive leadership.

Figure 3.23 – Community Strengths

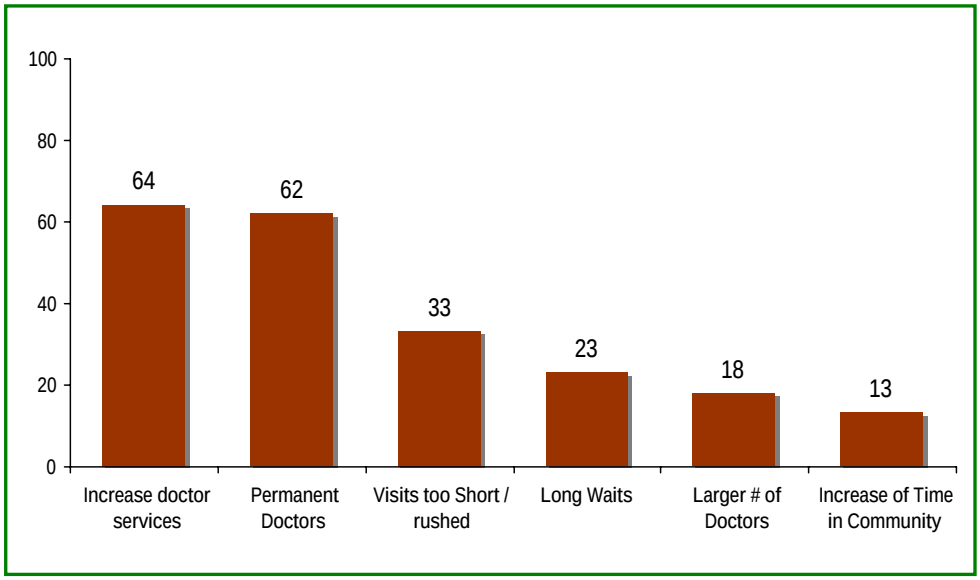


The Current Health Care System

We also asked informants for their perceptions of the existing health care system and the current level of service delivery. On the measure of satisfaction a total of 147 (46.23%) respondents indicated they were not satisfied with current health services; 152 (47.80%) indicated they were satisfied; while the remaining respondents were either partially-satisfied, ambivalent or unresponsive. These individuals were also asked about their perception of the satisfaction of others with health care services and 153 (48.11%) felt that others were not satisfied; 94 (29.56%) felt that others were satisfied; while the remaining respondents were either ambivalent or offered no comment on the satisfaction level of others with health services.

The lack of physician services at the community level is an issue in the Sioux Lookout area and a total of 228 responses dealt specifically with this problem. Responses ranged from insufficient physician services at the community level to long wait times. The responses are shown in Figure 3.24.

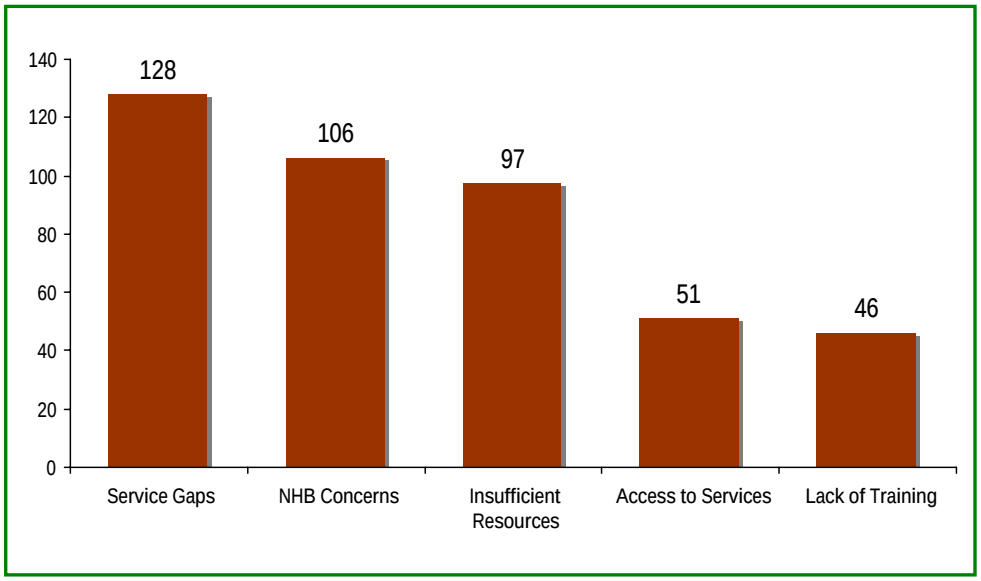
Figure 3.24 – Physician Service Issues



A total of 209 respondents indicated at least one or more concerns re the quality of their health care services. These concerns are shown in Figure 3.25 and were identified as:

- problems with NIHB travel and escort provisions;
- service gaps in areas of staff, equipment and programs;
- insufficient resources;
- issues with access to services via appointments; and
- lack of training.

Figure 3.25 – Quality of Health Service Problems



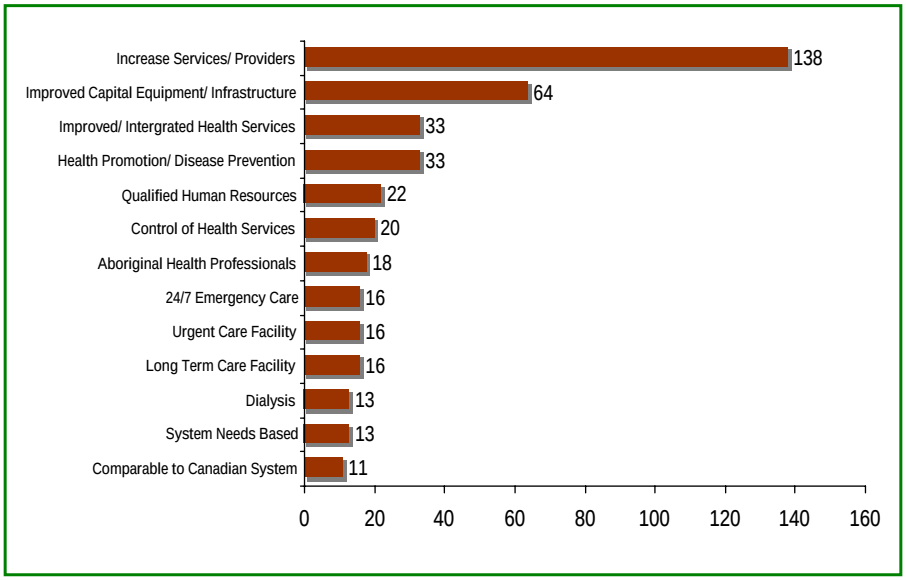
The New Health System

We asked key informants for comment on one final subject area: a vision for a health care system for themselves and their community.

Responses are categorized as follows:

- The majority of respondents said they wanted to see an increase in the number of providers and the level of services provided at the community level;
- The second most commonly-identified service requirement was the need for improvements in capital equipment and infrastructure such as facilities;
- The third and fourth most common requirements were the need for more integrated/improved health services at the community level and the need for health promotion and disease prevention programming;
- Some respondents identified the need for qualified human resources;
- Some respondents also indicated that more local control of the health system was desirable; and
- Other responses included the desire for more aboriginal health professionals; 24/7 emergency care services; a hospital/urgent care facility; long-term care services; dialysis services; and the necessity for a needs-based system with adequate resources more comparable to the Canadian system

Figure 3.26 – Vision of Health System



We asked informants if there should be a role for traditional healers or alternative healing practices in their community and the responses follow:

- 236 respondents replied positively and 12 offered a vehement no;
- Additional respondents were not in favour of traditional healers but qualified their responses with 54 saying that herbal/plant remedies were acceptable, while 23 answered positively except when it came to traditional ceremonies;
- 51 indicated that alternative healing practices should be an option but that it must be a personal choice; and
- 5 respondents indicated that health care professionals need to recognize traditional healing practices.

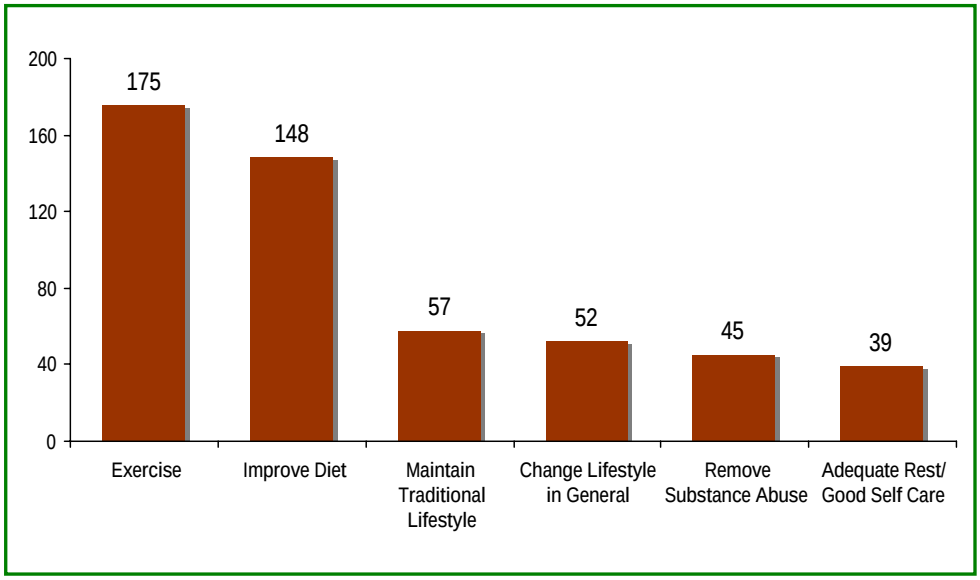
Improving Health Status

The final question related to personal responsibility for improving health status. When respondents were asked what people should do to improve their health the responses were overwhelmingly linked to lifestyle factors as shown in Figure 3.26:

- The number-one response was exercise;
- This was followed by changing/improving diet;
- Returning to or maintaining a traditional lifestyle was the third most common response;
- Some respondents indicated that changing one's lifestyle in general would improve health; and

- Other responses like ridding oneself of poor personal habits, such as substance abuse, and ensuring adequate rest and good self-care were thought to play a role in improving one's health.

Figure 3.27 – Improve Health Status



Conclusion

The Needs Assessment process completed in 1994-95 identified the five major health problem areas as infectious diseases, chronic diseases, psychosocial health problems, accidental injuries and oral health problems.

In the current needs sssessment, participants indicate the top ten health problems as diabetes, respiratory problems, addictions, mental health issues, heart disease, musculoskeletal disease, cancer, kidney disease, skin disorders and dental problems.

If we compare the data collected in 1995 to the present data, chronic diseases, psychosocial health problems and oral health problems are still considered significant. Of significance is the presence of addictions as an emerging category of health problems. Some would argue that addictions could be placed under the umbrella of psychosocial health but in this assessment it was given a stand-alone distinction, in its identification as the third major health problem area.

It is also interesting to note that unintentional injuries are not reflected in the current data. In the early and mid-1990s the Sioux Lookout Zone was actively carrying out the Canadian Hospital Injury Reporting Program (CHIRP) which resulted in the communities reporting all childhood unintentional and accidental injuries to a central database.

Due to this requirement one could conclude that injuries and accidents were already on the radar, and programming was targeting this problem. One could also conclude that the 1990s programming was effective, thus indicating the injury rate has decreased, which is why it is no longer being identified.

Unfortunately there is no hard evidence to support this theory and the anecdotal evidence indicates that unintentional injury and accidents are still a leading cause of morbidity and mortality in First Nations communities. Based on this, an assumption may be made that accidents and injuries are not identified as a leading health problem simply because they are not in the forefront of people's thinking on health issues.

The discrepancy between what communities identified as their major health problems and what providers view as a significant health issue cannot be further explored, validated or negated due to the lack of adequate morbidity and mortality data at this time.

Due to the prevalence of chronic diseases which were identified as major health problems, and the associated morbidity and mortality accompanying them, the requirement for valid and current data in this area is very urgent.

The new Primary Health Care system will require a comprehensive health information system that provides current information on the populations' health status.

A new comprehensive allied health service is required for the Sioux Lookout First Nations that avoids, as much as possible, the difficulties of travel for people especially who are injured or disabled due to chronic illness. Further discussion of how to respond to these care needs is found in Chapter 4 and Chapter 5.

CHAPTER 4 – The Anishinabe Health Plan

Key Ideas

- Use the NAN Chiefs Primary Health Care Model to ensure action in all five areas: support, promotion, prevention, treatment and rehabilitation.
- Strengthen resources and action in community development, health promotion, disease prevention, and rehabilitation.
- Improve access to primary care to deal with existing high levels of illness.
- Form multi-disciplinary community Primary Health Care Teams.
- Add allied health services to the Primary Health Care system.
- Establish First Nations direction for Primary Health Care services and staff.
- Clarify roles for agencies beyond the community level.
- Reinvest in community health priorities.

The NAN Chief's Model

In 1990, the Nishnawbe-Aski-Nation Chiefs moved to improve health in their communities. They passed Resolution 90/10 adopting "Primary Health Care as the framework for the development of community health services and the establishment of First Nations Health Authorities".

Reasons for this change included:

- "The present health system which focuses mainly on treatment services condemns our people to poor health status."
- "The Chiefs…support the principles of local control, community participation and local decision-making for the design of community health programs."

The NAN Chief's Model has been used in a consultative and collaborative process to build the Anishinabe Health Plan. Tribal Council Health Directors, First Nations Health Directors, Sioux Lookout First Nation Health Authority staff, physicians, the Ontario Ministry of Health and Long Term Care, Health Canada's FNIH and other stakeholders have all contributed to the development of the Plan.

The Model diagram is on the next page. The Individual, Family, and Community are at the centre. The spiritual, cultural, environmental, and political context surrounds and guides the health system. There are five main Areas for Action. When the five Areas for Action are in balance, it means better health for all.

- Supportive
- Promotive
- Preventive
- Curative
- Rehabilitative

Some Definitions

- **Supportive** means building and maintaining community, cultural and spiritual activities and teachings, helping each other, healing work, and helping those who are ill, especially: those with chronic illnesses, those who are grieving and those who are going through unusually hard times.
- **Promotive** focuses on changing community conditions for the whole population.
- **Preventive** reduces environmental hazards, preventing or decreasing risks of specific diseases for groups or individuals.
- **Curative** is tending to people who have become ill. (People often call this "primary care" – the first contact for care, usually at the community level. People consider in-patient hospital care "secondary care" because it happens later.)
- **Rehabilitative** is intensive work to recover the best possible level of health.

Figure 4.1 – NAN Chiefs Primary Health Care Model

Re-Powering Anishinabe Ways

Before contact with Europeans, Anishinabe people had an intact culture, with knowledge, responsibility and authority thriving in a very challenging environment. This has been systematically broken down. The result is poor health in all four aspects of life, spiritual, mental, emotional, and physical.

'Re-powering' the Anishinabe means Anishinabe culture and traditions build health for all. More than "empowering", it is returning rightful power over health to our people, our communities and governments. Anishinabe ways and values guide our behaviour, and decisions. We use and encourage Anishinabe languages.

Anishinabe values are strongly rooted in several major teachings. One effort to write down these values gives this description.

- ***Honesty*** is to achieve honesty within yourself; to recognize who and what you are. Do this and you can be honest with all others.
- ***Humility*** means you humble yourself and recognize that no matter how much you think you know, you know very little of all the universe.

- ***Truth:*** To learn truth, to live with truth and to walk with truth, to speak the truth.
- ***Wisdom*** is knowing the difference between good and bad, and knowing the results of your actions.
- ***Love***, unconditional love, means understanding that when people are weak they need your love the most. Your love is given freely and you cannot put conditions on it or your love is not true.
- ***Respect*** others, their beliefs, and respect yourself. If you cannot show respect to others, you cannot expect respect to be given.
- ***Bravery*** is to do something right, to act with integrity, even if you know it's going to hurt you.[36]

Re-powering means using Anishinabe ways, languages, and traditions in the daily work of providing health care. We ensure, through specific steps, that teachings pass to subsequent generations. *Every* interaction within the health service reflects traditional values. In addition, we combine the best of both Anishinabe and western medicines, honouring the ability of the Anishinabe to adapt and use what works.

When we see a vigorous Anishinabe culture, we see things like the following:

- From the time of conception, a child is valued and respected. Mothers live in healthy ways, eating good foods and staying active, avoiding any alcohol, drug, or tobacco use. Fathers support their partners. Appropriate ceremonies celebrate the coming child. We provide proper care to ensure the child's health. Couples learn how to look after themselves and the new life. When the time comes for the birth, fathers are able to be with their partners to welcome the child.
- The whole community supports the new family. There is love and kindness, appropriate healthy housing and food, guidance from elders, care from the health service, help from family and friends. The child learns how to be a helpful member of the clan and community.
- As the child grows, there is continued support, education, and accountability from the family, clan and community. Children spend time with adults learning their language, traditions and culture. Adults take time with children to teach them these things. All services in the community, including the school, use the local language, teach and use the traditions, and support the culture.
- When the child becomes an adult, he or she steps in to provide care and support to others. As we age, we also look after parents with love and kindness. Elders pass along their knowledge to youth who listen and learn. Wherever possible, people pass on with their loved ones close. The circle of life continues.

[36] NAN Anishinabe Healing Program (n.d.)

What is different in our ways of being healthy?

People are more active, and look after themselves more often; they depend less on the government or Band Office for help. They expand their responsibilities for strengthening and maintaining their own health and, using traditional parenting, support their family members in difficult times. There is widespread support for people seeking healthier ways to live; gossip and jealousy are greatly reduced. More people participate actively in community life. Traditions and teachings are passed along to children and youth in the home as well as in school. Traditions are used to stay healthy, to heal individuals and relationships.

What is different in our health services with re-powering?

- Elders participate as guides in our health services. They are regularly involved with planning, problem-solving, supporting staff, patients and clients, mediating when difficulties occur. Elders are active on the Health Committee or Board, they advise Chief and Council. They assist staff in understanding more about Anishinabe ways, and how to use them as the foundation for our health services.
- Staff behaviour reflects the seven basic values of honesty, humility, truth, wisdom, love, respect and bravery. People are treated with courtesy and dignity. People are not told what to do, but together we create ways to improve health.
- We understand the importance of life's spiritual aspect, and how it can help people regain good health. We incorporate it in our health services wherever appropriate. We also respect the different paths our clients and patients may take toward spirituality.
- A new partnership develops between those who seek heath care and those who provide it. Both work on the basis that the individual is responsible for healing, and health workers are helpers. The health service and its staff help people, and are careful not to take over responsibilities of the individual, family and the community.
- People who speak the language are available to translate when needed. The staff use the local language at work. Materials to help educate people about health are available in our languages. Elders review translated materials to ensure the quality of translation.
- Ways of recovering health, both traditional and western, are accessible to people. We arrange access to "ooweechiwaywin" through the community. Funding is not a barrier to access. Communities without resident ooweechiwaywin know where to refer their people.
- We respect traditional ways. People trained in western medicine are oriented to traditional ways. Referrals take place between the nurses, doctors, mental health workers, addiction workers, and ooweechiwaywin.
- The person who manages and leads the health service is culturally knowledgeable, an Anishinabe.
- Staff are oriented to Anishinabe ways. Staff from outside are welcomed into the community. A local person volunteers to be a guide to the culture and traditions, and community ways.
- We respect Anishinabe ways of knowing and solving problems. We combine 'scientific' evidence with community wisdom to create new understandings. Staff uses these in working with people.

- Staff job requirements include cultural knowledge and language skills.
- We do performance appraisal in traditional ways, and include accountability for acting in culturally appropriate ways.
- Program plans reflect culturally appropriate approaches. Community members, especially elders, are involved in planning and evaluating work.
- A community health committee or advisory board provides guidance and support to the health staff and services.
- Chief and Council provide healthy direction and are good role models for the community.
- People take responsibility for their own health.
- Community members learn how to look after themselves and their children. Call-outs for the nurse include only those that are truly urgent.
- Together, all groups in the community work to improve the determinants of health.[37]

Shifting to an Anishinabe Foundation

To shift a health service onto an Anishinabe foundation requires:

- Time to do the planning and program re-design work, starting with priority programs;
- Knowledge and skill to take traditional ideas and turn them into organizational behaviours;
- Resources (time, funding, people) for orientation, especially for outside staff; and
- Agreement with partner agencies and their staff for using traditional ways while working in community and with Anishinabe.

[37] The determinants of health include: income and social status, social support, education, employment and working conditions, genetics and biology, personal health behaviour and coping, healthy child development, culture, gender, access to health care.

The Anishinabe Health Plan

Our Vision

"We envision our communities as safe, clean places where everyone is respected, people are healthy in the spiritual, physical, mental, emotional and social aspects of their being and where all have access to affordable food and clean water, education, employment, healthy housing, and necessary health services staffed and governed by Anishinabe."

Our Mission

"The Anishinabe Health System strives to maintain and improve the health of Sioux Lookout First Nations through effective and responsive services and programs, productive team relationships, holistic continuity of care and quality infrastructure, services, management and governance."

Our Principles

Our Anishinabe Health System is grounded in Anishinabe ways, holistic, First Nations directed, accessible, highest quality, accountable, organized, balanced, patient and flexible, and developmental.

- ***Grounded in Anishinabe Ways***
  - We address the holistic health of individuals, families, communities, and nations, in all four aspects of life – physical, spiritual, social/emotional, and mental
  - Values and traditional ways are our foundation. Our ways are respected and reflected in our work. We use Anishinabe ways in governing and managing our services.
  - Our medicines and medicine peoples' methods are respected and included, along with other ways. People have choice.
  - Our communities and people do what they can, and others support as needed.
  - We use confidential information and data to benefit Anishinabe.
  - We share knowledge and focus on things that are working so that we are not always "reinventing the wheel".
- ***Holistic***
  - Our services have a holistic approach: working with individuals, families, and the whole community to improve health.
  - We work with other organizations, agencies, and groups in the community.
  - We work together across all our communities, cooperating and collaborating where we can to strengthen our services and the health of our people, while respecting First Nation autonomy.
  - Economic and social development advance together.

- Health and environmental sustainability are closely linked.

- ***First Nations-directed***
  - Our people have the right and responsibility to participate meaningfully in health decisions affecting their lives.
  - Our governments, agencies, and people enter into leadership roles in our services.
  - Our leaders and staff are role models to our people.
  - Our services are community-driven. They work for individuals, families, and communities.
  - Our first priority is communities' services.
- ***Accessible***
  - Services are as close to home as possible.
  - All people have equal access to services, even though not all services are available in every community.
- ***Highest Quality***
  - Our services and programs are of the highest quality based on practical, scientifically sound and culturally respectful methods and technologies.
  - Our services are consistent, with the same standards of care in all our communities.
  - Our staff is fully-qualified. Staff members are supported by on-going learning and development.
  - There is effective case management, and advocacy when required.
- ***Accountable***
  - We are accountable to each other throughout the system.
  - Our services are accountable to the people they serve.
  - We respect the different responsibilities of those who govern our services and those who manage them. Our organizations have clear lines of responsibility and authority. We separate politics and services. There is no favoritism; decisions are open and transparent.
  - We continually reflect on our work, evaluate our progress against established benchmarks or standards. Learning from our experience, we make improvements.
- ***Organized***
  - We divide the work among our organizations in different parts or locations of the system to achieve the greatest impact in improving health. Our divisions of responsibilities and roles are clear to each other, as well as our partners in the larger system.
  - There is on-going communication with each other: in our community teams, in and among our organizations and agencies, between First Nations government and their agencies, with the other service partners and governments and their agencies linked with our system.

- Each organization and worker knows the job it is responsible for.
- Our people understand over time who to go to for help, if needed.

- ***Balanced***
  - There is equal emphasis on supportive, promotive, preventive, curative, and rehabilitative supports, helpers, and services.
  - Curative and rehabilitative services move on complementary tracks with preventive and promotive services, as both are required.
  - We work towards earlier detection and intervention when our people are struggling with their health.
- ***Patient and Flexible***
  - Primary Health Care is a multi-general change process. Long periods for complete development are built-in.
  - Change in the system occurs at the community's pace.
  - Plans are adapted to fit community needs and circumstances.
  - Capacity is built before responsibilities are moved to communities or new organizations.
- ***Developmental***
  - We seek and use opportunities to increase our people's abilities to improve and control their own health.
  - We maximize the participation of Anishinabe people in our services.
  - We build capacity in the ways we work and the actions we take.
  - Community development work is central to our action and services. We work with our people and communities, not just provide services for or to them.
  - Our services build on strengths: of our Anishinabe ways, our communities and people, our clients and their families, and our fellow workers and leaders.

Rebalancing the System

Presently, the health care system that serves our communities is involved most often in curative work, with some, too, in rehabilitation and prevention. With the Anishinabe Health Plan, we see a shift with action occurring in all five areas. Even though they may work primarily in one area, PHC Team members may participate in others.

Community Primary Health Care

Community Participation

One fundamental idea in Primary Health Care is that people participate fully in health, looking after themselves, supporting others, working together to change community living conditions, and guiding their health services and staff.

Using Anishinabe culture and ways to guide all our actions and decisions means that health care is consistent with our culture and traditions. We weave it through all our work. Our elders participate as part of our health committees, as advisors and wise guides in working with people in crisis and healing, as educators of the PHC Team and the community. This reflects our use of culture and Anishinabe ways. Traditional specialists, herbalists and midwives assist people with healing and provide guidance to other health practitioners from outside the community. By using our culture as the base for our work, we also strengthen it and build health for all.

Creating community health plans jointly with health leaders, community members and staff is an important form of participation. We gather and use information, including community wisdom, to help us form plans. When we put our plans into action, community members, leaders, elders and staff meet regularly to review progress and to adjust plans as necessary.

Other ways of participation include in-community health and healing activities, serving on health committees or organizing groups for healthy community activities. People also participate by supporting others in grief, celebrating accomplishments and life events like births.

Our people are active in the political life of the community, and ensure that wise leaders are elected to serve them. Being wise, our leaders separate politics from services, recognizing their role as setting direction and ensuring accountability. They delegate to community committees or boards, the job of supporting and guiding the health service on a regular basis. These groups delegate the job of managing the services to the health director and staff. (See Chapter 7 for more on governance and management.)

Access to Community PHC

Our reality is that our First Nations do not have equitable access to health services. As well, many services are available only outside the community.

In the Anishinabe Health Plan, people living in our communities have access to the same services.

- Health promotion, community development, and prevention work is done in all communities.
- Access to services occurs both in the community through visiting staff, and in some situations by travelling to a hub community.
- Access to traditional specialists, herbalists and midwives occurs through community decisions about whom is considered a traditional practitioner. Where there are no traditional practitioners, communities can decide who will be invited and how they can be involved.
- Generally, larger communities have more specialized PHC Team members. In smaller communities, the PHC Team members will perform more varied tasks.
- It is *essential* that all PHC Team members are qualified. This means *on-going* investments to build capacity, and ensuring Anishinabe have accessible health-career training and upgrading options.
- All staff need access to continuing education. We can provide this through telehealth, visiting continuing educators, and travel to education workshops and courses.
- Our people have access to continuing education in health and community change. Elders and others very knowledgeable in Anishinabe ways educate community members, including children. They pass along the teachings, stories, traditions, and language to the next generations.
- Community PHC staff provide workshops, presentations and radio shows, distribute educational resources, and talk with people one-to-one, in family groups, or small discussion or healing groups. Telehealth connects community members with outside learning opportunities.

Scope of Community Primary Health Care Services

Work occurs in three broad areas: Primary and Chronic Care; Population and Public Health; Mental Health and Addictions. Community health education is a core service, as is community development and health promotion action.

People in each community have equitable access to core services from the five areas of the NAN Chiefs Model described above.

Through referral, our people access secondary services, including hospital and medical specialist care.

Primary Health Care Teams

In the existing health care system, most people work on their own, not in a team. With specific types of programs, staff usually work only in that program. The exception is the Community Health Representative, who works on many different programs and health issues.

In the Anishinabe Health Plan, people work in an integrated multi-disciplinary PHC Team. First Nation Health Directors have support from Health Committees, community leadership and second-level services to carry out their work. Some smaller communities have a lead staff person who carries out some functions of a health director.

PHC Teams include both resident and visiting members. Typically doctors, pharmacists and allied health professionals visit, while other team members live in communities. (See Chapter 5 for more detail.)

We provide additional supports in administration, translation, and clinical work.

We wrote Our Plan around core services and major activities, *not* around specific staff.

PHC Team members share some responsibilities.

- Health education of clients.
- Rapid assessment for involvement of other team members (such as addictions or mental health).
- Supporting team members, being good team-mates.
- Being good role models in health.
- Being active as citizens and volunteers in community-building and maintenance work.

Some work is specialized. A primary care system exists supported by nurses, doctors and other professionals. Because of our unique situation, nurses are in the community most of the time. Primary care nurses are usually the first contact with people who are ill. We expect each provider of primary care to work as part of the team to provide the best care possible.

Mental health staff coordinate responses to crisis mental health situations as well as providing non-urgent care, counselling, and follow-up. Addictions staff provide both rehabilitation, follow-up and counselling support. Prevention and promotion staff carry out most community development, healing, and health education activities. Public health staff in communicable disease control and maternal and child health work in these areas, not in treatment.

Ooweechiwaywin or Traditional Specialists

We add “ooweechiwaywin” to our primary health care system. Ooweechiwaywin serve many functions. They provide help to clients across all five areas of action in the NAN Chiefs model. As well, they assist communities, families and individuals who wish to discover their traditional values, culture and language. Each community will decide how or if they wish to have an ooweechiwaywin work with it in re-powering Anishinawbe ways. When a community does not have a resident ooweechiwaywin, and their help is required, PHC team members refer to appropriate helpers. We respect community wishes in this regard, however, ooweechiwaywin are available when individuals and families wish to have their assistance.

Traditional people in supportive work begin with helping to re-power the culture and assist elders in spiritual, social and emotional wellness. In promotive work, ooweechiwaywin help people learn about how Anishinabe lived in a healthy way in the past and then finding ways to achieve a similar healthy lifestyle in the present. In preventive work, ooweechiwaywin help people understand the value of personal, family and community hygiene as well as good parenting and healthy social interaction. In curative work, ooweechiwaywin provide medicine and counselling to people who need help. In rehabilitative work, ooweechiwaywin assist individuals, families and communities, as herbalists and as helpers, to return to a state of holistic health.

Allied Health Services

Allied health services support and supplement other PHC Team services. Our Allied Health Service is centrally organized. The Allied Health professionals provide direct service to the community with follow-up using telehealth and other communication methods. Paraprofessional staff located in communities support Allied Health Service work between visits. Members connect to other team members directly and electronically. Communities make referrals to a central location and the service delivery is planned for each community. (See Chapter 5 for more detail.)

Other PHC Team Supports

Adequate administrative and support staff ensure other team members can work full-time with their regular duties. These include trained medical translators available 24/7; clerks for major program areas for clinic scheduling and administrative support; pharmacy technicians supporting physician and primary care nurses; allied health paraprofessionals; and telehealth coordinators. In bigger communities, an office manager leads the administration support service.

Other clinical support staff is available, on call, to support the primary care service; for example trained and certified radiographic workers.

Health buildings invite community members to come together. Office and clinical environments encourage teamwork. Offices provide appropriate space for all tasks (including clinical work, confidential interviewing and counselling) along with storage of files, equipment, and other resources. Allied health services and other visiting services have the space they need. Overnight accommodation is available for visiting PHC Team members and second-level program development staff.

Helping PHC Team Relationships Flourish

It is tempting to think that change to PHC Teams will occur naturally. Experience in other jurisdiction shows this is unlikely. People are accustomed to working separately. In our Anishinabe Primary Health Care system, we emphasize good relationships.

Working together requires knowledge and skills in teamwork, time to discuss issues and resolve conflict or difference in view. It also may require doing different things, as well as the same things done slightly differently. Power and custom will change. In our system, staff turnover, particularly in nursing and mental health, poses additional challenges, as will having teams of Anishinabe and other cultures on board. By shifting to base our work on Anishinabe culture and values, we create strong teams. Health Directors have knowledge and skill in creating, leading and managing teams. Elders and health committees advise Health Directors in doing this work.

Where necessary, other coaching and team-building expertise is available within the system. When asked, coaches spend time with teams and their leaders.

Professional development resources are available for staff, and used to engage teams in on-going training. This includes Anishinabe cultural education.

Specific time and careful thought is devoted to making cross-cultural teams work within Anishinabe culture and communities.

Team members are accountable for team behaviour, including resolving differences in view and style.

Community PHC Teams meet regularly with community members, leaders, elders and health committees to discuss community health priorities, to jointly plan and solve problems, and to provide support to members. We schedule case conferencing during work-time and as needed in emergencies.

Staff are oriented and trained for responsibilities, supported by and accountable to the Health Director. Continues learning is a fundamental task of the health service and the responsibility of all staff members. Based on First Nation choices, staff may be employed by the First Nation, the Tribal Council, the Sioux Lookout First Nation Health Authority, or any organization.

Our Anishinabe Primary Health Care Service in Action

Preventing and Managing Diabetes: A Case Example

The common view of health services shows different people doing distinct jobs. Thinking about working together can be challenging. Relationships are central, in the Anishinabe way, which means creating and sustaining connections, basing our behaviour on traditional values. We want to help everyone understand the Anishinabe Health Plan. Here is an example of Anishinabe community PHC Team helping prevent and manage Type 2 Diabetes. Like any difficult health problem, diabetes prevention and management needs a strategy that involves multiple coordinated and interactive pieces.

Community members, as well as clinical and statistical evidence, pointed to the importance of preventing as well as managing diabetes. To make a plan, community elders and others agree to work with health staff to create a community action plan on diabetes prevention and management.

Elders raise awareness of how traditional ways kept people healthy. They remind everyone that eating from the store and sitting around are not traditional. They help guide planning so that all the work is consistent with Anishinabe ways and values. They play a significant role in supporting our plan as we put it into action.

The Health Committee and Health Director work with Chief and Council to gain approval for a general approach to diabetes prevention throughout the community, and have all public functions ‘diabetes-prevention-friendly’.

Working with the visiting nutritionist/dietitian, the Health Director and perhaps the public health nurse or community health educator helps the school develop a healthier approach to food and helps the day-care/pre-school change to healthy snacks.

Community development (CD) staff works with other community agencies including education, economic development, social development, the Band office and Chief and Council. They focus on increasing access to affordable healthy food and healthy daily activity.

Community volunteers and members, with support from the CD staff, establish food co-ops, work with the local store to increase food options, organize hunting and fishing trips that include younger community members, encourage vegetable gardening. Young people with time on their hands help to build and maintain walking trails, ski sites, and 'neighbourhood' skating areas. With support and involvement of Band Housing, CD staff organizes volunteers to adapt housing for disabled people.

Health promotion and health education staff (formerly CHR's and others) share responsibility for organizing healthy community activities. They work with volunteers, other community groups and organizations. Community members hold potluck feasts and all families are encouraged to bring something "diabetes-prevention-friendly". Staff and community members visiting around the community share ideas for these dishes and encourage participation.

Elders' stories on the radio and at school underline how the Anishinabe traditionally maintained their health. Diabetics who have been able to manage their condition are asked to share their stories with the community so that others can learn from their experiences on the radio, in community meetings, workshops, and at school.

The staff organizes family fun nights with the Recreation and Education staff. Walking circles – groups of five people who want to be more active and support each other – are organized. Staff offers many ideas through radio, school newsletters, workshops, and flyers at the store about "diabetes-friendly" snacks. More people have good choices available when diabetic relatives and friends come to visit.

A support group for those wanting to lose some weight and keep it off gets organizing help from the health education staff. Regular radio and school presentations and community workshops help people understand Type 2 diabetes.

Through telehealth, the health education staff gets regular advice on making effective presentations from the health promotion consultant in the second level service.[38] Community members use telehealth to increase their knowledge, participation in education events and support of group discussions with people from other communities.

On a regular basis, nurses screen clients for diabetes at wellness clinics. We refer those diagnosed with diabetes to the primary care team or to an *ooweechiwaywin* or to both, as the client prefers. Electronic records help members of the health care team track high-risk and newly-diagnosed diabetics, to provide encouragement and support. We give newly-diagnosed diabetics, regardless of who initiated the diagnosis, a thorough screening for known risk behaviours (including alcohol). We build appropriate referral into the screening process. We request elders to follow up with all newly diagnosed diabetics, to provide support and encouragement.

Primary care staff, both nurses and physicians, routinely screen known diabetics for complications. Through the visiting chiropodists and other community-trained staff, foot care is available for diabetics. As well, physiotherapists, occupational therapists, prosthetists and trained community support workers provide assistance to amputees and others physically limited by diabetes. When known diabetics have complications, primary care staff ensure careful follow-up. We maintain

[38] Second level services come from Tribal Councils and the Sioux Lookout First Nations Health Authority. These are program consulting and specialized services.

contact with outside specialists through telehealth, electronic records and through a specific protocol for diabetic follow-up. Visiting physical and occupational therapists work with amputees in their rehabilitation. Community-based paraprofessionals continue to work with clients between visits by physical and occupational therapists.

Appropriate PHC Team members hold case conferences on clients having significant challenges in managing their diabetes. These include primary care, mental health, addictions, and wellness/chronic care staff. Where appropriate, home care staff is also involved. We ask elders and other helpers including the allied health paraprofessionals to add their wisdom and experience.

Addiction workers, along with health promotion and education staff, recreation staff and volunteers, help organize healthy activities. We refer diabetics with a history of drinking routinely to addictions staff for follow-up and support.

Mental health workers follow up newly-diagnosed diabetics to see if they're open to help from an elder or a PHC Team. They help people work through the anger and depression that often come with the diagnosis. They work with a support group of diabetics who are struggling to follow healthy ways of living.

The health promotion and education staff visits women diagnosed with gestational diabetes. We help, through home visits and group education; these women increase their knowledge about Type 2 diabetes and maintain a healthy weight through their pregnancy. Breastfeeding is encouraged. Where possible, we pair these women with a volunteer who is diabetic to help both partners stick to their healthy living strategies.

Diabetics are encouraged to join the "twinners group" that meets monthly to have fun, cook a meal, and hear someone's personal story about living well with diabetes.

The PHC Team meets every four months with the Health Director, elders, and Health Committee to review the community action plans on preventing and managing diabetes. They look for successes and learning opportunities. Together they decide on any improvements. The Health Management Information System allows them to track their work, and review trends yearly. A research and evaluation specialist from the Sioux Lookout First Nations Health Authority helps the group design ways to evaluate its strategy on a regular basis. The group compares its results with the plan, and with established standards or benchmarks for similar programs.

All members of the Health Service, including Health Committee, maintain their efforts to be good role models.

Work in the Five Areas of the NAN Chief's Model

By balancing work in the five areas of the NAN Chiefs' Model, we automatically emphasize the profile of – and action in – public health, health promotion, risk and illness prevention, community development, rehabilitation, and support.

Supportive

In the supportive area, there are four main groups of activities:

- Re-powering Anishinabe ways (See above)
- Community development
- Support to community healing, and
- Home care and care of people with chronic diseases.

In all these groups of activities, staff works toward the standards or benchmarks of quality they have set for their programs, upon which they regularly reflect and evaluate. To support the desire for providing the highest quality services possible, staff is supported by on-going education, training, and management guidance.

Community Development

The Anishinabe Health Plan ensures that resources are available for community development work. Public and population, mental health and addictions — all contribute resources. Community development staff works with community agencies, volunteers, Chief and Council, committees and other groups to support community change. Examples could include getting young men to form a hunting and fishing group so that elders and people living with diabetes can have land food to eat. A group creating a youth activity program could benefit from CD workers' knowledge in community organizing. They could participate on a community committee trying to tackle addiction challenges.

To do this work, community development staff is knowledgeable in community planning and action, skilled at working with groups, come from a strong value base, and efficient with a wide variety of people. People respect their abilities as facilitators, and always build capacity in others through their work. Like others on the PHC Team, they are knowledgeable about their culture and community.

All community members and health staff, including the visiting Allied Health Service participate in community development activities to some extent. This helps the health staff focus by keeping the building of health as well as dealing with illness in plain view.

Community Healing Support

As well, resources from mental health and addictions support community-healing activities. This could mean sharing-circles; group or individual healing retreats and workshops; collaborating to gather and record community history; and promoting celebrations of healing work by people in the communities. They could support people in the initial stages of setting up self-help groups. This

staff is well-grounded in their culture, have completed significant healing work, and have necessary professional training for their work.

Home Care and Care in Chronic Disease

Another area to which we assign resources is home care and other chronic disease management services. These could include respite and palliative care in community, or assisted living or continuing care. Allied health team members provide physical therapy, occupational therapy, foot care, fitting and adjusting prostheses, for example. People involved here are qualified to provide the levels of care their jobs require. They reflect Anishinabe values in their work, and incorporate its culture into their care.

Changes in Resources

Presently most communities have some home care resources ranging from home support workers to home care nursing. In some communities, mental health and addictions staff assist with community healing activities or with self-help groups. There are, however, relatively few resources available for this work at present. No communities have any assigned community development staff employed by the health service, although many people in existing health services play a role in community development. Using extra resources, we continue and supplement this work.

Additional detail about supportive resources is in Chapter 5, Service Delivery Model.

Promotive

There are three main groups of activities in the promotive area. As explained earlier, promotion work focuses on changing conditions of living for the whole community. It is this population, or whole-community focus, which distinguishes promotive work from preventive work. In some places, people call this work “population health promotion”.

- Work with others to organize family and community supports, and healthy community activities.
- Community action on environmental health issues.

Although the staff in population and public health, mental health and addictions, is more active and visible in promotion work, there are roles here as well for staff from other areas. One important role from primary and chronic care is to identify health issues causing illness and injury. In this way, promotion work stays in tune with community needs.

In all these groups of activities, staff works toward the standards or benchmarks of quality they have set for their programs. The staff regularly reflects on the work and evaluate the programs. To support the desire for providing the highest quality services possible, staff is supported by on-going education, training, and management guidance.

Healthy Family and Community Supports and Activities

Healthy communities spend more time celebrating together than they do solving problems. There are more occasions to celebrate than there are crises to deal with.[39] Over time, our communities are able to recover from crises and move to this more balanced life. In the Anishinabe Health Plan, staff works with others to help organize healthy community activities that bring people together in celebration. These include feasts honouring school achievement – from kindergarten through to the new graduates from training and education programs outside the community. Sports days, community talent shows, family fun nights at the school, winter festivals are all examples of healthy community activities. These require hours of work to create and involve many community volunteers. Finding, supporting, and keeping volunteers is one of the primary ways health staff support these events. This work takes time, skill and knowledge and staff share the work with others, such as the school or Band office. The emphasis here is on working with – not doing for – people, to capacity building.

Healthy family and community supports are vital to community life. Communities use them in times of crisis, such as volunteer Rangers or people with skills in assisting with suicide watches. Communities also use them on an every day basis. We ask elders to help with pregnancy education for young women. Young men clear steps of snow for someone who recently had a bad fall. People grieving need quiet company. Young people listen to elders in youth leadership workshops. People with long sobriety help those who are new at walking this path. People who are able to manage their diabetes well offer help to those who are just learning how to adjust their diet and exercise.

Again, the emphasis is on mobilizing the many talents in our communities for use by more people. Some places call this work 'asset mapping' and using informal community resources. As with any work to encourage people to help out, there are times when health staff make several visits to get agreement to help from someone who is shy. It also means that promotive staff is well informed by others in the PHC Team about people who may need help.

While resources that fund work in these areas come from mental health and addictions, staff maintains close connections with all programs. Resources that flow toward this work can include some of the Brighter Futures, Building Healthy Communities funding. People who do these jobs are community health educators, and/or mental health/addictions resource workers focused on primary prevention. They are knowledgeable in community planning and organizing, able to make relationships with people easily, grounded in their culture and language, and eager to learn more about community development processes from their team-mates.

Community Action On Environmental Health

Through new positions, environmental technicians help to monitor community environmental health. They participate in making sure community water supplies are safe, sewage is properly disposed of, monitor garbage collection and disposal, and other community environmental health hazards. They are in close touch with the Environmental Health Officers (EHO's) and act as a community liaison for the EHO's. When environmental health problems need action, they work with all other agencies to ensure community the safety of communities. Because of the technical work they do, special training is part of their regular job requirements. They, like other PHC Team members, also continue to learn on the job.

[39] Mittlemark, M. 2001

Changes in Resources

Resources here combine existing resources in community health education (using CHRs in their intended roles) with new resources. Environmental health technicians are new resources as well, for nearly all communities.

Additional detail about promotive resources is in Chapter 5, Service Delivery Model.

Preventive

Work in the preventive area helps individuals avoid diseases or poor health outcomes, reduces the risks of diseases, and monitors individuals and the community environment for disease outbreaks or signs that diseases are worsening.

There are several major groups of activity in the preventive area:

- Health education and community awareness, promoting healthy lifestyles;
- School health programs;
- Environmental health monitoring and dealing with hazards and outbreaks;
- Communicable disease control;
- Mother and child health screening, education, follow-up and immunization;
- Wellness clinics and programs; and
- Allied health services risk prevention and reduction (injury prevention, nutrition, early childhood development).

In all these groups of activities, staff work toward the standards or benchmarks of quality they have set for their programs. Staff regularly reflects on the work and evaluates the programs. To support the desire for providing the highest-quality services possible, staff is supported by on-going education training, and management guidance.

Community Health Education and Awareness

Community health education and awareness brings to peoples' attention the importance of healthy behaviour in reducing risk of disease or poor health. These programs focus on encouraging healthy eating, active living, use of tobacco only as a sacred substance, maintaining a healthy weight throughout life, preventing injuries, and living without harmful influences from alcohol and drugs. Fostering healthy sexual behaviour, avoiding the risks of sexually-transmitted infections is another focus. In keeping with the traditional respect for women and children, healthy family life and parenting are promoted.

Health education use posters, community radio, classroom activities, community workshops and awareness campaigns. It provides people with information to make healthy choices. It helps create sufficient awareness that people are encouraged to make healthy choices.

Staff doing this work include community health educators as well as other staff who have contact with clients and patients. Allied health practitioners, for example, hold injury prevention, healthy

eating and dental hygiene workshops. Resources from mental health and addictions support this work. Elders, community leaders and role models are vital to demonstrating these choices as possible even when other choices are visible in the community.

Specific skills are required to do this work well, and we train staff so they work with maximum effectiveness. Using Anishinabe ways as a central part of their work, staff draws on the resources of community members to expand effectiveness. Priorities for health education mirror community health priorities. Staff are able to draw on resources from outside the community to create effective programs and campaigns.

School Health Program

The school health program falls into the public health work. It reflects a concern for the health of school-aged children and seeks to protect their health by providing a combination of screening and health education. Screening makes it possible to identify problems before they become severe. Health education in classrooms helps provide children with information to make healthy choices.

Both the public health nurse and the community health educator are active in the school health program. Allied health staff hold in-school workshops on injury prevention, dental health, good nutrition and other topics. They collaborate with school staff, parents, and others in the community to help protect children's health.

Staff work with information and tools based on best practices as well as those informed by Anishinabe culture.

Environmental Health Monitoring and Response

If diseases caused by unsafe water, bad food, or other environmental hazards occur, the community PHC Team responds in several ways. Staff with curative responsibilities may be the first to know about the diseases. They notify both the public health nurse and the environmental technician. Further work may be necessary to notify Band office staff or others responsible for community health and safety – say in the event of a major gas spill or other pollutant.

We take rapid action to identify the source of the problem, drawing on the expertise of Environmental Health Officers, Medical Officers of Health and others. We work closely with Chief and Council, Band office staff responsible for community infrastructure and others, to ensure a coordinated effort to fix problems. We call in if necessary, resources from outside the community to ensure health and full safety.

The levels of expertise required here vary widely, and mean that a flexible team needs to be available at short notice.

Communicable Disease Control

Communicable diseases are the ones that we can give to each other, usually with serious consequences for the health of many people in the community. The classic example is tuberculosis. Another group is the sexually-transmitted infections.

Members of the PHC Team providing primary care assess, diagnose, and treat the illness. Through good reporting by curative team members, we make public health systems rapidly aware of any outbreaks. Public health nurses follow up at the community level with the affected individuals. At times, other levels of service help, such as the tuberculosis program at the Sioux Lookout First Nations Health Authority.

All staff involved are qualified to respond to disease outbreaks. A health information system monitors all communities for outbreaks, as disease knows no boundaries. This essential tool allows staff in all our communities to protect our health through follow-up and rapid treatment action where needed.

Mother and Child Health

Through good mother and child health programs, we ensure the good health of the coming generation. In Anishinabe culture, there is special respect for pregnant women, as they carry the next generation. Elders provide their wisdom and support. All community members support the new developing family, helping the family members to live in the healthiest ways possible. In the initial phases of the Anishinabe Health Plan midwifery services will be available at the Meno-Ya-Win Health Centre. Dr Terry O'Driscoll is currently working on a plan to establish a midwifery service at Meno-Ya-Win.

Pregnant women receive screening, follow-up and referral through the primary health-care nurse practitioner. This nurse, along with the community physician follow them through their pregnancy. Fathers are involved in the care process, and both parents-to-be receive education from elders and PHC Team members. The public health nurse and community health educator ensure support for the parents-to-be in making healthy choices through education and information sharing.

Fathers are able to attend the birth of babies, and have this special time to form strong bonds. We support new mothers in breastfeeding, a tradition that goes very far back among countless Anishinabe traditions.

Once children are born, we screen regularly so we identify problems early. By finding small differences in development early, parents can help all children grow to their full potential. Both public health nurses and public health aides/clerks-interpreters are involved in screening work. Visiting early childhood specialists help families create healthy development plans for children with difficulties. Other visiting allied health professionals such as physiotherapists, speech language pathologists and occupational therapists may also help.

To keep children safe from communicable diseases that used to kill hundreds, public health nurses immunize children at regular times determined by best practice. The health information system keeps track of immunization records even when children move to another location.

Wellness Services

To maintain good health, even with chronic disease such as diabetes or high blood-pressure, it is important to get regular check-ups. The primary health care nurse practitioner holds regular wellness clinics and provides other wellness services. In this way, we monitor small changes, and people have time to act to maintain their health, or deal with problems before they become serious. In this work, the PHC Team draws on elders, volunteers and community health educators to support wellness programs.

In addition, adults with good health are encouraged to have regular check-ups. The schedule for check-ups is based on best practice, and support people in maintaining good health. Because of the high risk of developing diabetes among our people, we regularly screen people with diabetes.

Allied Health Service Risk Reduction and Prevention Work

Allied health services are part of the PHC Team. Professional staff visits communities regularly. There is more information on allied health services below, in the section titled Our Framework, the sub-section on Primary Health Care Teams.

Visiting allied health service team members such as nutritionists/ dieticians, early childhood development specialists, dental hygienists, dentists, or physiotherapists help us reduce the risk of poor health. They identify risks such as faulty play equipment, risks that have resulted in injuries. They work with community agencies like the school to set up healthy eating guidelines. Programs to encourage healthy child development draw on allied health professionals' expertise. Working with the community health educators, they help people review choices to reduce risk and improve health.

Changes in Resources

We now do some preventive work in communities. Funding for this work comes through Brighter Futures, Building Health Communities, National Native Alcohol and Drug Program, Healthy Babies, Canada Pre-natal Nutrition Program, and other initiatives including some mental health funding. Much of the work done with these resources is one-to-one or small group work.

Additionally, public health nurses, primary care nurses and physicians are involved in prevention work.

We need additional resources, particularly in public health nurses, environmental health technicians, primary health care nurse practitioners, public health aides, and allied health services.

Detail on preventive resources is in Chapter 5, Service Delivery Model.

Curative

Curative work is concerned with treating illnesses or conditions that harm or hamper health. It includes action in the following areas:

- Primary care emergency/urgent and non-urgent illness care;
- Mental health and addictions emergency/urgent care, crisis intervention, and non-urgent illness care;

- Chronic disease care; and
- Allied health services (e.g., dental services, hearing and vision care, speech language therapy, early childhood development).

Because our people suffer from very poor health at present, we need to make sure people have good treatment. This means strengthening primary care nursing, enhancing access, increasing physician time in communities, ensuring mental health care including crisis care, and adding supports, such as pharmacy technicians and electronic records.

Allied health services, (for example physical therapy for injuries or early childhood development) advice, need to be available in communities. We must increase treatment provisions until people become healthier. People need to feel safe in order to focus on prevention and promotion action.

In all these groups of activities, staff works toward the standards or benchmarks of quality they have set for their programs. The staff regularly reflects on the work and evaluate the programs. To support the desire for providing the highest quality services possible, staff are supported by on-going education and training, and management guidance.

Primary Care: Urgent/Emergent and Non-Urgent Illness Care

In urgent/emergent care, the goal is to provide timely professional care including assessment, diagnosis and treatment on-the-spot or stabilizing and transporting people for treatment to another facility i.e. a hospital. If several people have medical emergencies at once, primary care staff give priority to those in the most life-threatening situations. Urgent/ emergent primary care is available around the clock.

In urgent/emergent primary care, people with different types of training and knowledge are available. These include first responders, primary care nurses, ooweechiwaywin, physicians, translators, telehealth coordinators, and others.

All PHC Team members involved in primary care, are trained and qualified to do their part of the work and know Anishinabe culture. Those who come from outside are given an introduction and orientation to our culture. We assist them in their cultural learning. The combination of technical, cultural knowledge and skills enables our staff to carefully assess, diagnose, and treat people in need of care.

Primary care staff contribute to emergency response planning for the community and are involved in disaster-planning exercises.

Community people including ooweechiwaywin, elders, spiritual advisors, Chief and Council, Health Committee, respected community members and family members may also help.

In non-urgent illness care, the emphasis is on treating those who, while not facing emergencies, are ill and in need of treatment or help. These services include referral to other team members, other professionals in the community, or helpers both inside and outside the community. Other services include foot care, dispensing medications, teaching, intervention, case management, follow-up and on-call support for urgent/emergent services, assessment, stabilization, and assistance for patients and clients in varying ways.

Providers involved are primary care nurses and physicians, specialists (visiting or outside the community), allied health team members, traditional medicine people, pharmacy technicians and visiting pharmacists, laboratory staff (phlebotomist, basic radiography worker), clerk/interpreters, telehealth coordinators, and visiting technicians for cardiac care services such as monitoring pacemakers.

Providers working in these service areas maybe from within the Anishinabe culture, a licensing body, or a certification process based on a combination of training and experience.

Mental Health and Addictions Urgent/Emergent Services, Crisis Intervention, Non-Urgent Illness Care

Many communities have mental health staff that counsel clients, do prevention work and respond to crisis. Currently, Nodin provides visiting psychologists, art therapists and traditional specialists. Nodin provides crisis response teams for communities who are experiencing trauma and grief due to suicide and other tragedies, as well as clinical social workers and mental health therapists who work with clients with acute mental health needs. (Nodin/CFI completed a review in 2006 that calls for a refocusing of the agency's work on longer-term, less acute care.)

Crisis response in mental health and addictions illnesses has the same goal as primary care – to intervene and provide timely professional care, to stabilize the person situation and ensure appropriate assistance. In this service, there is also work to help women who are addicted and pregnant, as the risk to the baby's health is urgent.

A wide range of people may be involved, including members of the PHC Team. Community people, the elders, spiritual advisors, traditional medicine people, family members, respected community members and Chief and Council or Health Committee members.

PHC Team members include first responders, mental health crisis coordinators and crisis intervention workers, addiction workers including those working to prevent alcohol damage to the baby, and translators. Specialists including members of the allied health services contribute as needed. Primary care team members are involved as necessary. At times, police are involved.

Like other members of the PHC Team, staff here are qualified through a combination of formal training and certification with life and job experience. These staff members are knowledgeable in Anishinabe culture. Those who come from outside are provided with an appropriate orientation to Anishinabe culture.

In non-urgent illness care, mental health and addictions staff are available to help people before things rise to a crisis. Often, mental health or addictions issues build over time. In our Anishinabe Health Plan, we consider this a process. Help before a crisis reduces our communities' crises over time.

These non-urgent mental health and addictions staff, like those involved in crisis and urgent/emergent services, are qualified through a combination of formal education, training, life and job experience. Similar to urgent care staff, these staff members are already knowledgeable in Anishinabe culture or we provide the means for a proper orientation.

Chronic Disease Care

People with illnesses that last for a long time, sometimes for a lifetime, have chronic illnesses or diseases. Examples include diabetes and heart disease, along with a number of others. Here it is particularly important that people are responsible for managing their illness, with encouragement and support.

People who can be involved include others with similar illnesses, elders, spiritual advisors, family members and friends. *Ooweechiwaywin* also play a role, for those who follow this path.

Major activities in chronic care for the PHC Team includes: developing care plans and making referrals; teaching self-care; adapting home environments; coordinating care with home care and others; providing respite care; case management; and preventing other illness through actions like flu immunization. We include in community events people with chronic illnesses through referral by chronic care staff. These staff also work with others, including the community health educators and community development workers to organize events with chronic disease in mind.

There are many PHC Team members involved in chronic care. Case managers organize the many helpers involved, and advocate for clients. Physicians provide medical care, and primary health care nurse practitioners and others provide follow-up. Laboratory staff and clerk-interpreters play a role when needed. Pharmacists help ensure proper prescription drugs are available. Addictions or mental health staff help people adjust to their new health realities and to establish stability. Visiting members of the allied health service also help: chiropodists (foot doctor), physical or occupational therapists, psychologists, optometrists (eye doctors), and others as needed.

As with other curative service staff, those involved with chronic disease care have a range of knowledge and skill. Most have formal certification through various processes, including traditionally. Others, such as elders, use the wisdom gained from life experience.

Allied Health Services

As mentioned above, allied health services are part of the PHC Team. Professional staff visits communities regularly. Community-based paraprofessionals help with treatment as well. Between visits, follow-up and on-going contact occurs through telehealth and telephone. There is more information on allied health services below, in the section titled Our Framework, the sub-section on Primary Health Care Teams.

Dental services deal with dental disease, with a special focus on children to ensure they have a good set of permanent teeth. Both adults and children who need hearing care see audiologists. Ophthalmologists, optometrists, and opticians see to those who need vision care. Ophthalmologists routinely screen diabetics, sometimes using telehealth technology.

Physical therapy deals with functions of the skeleton and its muscles. Occupational therapy helps people adapt environments to their needs. Both these are available if needed. People with head injury or stroke damage use these services. As well, children with developmental delays and people with handicaps get the help they need from these two professionals. Trained paraprofessionals in the community help implement care plans.

Children with speech or language delays or development problems access therapy from visiting speech language pathologists. Trained communication assistants in the community support treatment work.

Often, parents and extended family identify early childhood development problems, but sometimes they're spotted by PHC Team staff such as public health nurses, physicians, or addictions workers. Education, pre-school or day-care staff may also refer children to the PHC Team for assessment and referral. Visiting early childhood development professionals work with families and others to create helpful multi-disciplinary plans. Community professionals and paraprofessionals help with parts of the plan.

In this way, we avoid future problems and children develop to their full potential. If there is evidence of problems due to the mother drinking during pregnancy, we refer the woman and her family to addictions workers and other caregivers, including *ooweechiwaywin* as appropriate. We ask elders to be involved to help stabilize the family.

People living with chronic diseases that need endorsement and support in changing their eating habits can rely on help from nutritionists/dieticians as well as other members of the PHC Team. People who can benefit from this help include diabetics, those with heart disease and other conditions.

Allied health professionals are certified and licensed in their work by their professional groups. Paraprofessionals learn from training programs and allied health professionals on the job.

Changes in Resources

At present, we use most health care resources in our communities in curative work, especially responding to repeated crises. This larger investment of resources in curative work is designed to help other staff return to their designated work. This includes Community Health Educators (CHRs), some mental health and addictions resources and staff-funded programs like Building Healthy Communities.

As well, these changes should create equitable access to curative services. Now some smaller communities do not have full-time primary care, although in many, Monday-Friday care is available.

New enhanced resources in curative services include: more primary care nurses, primary health care nurse practitioners, clerk-interpreters, pharmacists and pharmacy technicians, laboratory staff, diagnostic imaging staff, cardiac care technicians, allied health professionals and related paraprofessionals and assistants. We double physician time in communities.

One can find detailed description of curative resources in Chapter 5, Service Delivery Model.

Rehabilitative

Rehabilitative activity helps people regain the best possible level of health.

This includes:

- Chronic care rehabilitation work, and
- Addictions and mental health rehabilitation care.

In all these groups of activities, staff works toward the standards or benchmarks of quality that have been set for their programs. The staff regularly reflects on the work and evaluates the programs. To support the desire for providing the highest quality services possible, staff are supported by on-going education, training, and management guidance.

To help people with mental health and addictions rehabilitation and follow-up needs, staff provide counselling and education. These services are offered in the community, as well as being available as needed outside the community in residential rehabilitation programs.

Also, through case management — including assessment and intake for residential programs — staff ensure that people needing help get it from the most appropriate sources. We accomplish this by coordinating community resources including elders, *ooweechiwaywin*, justice, education, and child protection staff. It means we advocate for clients to ensure we meet their needs. It also means working intensively with clients' family members and close friends to support rehabilitation.

In order to bring services as close to home as possible, rehabilitative services for addictions are available on an out-patient basis in the community. Likewise, rehabilitative mental health services are available on an out-patient basis where and when needed, which means staff have the necessary knowledge and skill to provide these services.

Staff doing mental health and addiction rehabilitation have a solid grounding in their culture, or are given in-depth orientation and support for learning about Anishinabe ways. They also have appropriate formal training, relevant life experience, and are respected for their confidentiality.

People who have chronic conditions or illnesses may need intensive rehabilitation. One example is someone injured in a car, snowmobile or hunting accident. Another is a person who has had a stroke. Children born with or developing handicaps or developmental delays need rehabilitation. We meet these needs by combining visiting allied health services with paraprofessional help in the community. It is in rehabilitative work that we see the heaviest use of allied health professionals such as audiologists (hearing), physical therapists, occupational therapists, early childhood development specialists, speech language pathologists, and nutritionist/dieticians.

This work helps people adjust to their new health realities, and at times regain some functions.

Allied health professionals are certified and licensed in their work by their professional groups. Through training programs and training from allied health professionals on the job, paraprofessionals become qualified for their jobs.

A more detailed description of what allied health professionals do and how they are part of the PHC team is found in Chapter 5.

Changes in Resources

In rehabilitative work, we significantly increase/enhance resources as currently, allied health services are very limited or unavailable. Additions to the PHC Team include occupational therapists, speech language pathologists, and early childhood development specialists. (We access Audiology services for children centrally, due to the need for sound booths etc.).

One can find detailed description of rehabilitation resources in Chapter 5, Service Delivery Model.

CHAPTER 5 – Service Delivery System

Key Ideas

- Define primary health care service delivery at the community level.
- Identify staffing requirements for the delivery of these services.
- Define the major roles of providers in the system.

This chapter will identify the major service delivery components of a comprehensive primary health care system being proposed for the Sioux Lookout area. It will describe the current service delivery model and present the new Primary Health Care service delivery model being proposed in order to better meet the needs of the communities.

Existing Service Model

The current health care system has multiple service providers employed by a variety of organizations. There are community-based health care workers in addictions, mental health and child health programs, to name a few, employed directly by their First Nation. There are also program staff in these areas employed by a central agency such as SLFNHA and/or a Tribal Council.

There are Community Health nurses who are predominantly Health Canada employees with a few exceptions. There are three communities employing their own nursing staff under a Transfer Agreement and five other communities who employ nurses under a contribution agreement arrangement.

Other services are a mixture of contracted service arrangements through third-party organizations such as Meno-Ya-Win for physiotherapy, diagnostic services and other nursing station support services; McMaster University and the Independent First Nations Alliance (IFNA) for physician services; the University of Toronto and/or the Ontario Dental Association for dental services; and the non-insured health benefits (NIHB) unit from FNIH for optometry; other allied health services such as medical transportation.

In the existing model the emphasis is on the urgent/emergent care services with episodic illness and the demand for treatment consuming the majority of the health care resources. Nurses and community-based workers who should be delivering public and population health programs have become the core providers of primary care. Nurses have been cast in the role of physician replacements due to the lack of physician services at the community level.

Presently, no formal mechanisms are in place to ensure that public and population health programming is delivered. There are no mechanisms in place for workers employed by multiple employers to communicate and work with each other for the benefit of the individual patient, family and/or community. There are no formal mechanisms to ensure that First Nations have input into how

services are delivered within their communities. These issues will be discussed in more detail in the chapter on governance.

Proposed Service Delivery Model

We propose a new primary health care model for the communities of the Sioux Lookout area First Nations, shifting from the current model that is focused on acute care, to a model that will ensure services are delivered to meet the communities' needs in all five areas of action. These areas are curative, promotive, preventive, support and rehabilitative services.

Within these five areas of action, communities continue to receive urgent/emergent/acute care services, non-urgent illness care, mandatory public health programs and public and population health programs (health promotion and disease prevention).

We recognize that communities within the Sioux Lookout area are unique in terms of location and size. At the present time we propose a model framework for service delivery in communities of four distinct sizes. The rationale for this is to set minimum standards for service delivery across the range of communities within the district.

We expect that in the implementation phase each community will be assessed individually in terms of its requirement for services and resources. At the same time community specific gap analyses will be carried out.

Curative Care

Urgent/Emergent/Acute Care Services

Services provided in the curative area of action are predominantly those considered urgent and or emergent. These include a whole range of acute care services from true medical emergencies, acute episodic illnesses to mental health and addictions crisis.

The current curative component of the system is under constant stress to meet workload demands. In the current system nurses are bearing the burden of this workload. Community-based health promotion workers (CHRs) are required to support nurses in the delivery of acute care services, as a result they are cast into the roles of interpreter/translator, nurse assistant, pharmacy technician and basic radiography worker, to name a few.

Nurses also spend an inordinate amount of time carrying out non-nursing functions such as blood collection, medication preparation, dispensing and performing ECGs. These activities could be completed by properly trained support staff, thereby freeing up nursing time to better meet client needs for nursing care.

We propose in the new model that these supportive services be put into place to better meet the urgent/emergent care needs of the communities. The following two case studies will demonstrate how urgent/emergent services should be organized to meet the needs of community members.

CASE STUDY 1

A family of four from the community is involved in a multiple ski-doo /vehicle collision and the teenaged son has received multiple injuries including head trauma and a fractured leg; he is in shock. Only two members of the family were wearing helmets.

The daughter has sustained minor injuries. The parents have both sustained some major cuts and the father may have a broken wrist.

The intent of the case study is to demonstrate how a team approach is required to meet the health needs of the clients in an emergency situation. The intent is also to demonstrate the requirement for the necessary supportive services to enable nurses to provide high quality urgent/emergent care services at the community.

Table 5.1 – Case Study 1 Services Required

Services Required by the Family	*Most Appropriate Urgent/Emergent Service Helper*
Initial assessment and triage at accident scene	• On-call first responders arrive on the scene and perform initial triage
Transport to Nursing Station	• Ambulance/first response team transfers clients to nursing station
Triage and assessment	• Medical translator required to assist nurse with collecting history from clients. • Clinic receptionist/clerk required to pull client records, fields phone calls, track down next of kin, manage visitors to facility etc. • Primary care nurse triages clients and prioritizes care • Primary care nurse(s) assess and treat clients as per priority • If physician is in community he/she is called in to manage care • *Ooweechiwaywin* is called in to assist the team and offer family support and healing
Blood collection services	• Phlebotomist (lab technician) required to collect baseline blood sample on head-injury teen
X-rays to rule out fractures of the limbs	• Basic radiography worker required to x-ray teen and father to rule out and/or determine extent of fractures
Intravenous therapy	• Primary care nurse commences intravenous therapy to counteract blood loss
Suturing	• Primary care nurse with assistance of medical translator sutures lacerations sustained by other family members

Services Required by the Family	Most Appropriate Urgent/Emergent Service Helper
Pain medication administration and antibiotics for the prevention of wound infections	• Primary care nurse administers appropriate pain medications • Pharmacy technician prepares antibiotic prescription based on order from nurse/physician. • Herbalist may recommend appropriate remedy for wound healing
Telehealth consultation with physician-on-call in Sioux Lookout	• If physician is not in community primary care nurse consults with physician on call in Sioux Lookout re clients and transfer of critically injured teen
Informing family about transfer of son.	• *Ooweechiwaywin* in collaboration with the primary care nurse informs the family of action required for son. This begins process to establish connection with family for follow up response
Arrangement of medical evacuation for teenaged son	• Primary care nurse contacts air ambulance to arrange transfer • Medical translator works with nurse to inform family of action required
Referral to the allied health team for rehabilitation	• First response team required for transfer of client to airport • Occupational therapist and/or speech language pathologist for head trauma, physiotherapist for fracture recovery.

CASE STUDY 2

In the past six months, the community has experienced a youth suicide. There have been seven attempts that required PHC Team care. The most recent attempt is a 17-year-old male youth who shot himself but did not die of his wounds. He is a cousin of the young person who completed a suicide.

The intent of the case study is to show how a team approach is required to meet emergency health needs of clients. The intent is also to demonstrate the requirement for the necessary supportive services to enable mental health staff to provide high quality urgent/emergent care services at the community.

Table 5.2 – Case Study 2 Services Required

Services Required	Most Appropriate Helper
Initial assessment and triage at accident scene	• On-call first responders arrive on the scene and perform initial triage
Transport to Nursing Station	• Ambulance/first response team transfers clients to nursing station
Triage and assessment	• Medical translator required to assist nurse with collecting history from clients. • Clinic/receptionist/clerk required to pull client records, fields phone calls, track down next of kin; security staff to manage visitors to facility etc. • Primary care nurse(s) assess and treat client • If physician is in community he/she is called in to manage care
Intravenous therapy	• Primary care nurse commences intravenous therapy to counteract blood loss • If physician is not in community primary care nurse consults with physician on call in Sioux Lookout re; transfer of critically injured teen
Arrangements for emergency transport to hospital	• Clerical medical travel coordinator contacts air ambulance to arrange transfer
Informing family about transfer of youth.	• Mental health worker and/or *ooweechiwaywin* informs family of action required for youth; begins process to establish connection with family for follow-up response
Transfer youth to hospital	• First response team required for transfer of client to airport
Emergency service counselling with immediate family	• *Ooweechiwaywin* and mental health workers meet with family members to deal with immediate grief and shock
Talking circles and support to grieving friends of youth	• *Ooweechiwaywin*, elders, and mental health staff
School-based intervention to help stabilize youth and family members in school	• School guidance staff and prevention/ promotion team member
Grief support for family and friends	• Family, friends, community members, *ooweechiwaywin*, elders
Family therapy for family of youth	• Mental health worker, addiction worker, *ooweechiwaywin*, visiting psychologist (case monitoring, staff capacity building)
Follow-up services for youth, including individual and family therapy	• Mental health worker with support from visiting psychologist
Monitoring medication with youth	• Physician and/or primary care nurse in team with mental health worker
Follow-up with rehabilitation services for youth as needed	• Allied health team members as needed
Community work continues to lessen risk environment for youth suicide	• Prevention/promotion team continues to do community work to lessen risks, improve hope, help strengthen community response in healthy ways

Health Human Resource Requirements

Many of the services identified in Table 5.1 and Table 5.2 are either not available in the current system or are being provided by nurses and other personnel such as CHRs. This takes time away from these providers that should be spent on other program activities such as public and population health. They may also not be the most appropriate health care provider to deliver that specific service or type of care to the client.

The Primary Health Care Working Group identifies the major activities and/or functions that should be included in any PHC model for community based curative services. These are on-call first response, telehealth, Medevac, 24/7 tele-triage, 24/7 primary care nursing, 24/7 physician on-call, physician services in community, 24/7 medical translator/interpretation services, crisis intervention and response.

The working group identified the types and numbers of health care providers and professionals required to do these jobs, dependent on community size by population categories and this data is identified in Table 5.3.

Table 5.3 – Curative Urgent/Emergent/Acute Care Human Resource Requirements

PHC Model Component	Type of Worker	Number of Required FTEs			
		200	500	1000	2000
Curative – Urgent/Emergent/Acute Care Services	On-call First Responder		0.25	1.00	2.50
	Primary Care Nurse	1.50	2.50	4.00	8.00
	Physician	0.10	0.25	0.50	1.00
	Physician – community support*	0.15	0.40	0.75	1.50
	Medical Translator/ Interpreter**	1.00	1.50	3.00	7.00
	Crisis Coordinator***				
	Crisis Intervention Worker***				
	MH & Addictions Worker***	0.05	0.10	0.20	0.25
	Ooweechiwaywin****	0.25	1.00	1.25	2.00
	Herbalist****	0.25	0.50	0.50	1.00
	Pharmacist		0.25	0.25	0.50
	Pharmacy Technician				1.00
	Phlebotomist	0.25	0.50	1.00	1.00
	Basic Radiography Worker			0.25	0.50
	Ultrasound Technologist				
	Telehealth Coordinator				
	Technician				
	TOTAL	3.55	7.25	12.70	26.25

* *All physician services are included here (24-hour telephone back-up, hospital emergency coverage, and outpatient clinics in Sioux Lookout) although physician services will also be used to cover curative non-urgent and health promotion activities.*

** *The resources for medical translator/clerk interpreters shown here for urgent/emergent care will also be used for the non-urgent care illness care services as well. These are combined in one overall allocation within the service delivery model*

****The resources for the curative aspect of mental health and addictions are not shown here. These will be combined into one overall allocation within the service delivery model and identified in the preventive/promotive component.*

**** *The Ooweechiwaywin and herbalist resource requirements have yet to be determined therefore actual numbers of FTEs are not reflected in the plan. This will be done once the best practices are defined.*

Gap Analysis

Gap analysis is simply the process of comparing information about the current supply of human resources to the actual requirements. The analysis identifies the areas where the existing allocation and/or type of human resources present will not meet the type and number requirements in the proposed PHC model.

The gap analysis for urgent/emergent care services inclusive of nursing and physicians is found in Table 5.4.

Table 5.4 – Gap Analysis for Urgent/Emergent Care

Urgent / Emergent Care Component	Population 200			Population 500			Population 1000			Population 2000		
	E	*R*	*G*	*E*	*R*	*G*	*E*	*R*	*G*	*E*	*R*	*G*
On-call First Responder	0.00	0.00	0.00	0.00	0.25	-0.25	0.00	1.00	-1.00	0.00	2.50	-2.50
Primary Care Nurse	0.00	1.50	-1.50	2.00	2.50	-0.50	5.00	4.00	1.00	9.00	8.00	1.00
Medical Translator / Clerk Interpreter	0.00	1.00	-1.00	1.00	1.50	-0.50	1.00	3.00	-2.00	2.00	6.00	-4.00
Physician (in community)	0.05	0.10	-0.05	0.15	0.25	-0.10	0.25	0.50	-0.25	0.50	1.00	-0.50
Physician (community support)	0.15	0.15	0.00	0.40	0.40	0.00	0.75	0.75	0.00	1.50	1.50	0.00
Pharmacist	0.00	0.05	-0.05	0.00	0.10	-0.10	0.00	0.20	-0.20	0.00	0.25	-0.25
Pharmacy Technician	0.00	0.25	-0.25	0.00	1.00	-1.00	0.00	1.25	-1.25	0.00	2.00	-2.00
Phlebotomist (lab technician)	0.00	0.25	-0.25	0.00	0.50	-0.50	0.00	0.50	-0.50	0.00	1.00	-1.00
Basic Radiography Worker	0.00	0.00	0.00	0.00	0.25	-0.25	0.00	0.25	-0.25	0.00	0.50	-0.50
Ultrasound Technologist	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	-1.00
Telehealth Coordinator	0.00	0.25	-0.25	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	1.00	-1.00
Technician (ECG/Cardiac Care)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.25	-0.25	0.00	0.50	-0.50
TOTALS	0.20	3.55	-3.35	3.55	7.25	-3.70	7.00	12.70	-5.70	13.00	25.25	-12.25

E = Existing *R = Required* *G = Gap*

Non-Urgent Illness Care Services

Other services provided in the curative area of action are those that would be considered non-urgent illness care. These include a whole range of acute care services ranging from minor episodic illness care to chronic disease management services.

The current curative component of the system is presently under so much stress to meet the workload demands placed on it from the urgent/emergent and non-urgent illness care that primary health care services such as Chronic Disease Management are often neglected.

Primary care nurses are not the best provider to deliver these services. The new model proposes that chronic disease management be provided by qualified Primary Health Care Nurse Practitioners (PHC-NP). PHC-NP are very well positioned with their current scope of practice to provide a significant portion of the non-urgent illness care as well as the chronic disease management services required to meet community needs. The following case study will be used to demonstrate how non-urgent illness services should be organized to meet the needs of this individual.

CASE STUDY 3

A woman age 45 at the nursing station presents with a serious cough and fever. She is also an insulin-dependent diabetic who is also on medications to control her high blood pressure.

Table 5.5 – Case Study 3 Services Required

Services Required by the Individual	*Most Appropriate Provider*
Initial assessment in the clinic	• Primary Health Care Nurse Practitioner assess client for her episodic illness • Medical translator required to assist nurse in collecting history from clients • Clinic receptionist/clerk required to pull client records
Treatment of lower respiratory tract infection with antibiotics	• Primary Health Care Nurse Practitioner prescribes antibiotics
Chest x-ray to rule out pneumonia	• Basic radiography worker required to x-ray client
ECG examination	• ECG/Cardiac technician performs ECG • Telehealth Coordinator transmits ECG to physician for interpretation
Assigning antibiotics with appropriate instructions	• Pharmacy technician prepares antibiotic prescription based on order from PHC-NP

Services Required by the Individual	Most Appropriate Provider
Review of chronic disease medications	• PHC-NP in collaboration with physician reviews chronic medication regime and revises as appropriate • Pharmacy technician prepares new medications for chronic conditions based on change in orders from PHC-NP • New medication regime is reviewed by visiting pharmacist as part of quality assurance program
Routine laboratory work to monitor chronic conditions	• Phlebotomist (lab technician) required to collect blood sample and prepare sample for transport
Referral to home care services	• Assessment by Case Manager for monitoring of changes in medications and blood pressure checks

Health Human Resource Requirements

Many of the services identified in Table 5.5 are unavailable in the present system. Non-urgent episodic illness care is being provided by the primary care nurses. Chronic disease management services are currently unavailable in a comprehensive manner, as identified. The other supportive services are being provided by nurses and other personnel such as CHRs who are already quite overwhelmed with the demands on their time for urgent/emergent care.

The Primary Health Care Working Group identifies the major activities and/or functions that should be included in any PHC model for community based non-urgent illness care services. These are non-urgent illness care clinics, pharmacy, laboratory, diagnostic imaging, medical translation /interpretation, telehealth, cardiac care, chronic disease management and case management services.

The working group also identifies the types of health care providers and professionals needed to do these jobs and the numbers required, dependent on community size by population categories. This data is identified in Table 5.6.

Table 5.6 – Curative – Non-Urgent Illness Care Human Resource Requirements

PHC Model Component	Type of Worker	Number of Required FTEs			
		200	500	1000	2000
Curative – Non-Urgent Illness Care	PHC Nurse Practitioner	0.50	1.00	2.0	4.00
	Physician*				
	Medical Translator/Clerk Interpreter*				
	Pharmacist*				
	Pharmacy Technician*				
	Phlebotomist*				
	Basic Radiography Worker*				
	Telehealth Coordinator*				
	Technician*				
	Case Manager**				
	TOTAL	0.50	1.00	2.0	4.00

* *The resources for physicians (both in-community and community support), medical translator/clerk interpreters, pharmacists, pharmacy technicians, phlebotomist, basic radiography worker, telehealth coordinator, technician are not shown here as they have already been identified in the urgent/emergent care service component. These are combined in one overall allocation within the service delivery model*

** *The resources for the Case Manager are assumed to be connected to the Home and Community Care Program and will be identified with the supportive care service component*

Table 5.7 – Gap Analysis for Non-Urgent Illness Care

Non-urgent Illness Care Component	Population 200			Population 500			Population 1000			Population 2000		
	E	R	G	E	R	G	E	R	G	E	R	G
Primary Health Care - Nurse Practitioner	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	2.00	-2.00	0.00	4.00	-4.00
Case Manager	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTALS	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	2.00	-2.00	0.00	4.00	-4.00

E = Existing *R = Required* *G = Gap*

As nursing services are the core service within the structure of the primary health care model it is beneficial to look at nursing requirements for curative care services per community size as a stand-alone.

Table 5.8 – Curative Care Nursing Requirements

PHC Model Component	Type of Worker	Number of Required FTEs			
		200	500	1000	2000
Curative Care	Primary Care Nurse	1.50	2.50	4.00	8.00
	PHC Nurse Practitioner	0.50	1.00	2.00	4.00
	TOTAL	2.00	3.50	6.00	12.00

Supporting Assumptions for Curative Care Resource Requirements

FNIH does not have a Workload Measurement system nor does it capture complete and accurate workload data. Nurses do, however, maintain an activity log at the community level, though the accuracy of the recording is questionable. There is a general perception from nursing management that this activity is under-reported.

Workload activity data is captured manually by the nurses and reported to the Zone Nursing Office with the month-end reports. These reports are then compiled into a spreadsheet format with cumulative numbers. This information is available for the years 2001–2005. There is no activity data collected by any other health care providers at the community level.

Activity data for the Shibogama transferred communities of Kingfisher Lake, Wapekeka and Wunnumin Lake is not included. Activity datum for some of the communities now hiring their own nursing staff under a contribution agreement arrangement is also absent. These communities are Lac Seul, Eagle Lake, Wabigoon and Wabuskang. Also missing from the data are the communities of Koocheeching, Wawakapewin, Saugeen and McDowell Lake, as they do not have services at the community level.

The data for 2004 was used to provide the supporting assumptions for this document, using the determination that the 2004 data set was the most complete. As a result they would most likely provide the best estimates of service demands. This data are provided in Appendix A.

The total workload activity data reviewed for 2004 verifies the emphasis on acute care and treatment services. In 2004, nurses reported a total of 120,477 client interactions. Of these interactions many were for multiple services such as nursing assessment and treatment which may have included additional procedures such as X-ray or ECG. Prescribing and dispensing of medications could also be provided.

Treatment services were estimated at a total of 137,328 activities. This includes all client assessments for various health problems, the number of after-hour phone calls and non-emergency services. Emergency visits are recorded at 5,695 and Medevacs at 2,378 with an additional 7,566 hours in patient observation time. Nursing staff also recorded the number of procedures performed such as laboratory testing, X-ray, ECG, IV therapy and other procedures for a total of 101,338 procedures performed during client interactions.

In addition to the procedures there were 90,680 medication-related activities such as prescription, dispensing over the counter, and narcotic medications, refilling dosettes and dispensing chronic medications. Nurses also recorded their non-clinical activities such as consulting with the physician,

making referrals, taking phone calls and general activities that fall under the administration category. A complete breakdown of these nursing activities is detailed in Appendix A.

The data suggests that 9,357 immunizations were given in 2004. The FNIHIS system reports that 12,696 immunizations were given in the whole Sioux Lookout Zone in 2004. If we remove the immunizations given by the communities not included in the data then FNIHIS indicates that the total immunizations given for the communities in the data set is 10,737 which demonstrates that this activity is under-reported by 13%.

The data set also reports that 2,336 X-rays were performed but records maintained by FNIH for billing purposes indicate that a total of 3,032 X-rays were taken in 2004. This demonstrates an underreporting rate of 23%. However, two of the Shibogama communities not included in the data set have X-ray capabilities which would cause the rate to be somewhat lower. Based on these comparisons an assumption about the accuracy of the data can be made. It is estimated that there is – at a minimum – a 15% rate for under-reporting of these service activities.

The workload data provided for 2004 was extrapolated into a rudimentary workload measurement tool which is detailed in Appendix A. Appendix A indicates the total number of FTEs required to carry out the acute care services as identified in the workload activity data set.

The total workload for 2004 is estimated at 170.5 FTEs. Of this there are approximately 20.0 FTEs that could be classified as non-nursing clinical functions. This would include activities that could be carried out by trained paraprofessionals such as pharmacy technicians, phlebotomists, basic radiography workers and ECG/Cardiac technicians.

In addition there are 68.88 FTEs dedicated to administration and administrative type phone calls. If we remove the non-nursing clinical as well as the administrative functions then the total FTEs requirements for direct nursing care is 83.77.

If we account for a 15% under-reporting rate and an annual 10% increase in demand for services then the requirements for nursing FTEs for acute care service needs would be approximately 128,00 FTEs for fiscal year 2006/2007. The annual 10% increase is based on the monthly average visits provided in 2002 (10,295) and 2003 (11,591) which showed an average increase of 11.3% over those two years.

To validate these numbers, estimated by the PHCWG, as indeed the required number of resources, the nursing workload model in Appendix A was used to validate the numbers for a community of each sample size (200, 500, 1,000 and 2,000+) population. The data from the 2004 data set was extracted for one community of each type and inserted into the model. The results are shown in Appendix A.

The total workload for 2004 for a community of 200 is estimated at 2.90 FTEs. Of this there are approximately 0.33 FTEs of what could be considered non-nursing clinical functions. This would include activities that could be carried out by trained paraprofessionals. In addition there are 0.50 FTEs dedicated to administration and administrative type phone calls. If we remove these non-nursing care functions then the total FTEs nursing requirement is 2.08. The requirements as proposed by the PHCWG show the need for 1.5 nursing FTEs for the curative component of the model. Hence, the nursing numbers as identified by the PHCWG, are fairly valid assumptions on the number of nurses required to meet the urgent care needs of the communities.

The total workload for 2004 for a community of 500 is estimated at 8.55 FTEs. Of this there are approximately 1.45 FTEs that could be considered non-nursing clinical functions. This would include activities that could be carried out by trained paraprofessionals. In addition there are 3.54 FTEs dedicated to administration and administrative-related phone calls. If we remove these non-nursing care functions then the total FTEs nursing requirements is 3.56. The requirements as proposed by the PHCWG show the need for 3.0 nursing FTEs for the curative component of the model. Hence the nursing numbers as identified by the PHCWG are fairly valid assumptions on the number of nurses required to meet the urgent care needs of the communities.

The total workload for 2004 for a community of 1000 is estimated at 13.71 FTEs. Of this there are approximately 1.59 FTEs that could be considered non-nursing clinical functions. This would include activities that could be carried out by trained paraprofessionals. In addition there are 6.52 FTEs dedicated to administration and administrative-related phone calls. If we remove these non-nursing care functions then the total FTEs nursing requirements is 5.59. The requirements as proposed by the PHCWG show the need for 6.00 nursing FTEs for the curative component of the model. Hence the nursing numbers as identified by the PHCWG are fairly valid assumptions on the number of nurses required to meet the urgent care needs of the communities.

The total workload for 2004 for a community of 2,000-plus is estimated at 27.97 nursing FTEs. Of this there are approximately 3.07 FTEs that could be considered non-nursing clinical functions. This would include activities that could be carried out by trained paraprofessionals. In addition there are 12.90 FTEs dedicated to administration and administrative-related phone calls. If we remove these non-nursing care functions then the total FTEs nursing requirement is 12.00. The requirements as proposed by the PHCWG show the need for 12.00 nursing FTEs for the curative component of the model. Hence the nursing numbers as identified by the PHCWG are indeed valid assumptions on the number of nurses required to meet the urgent care needs of the communities.

If we amend the assumptions made by the PHCWG and reflect the numbers as indicated in the workload analysis the 2004 data indicates a nursing care workload as shown in Table 5.7. There is a negligible difference between both sets of numbers indicating the validity of the assumptions and data with which the numbers were determined.

Table 5.9 – Curative Care Nursing Requirements Validated

PHC Model Component	Type of Worker	Number of Required FTEs			
		200	500	1000	2000
Curative Care	Primary Care Nurse/PHC Nurse Practitioner	2.08	3.56	5.59	12.00
	TOTAL	2.08	3.56	5.59	12.00

The PHCWG proposed the use of several new paraprofessionals at the community level to deliver clinical services (that do not require the expertise of a nurse.) These paraprofessionals are pharmacy technicians, phlebotomists (laboratory technicians), basic radiography workers and ECG/Cardiac Care Technicians. The numbers for these positions are based on information obtained from the workload activity data by community size. This information is contained in Appendix A.

With the creation of Pharmacy Technicians at the community level there will be a requirement for a Pharmacist to provide supervision on quality assurance, risk management and standard-of-care issues. The model is proposing that approximately 3.7 FTEs are required across the district to provide this supervision. This is based on a monthly visit requirement of 1, 2, 4 and 5 days per month per community size of 200, 500, 1,000 and 2,000+. There will also be a requirement for these pharmacists to provide education, support and direction to nursing and medical staff.

The PHCWG identified the need for appropriately trained and skilled medical translation/ interpretation services. These staff members are required to support both the urgent/emergent and non-illness care services. In the larger communities this is deemed to be a requirement 24/7. In smaller communities the requirement decreases exponentially with a requirement for 16, 12 and 8 hours per day respectively by community size of 1,000, 500 and 200. The number of FTEs are calculated based on these requirements, and factor in vacation, sick time and other potential absences from work.

Currently the majority of communities have a telehealth coordinator. This funding is due to sunset as of March 31, 2006. The new model proposes that these positions need on-going funding.

The PHCWG also identified the need for trained First Responders at the community level. Based on the workload data for emergency and Medevac services and using a baseline of 2 hours per call for emergencies and 3 hours per call for Medevacs the First Response numbers were calculated. There was also some leeway given for the estimated under-reporting of workload activity.

The curative care services also include the provision of physician services at the community level. Currently the physician FTEs spent in community are 4.75. This provides 5 days of in-community service per month per thousand people. Physicians based in Sioux Lookout also use a further 14.25 FTEs to provide round-the-clock community support with 24-hour on-call coverage, hospital emergency and inpatient coverage, and weekday outpatient clinics.

This plan will double the number of physician days in community to 9.5 FTEs while community-support FTEs will remain the same (14.25). This plan for an increase in physician FTEs in-community is based on several need factors:

1) The overwhelming feedback from community informants in the needs assessment that in-community physician services must be increased to reduce waiting time and lack area of access;

2) The expert opinion of health directors that an approximate doubling of physician time is required to successfully address wait lists, especially for chronic care management;

3) The strong view of the physicians that current on-call, emergency room and hospital coverage cannot be maintained with fewer than the current complement of 14.25 FTEs;

4) The fact that while Sioux Lookout district has approximately the same number of physicians to population as other similar northern services, it has the highest proportion of its population in scattered remote communities accessible only by air; and

5) The growth in population of 400 to 500 per year, requiring an additional physician every two years to maintain current coverage.

Final physician numbers will not be determined until negotiations with the MOHLTC have been completed.

The model also proposes that 1.0 FTE for an ultrasound technologist be allocated to the 2,000-plus size communities. The Sioux Lookout District currently has 1.0 FTE for a travelling ultrasound technologist based in Sioux Lookout. The model is proposing to expand this service and have the technologists based in the larger communities who will act as hubs for outreach ultrasound services to surrounding communities. Data is available on the current program once it is analyzed these numbers may be adjusted.

Promotive and Preventive Care

Services provided in the preventive and promotive areas are predominantly considered as part of public and population health. These include a range of services such as environmental health, communicable disease control, maternal and child health, adult health, community development, mental health and addictions prevention and treatment. The Public Health program/service areas are not well-defined at this point in the model development and more work will be required at a later date.

The present preventive and promotive services within the current system have been sacrificed to the demands of the acute care system. Community based health promotion workers such as CHRs, mental health and addictions workers have been pulled into the delivery of acute care and crisis services. As a result they are often cast into the roles of interpreter/translator, nurse assistant, pharmacy technician, basic radiography and crisis intervention worker, just to name a few.

Nurses also spend the majority of their time delivering urgent/emergent and non-illness care. As a result public and population health programs are not being delivered. Nurses are managing to keep up with the immunization program as they make this their public health priority. Other programs such as communicable disease control programs are not managed as well. Population health programs such as school health, community health education and others are not being delivered by the nurses.

We propose in the new model that these preventive and promotive services have dedicated and protected resources to prevent seepage into acute care services. We require public and population health programs to reduce the burden of illness, ensure public safety and improve the health of the whole population.

CASE STUDY 4

To celebrate the four-year old children who will be going to kindergarten, the pre-school, school and health centre have worked together with a community committee to hold a feast and talent show in their honour. The pre-school and school is hosting the event, with cooperation from the health centre. The idea came up at the inter-agency group where the community development worker represents the health centre in creating healthy community change.

The mental health worker and elders have been working with a young men's group; they agree to help provide some traditional land food. The environmental health technician goes along to help preserve the food. A public health nurse has worked with parents to ensure immunizations are up to date, the community health educator has done an initial screening for hearing and vision and made referral to the allied health team for follow-up on two twins who may be having some problems. They were premature, and the PHC team has been working with the family for some time to help the twins catch up.

The ooweecheewaywin has been working with the family, along with the elders, community health educator, and the early childhood specialist. The health educator and the addiction worker have been making visits around the community to encourage people to come for a good, healthy, family time and celebration. They have been able to raise the issue of how the food people are bringing needs to be 'diabetes-friendly' so that even people with diabetes can eat healthy food.

We intend with the case study to demonstrate how a team approach can help in creating healthy community change. We intend also to demonstrate the requirement for the integration of preventive and promotive services at the community level.

Table 5.10 – Case Study 4 Health Supports

Health Supports Available to Children and Families	*Most Appropriate Helper*
Care before and after the birth of children	• Parents, Elders, Family, Community • Primary Health Care – Nurse Practitioner • Physician • Ooweechiwaywin
Child Health Examination and immunizations	• Public Health Nurse • Clerk Interpreter/Public Health Aide to assist with translation • Community Health Educator conducts vision/hearing screening on 4-year-olds

Health Supports Available to Children and Families	Most Appropriate Helper
Health Education child development	• Public Health Nurse • Community Health Educator • Allied Health Service team – early childhood specialist • Elders
Ensuring food availability and safety	• Elders & Young Men's Group, Mental Health Worker, Environmental Health Technician
Organize event	• Community committee of volunteers, School staff, Community Development Worker, Mental Health & Addictions Worker, Community Health Educator

Health Human Resource Requirements

The Primary Health Care Working Group identifies major activities and/or functions that should be included in any PHC model for community-based preventive and promotive services. These are mental health and addictions community development, environmental health, communicable disease control, maternal and child health, chronic disease management and health promotion.

The Primary Health Care Working Group also identifies the types of health care providers and professionals needed to do these jobs and the numbers required, dependent on community size by population categories. This data is identified in Table 5.11.

Table 5.11 – Promotive/Preventative Care Human Resource Requirements

PHC Model Component	Type of Worker	Number of Required FTEs			
		200	500	1000	2000
Promotive/Preventive Care	Primary Health Care Nurse Practitioner*				
	Physician*				
	Public Health Nurse	0.50	1.00	2.00	4.00
	Clerk Interpreter/Public Health Aide		0.50	1.00	2.00
	Community Health Educator	0.50	1.00	2.00	3.00
	Environmental Health Technician	0.25	0.50	1.00	1.00
	Mental Health & Addictions Worker**	2.00	4.00	8.00	12.00
	Community Development Worker		1.00	1.50	2.00
	Visiting Early Childhood Specialist***				
	TOTAL	3.25	8.00	15.50	25.00

* *The resources for Primary Health Care – Nurse Practitioners and Physicians are not shown here as they have already been identified in the non-urgent illness care service component. These are combined in one overall allocation within the service delivery model*

** *The Mental Health and Addictions resources for the curative, rehabilitative and supportive components are included here in the overall number of FTEs*

*** *See Rehabilitation and Support section for further details on allied health professionals.*

Table 5.12 – Gap Analysis for Preventive/Promotive Care

Preventive / Promotive Services	Population 200			Population 500			Population 1000			Population 2000		
	E	R	G	E	R	G	E	R	G	E	R	G
Primary Health Care Nurse Practitioner	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Public Health Care Nurse	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	2.00	-2.00	0.00	4.00	-4.00
Clerk Interpreter / Public Health Aide	0.00	0.00	0.00	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	2.00	-2.00
Community Health Educator	2.00	0.50	1.50	4.00	1.00	3.00	2.50	2.00	0.50	2.00	4.00	-2.00
Environmental Health Technician	0.00	0.25	-0.25	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	1.00	-1.00
Mental Health & Addictions Worker	2.00	2.00	0.00	4.00	4.00	0.00	9.00	6.00	3.00	8.00	10.00	-2.00
Community Development Worker	0.00	0.00	0.00	0.00	1.00	-1.00	0.00	1.50	-1.50	0.00	2.00	-2.00
TOTALS	4.00	3.25	0.75	8.00	8.00	0.00	11.50	13.50	-2.00	10.00	23.00	-13.00

E = Existing *R = Required* *G = Gap*

Supporting Assumptions for Preventive/Promotive Care Resource Requirements

Public Health Nursing

FNIH does not have a client information management system nor does it capture complete and accurate public health data. Due to the high demand for acute care services at the community level it is a well-supported assumption that preventive/promotive health services are delivered in a very limited capacity. As a result there is no benchmark data by which to determine the human resource requirements.

Labrador has adopted a similar service delivery model to the FNIH nursing station model with one major distinction. Treatment services/primary care is provided by expanded role nurses (Regional Nurses). Public health and health promotion programs are provided by different nurses who are hired separately as Public Health Nurses with no requirement to provide primary care services.

The Labrador model is being proposed as a best practice for the delivery of public health nursing services. It is a population-based model with 1.0 Public Health Nurse and 0.5 Clerk Interpreter/ Public Health Aide per 500 populations. Using this as a standard the number of Public Health Nurses and Aides has been determined per community size.

Primary Health Care Nurse Practitioner

The PHCWG also recognized a wide spectrum of health promotion and prevention activities that are not purely public health and fall within the realm of primary health care. Activities such as well-woman/man screening, pap smears, pre-natal and post-natal care, chronic disease management and follow-up, to name a few, are well within the scope of a Primary Health Care Nurse Practitioner. The resources for Primary Health Care Nurse Practitioners are identified in the curative care component.

New Approaches in Promotion and Prevention

In 2005, there was 33.0 FTEs of community-based mental health staff, [40] 6 of whom were officially employed by Nodin/CFI and based in the community. In addition, Nodin/CFI had 19 crisis counsellors, 2 traditional mental health specialists, 2 intake workers, 4 additional mental health clinical staff in crisis coordination and management, 6 relief crisis staff employed about .5 FTE each, a .25 FTE psychologist, .2 FTE art therapist, and .13 FTE psychiatrist. Nodin/CFI completed a review in 2006, and is beginning work on implementation plans that will take it away from an intense focus on crisis work and toward more long-term therapy with fewer clients. Staging this transition, along with an AHP orientation to broader range work for community-based staff will take time, community and political will, and considerable capacity-building.[41]

There were 29.5 community-based addictions workers, along with 13.5 FTE in FASD prevention and intervention in 2005. First Nations mental health and addictions workers spent the majority of their time dealing with crises, making referrals to treatment, and following up on treatment. Particularly in mental health, there was high turnover. High community demands, lack of support, incomplete professional training, and limited teamwork all contributed to burn-out and turnover.[42]

As well, there were 28.5 Brighter Futures Initiative workers, 22.5 Building Healthy Community workers, and 42.5 Community Health Representatives.[43] Many Community Health Representatives (CHRs) were involved in acute and crisis work, supporting nursing services not in community health education as intended. Workers for other smaller health programs such as Building Healthy Communities (BHC), Brighter Futures Initiative (BFI), or staff funded by Aboriginal Healing and Wellness Program were often not as effective as they wished to be. More effective work could occur with adjustments in program plans, more support and supervision, improved training matching skills to tasks, and a way to protect these staff from being drawn into crisis work.[44] All these programs have mandates for individual or small-group client work, as well as health promotion and community change projects; for instance, community kitchens or community healthy activities.

In the area of healthy mothers, children and early child development, some First Nations had staff in the Canada Pre-natal Nutrition Program (CPNP) funded by FNIH, or in Healthy Babies programs funded by the MOHLTC. There were 12.5 staff in CPNP, 8.5 in Healthy Babies, and one community health educator.

In the AHP, people in these positions work in different environments. Communities have the authority to combine funding in the smaller, separately funded programs, attaining program goals in flexible and creative ways. Over time, the divisions between each program's 'workers' become smaller. First Nations have the opportunity to create teams for health promotion, risk reduction and

[40] Tarrant, F. (2006)
[41] Key Knowledge interviews (2006)
[42] Primary Health Care Working Group discussions; key knowledge interviews (2005)
[43] Tarrant. F. (2006)
[44] Primary Health Care Working Group discussions (2005)

disease-prevention work. Through a combination of increased staffing in mental health and addictions, more training and professional development, increased teamwork, heightened support and supervision, and improved program planning, all prevention and promotion staff include community development, health promotion and prevention. Promotion and prevention staff work closely with health directors, health committee members, and other First Nations staff and community members.

Respecting the autonomy of individual First Nations, the AHP is flexible in the prevention and program work. It is up to individual First Nations to make program arrangements for stronger promotion and prevention programs and increased community development. Some First Nations may prefer to keep existing distinction in job descriptions and program plans, and concentrate on capacity building. Others may choose to create new amalgamated positions, blending funding from several sources and creating special teams of promotion/prevention workers. Some may identify the need for basic community health education, such as the work done now by CHRs, and see the need for separate prevention/promotion work specific to mental health and addictions risks and issues. Regardless of how it is done, First Nations representatives who planned the AHP and Chiefs who approved it were clear that greater effort, resources, and effectiveness were required in promotion and prevention.

It is also the case that within the AHP, every community has staff to help deal with crises and to stabilize communities, especially in the event of a suicide, traumatic death or event. To do so, some communities may wish to designate a "crisis worker" who can do non-urgent mental health counselling or other community prevention and promotion, when not dealing with crises. Other communities may wish to spread out the crisis work among staff, recognizing that dealing with too much crisis can lead quickly to burn-out. Others may create a formal team of community people including elders and *ooweechiwaywin*; community volunteers; trained First Responders; mental health and addictions staff; police; Council members; and clergy who can assist the community and families in crisis. As communities come to rely more on their own resources in times of crisis, greater stability can be maintained along with growing confidence in the community's coping power. This sends a powerful message about safety and security to all concerned.

AHP FTE of Community Health Educators, Environmental Health Technicians and Community Development Workers are estimates at this time. The numbers will be further refined with the development of the public health programs and services. The mental health and addictions services FTEs are estimates also, and will need further work during implementation. The community-based service needs to be a good fit with refocused Nodin/CFI work, and with transition to a more primary health care approach by all community health staff.

Community Health Education, Community Development, Mental Health and Addictions Staff

The PHCWG recognized the significant overlap in mental health and addictions' work. It is difficult, at times, to tell whether addiction is a means of coping with mental health challenges or mental health problems stem from addiction, or they feed each other. For these reasons, the mental health and addictions' work flows together in prevention and promotion and support. Mental Health and Addictions work occurs in all five areas of action: curative, preventive, promotive, supportive and rehabilitative. For the purposes of identifying the required resources, these areas are addressed in this component of the model. Further information on more core mental health and addictions services can be found in the rehabilitative and supportive section below, as well as a brief description in the curative section above.

Health education including:

- Increased workshops and community activities related to healthy families, focusing on: healthy living, active living, healthy eating, tobacco reduction, alcohol, drugs, and gambling reduction;
- Mobilized promotion efforts – get communities active and engaged;
- School-based programs for children and youth including working with education staff to incorporate health education into classroom activities and curriculum;
- Awareness of science, education, Health Fairs, STDs, at school, at music festivals, sports events, and other community activities;
- School competition essay and poster;
- Peer support and education programs for youth;
- Working with school staff on child and youth violence prevention and intervention; dealing with bullying and abuse; and
- Professional education for other community staff and leaders.

Health promotion activities including:

- More elder activities;
- More emphasis on recreational activities (e.g., Pow-wows, feasts);
- Using traditional teachings, traditional activities, spiritual ceremonies (traditional and Christian), educate children in traditional values; and
- Work on health determinants including community togetherness (cohesion).

Community development, youth development programs, economic development including activities such as:

- Elder supports and socializing activities;
- Talking circles with elders;
- Organize family and community supports for those with active mental health or addiction problems;
- Organize family and community supports for healthy socializing and interaction for addiction and mental illness prevention;
- Working with others on community activity program coordination;
- Youth activity groups including those working with others to establish recreation options;
- Work with others to increase volunteering in community, asset-mapping and better use of community assets;
- Cultural week, Family week, Youth retreats;
- Develop resource materials;
- Traditional Work Circles;
- Social gatherings, dancing, powwows, community kitchens;

- Follow-up/After care;
- Child Witness Program (family violence);
- Helping to establish Restorative Justice and victim-support programs; and
- Working with elders, community members and Band staff to increase conflict-resolution skills.

In addition, community development staff is involved in projects to ensure change in health determinants. Examples include working with Band housing and other departments to address the issues of mould in housing, which is linked to respiratory problems. These are in the list of top health concerns for communities. Another example is to work with a variety of people in the community and outside to increase access to affordable, healthy, food supplies, a key element in diabetes prevention. A third example would be to increase community safety by working with elders, volunteers, police, justice workers, schools, and others. A final example would be to create on-going volunteer groups to benefit the community. These could increase employment-related or traditional skills while building community cohesion. Groups could focus on minor housing repairs, hunting and trapping, building playgrounds or repairing community facilities. Such groups could increase the options for youth and young adults to come together in healthy and meaningful ways to improve community life.

Based on discussions with the current Mental Health Program (NODIN) the requirements for mental health and addictions can be based on the following assumptions for communities of 500 and extrapolated from there.

- 1.0 FTE is required for crisis intervention and support (75%) and case management (25%)
- 1.0 FTE is required for community awareness (35%), community activities (30%) and community healing/self-help (35%)
- 1.5 FTEs are required for outpatient treatment/follow-up/referral
- 0.5 FTEs are required for counselling and education

It is anticipated that these resources may decline over time as the results from the community development and healing services begin to improve outcomes for clients affected with mental health and addictions issues. Given experience in other jurisdictions, these changes take a decade or more to become stable and reliable.

Supportive and Rehabilitative Care

In the supportive and rehabilitative sections of our AHP, we work to strengthen our culture, traditions, and language, look after those who are home after serious illnesses or injuries help them recover, and work with those who need support services at home. Services provided in the supportive and rehabilitative areas of action are predominantly for clients with mental health, addictions and chronic diseases. These services range from community development and healing, home care, palliative care, respite care, continuing care, residential care, long-term care, physical therapy and other allied health services.

Some parts of the supportive and rehabilitative programs service and areas are not well defined at this point in the model development more work will be required in this area at a later date. We can see an example of how this part of the health service works.

CASE STUDY 5

A man in his late fifties has recently had part of his leg amputated. He was diagnosed with diabetes a long time ago. Due to his depression, drinking and denial, he did not look after himself. After his surgery, he moved into his parents' house. Both elders are receiving home care, with the nurse visiting from time to time and homemakers coming each week. He has decided that he wants to stop drinking and turn his life around.

We intend with the case study to demonstrate how a team approach can help in rehabilitative and supportive areas. We intend also to demonstrate the requirement for the integration of preventive and promotive services at the community level.

Table 5.13 – Case Study 5 Health Supports

Health Supports Available to a Family	Most Appropriate Helper
Regular dressing changes, checking on medications	• Home care nurse; primary care nurse
On-going health assessment for elders and son	• *Ooweechiwaywin* • Elders and family • Mental health/addictions worker
Homemaking and household help	• Home care staff • Family • Youth-elder support alliance in community, organized by CD worker & mental health/addictions staff
Help with adapting to long-term use of crutches; dealing with amputation's impact on daily living	• Visiting allied health team physiotherapist and occupational therapist
Measurement and fitting of a prosthesis	• Visiting prosthetist from the allied health team
Health education – nutrition	• Visiting allied health dietitian with local home care staff and community educator
Support with depression and addiction	• Assessment and treatment plan by visiting psychologist, link with local support group by community mental health worker, follow-up by Elders & Ooweechiwaywin, mental health and/or addiction worker

Health Human Resource Requirements

The Primary Health Care Working Group identifies the major activities and/or functions that should be included in any PHC model for community-based rehabilitative and supportive services. Services in the supportive and rehabilitative areas are predominantly those that would be delivered to clients with mental health, addictions and chronic diseases.

Additionally, in the supportive area we work to strengthen culture, language, Anishinabe ways, and community togetherness or cohesion. Social support is an important health determinant. We work on changing determinants of health other than health services. One of the core services in supportive work is community development including asset-mapping, encouraging community volunteering and participation, acting on health determinants, increasing community-ability to sustain purposeful change, and strengthening culture and traditions.

The Primary Health Care Working Group also identifies the types of health care providers and professionals required to do these jobs, and the numbers dependent on community size by population categories. This data is identified in Table 5.14.

Table 5.14 – Rehabilitative/ Supportive Care Human Resource Requirements

PHC Model Component	Type of Worker	Number of Required FTEs			
		200	500	1000	2000
Rehabilitative/ Supportive Care	Primary Health Care Nurses*				
	Nurse Practitioner*				
	Physician*				
	Public Health Nurse*				
	Mental Health & Addictions Worker**	0.25	1.00	1.00	1.50
	Community Development Worker*	0.25	0.50	1.00	2.00
	Community Development Worker**	0.50	1.00	2.00	4.00
	Case Manager	0.50	0.50	1.00	2.00
	Home Care Nurse		0.50	1.00	2.00
	Home Support Worker				
	Personal Care Worker				
	Rehabilitation Therapy Aide				
	Allied Health Professionals***				
	TOTAL	1.50	3.50	6.00	11.50

* *The resources for Primary Care Nurses, Nurse Practitioners, Public Health Nurses and Physicians are not shown here as they have already been identified in the non-urgent illness care service component. These are combined in one over-all allocation within the service delivery model*

** *The Mental Health and Addictions and Community Development resources have already been identified in the preventive/Promotive service component. These are combined in one over-all allocation within the service delivery model*

*** Allied Health & Dental Professional resources are allocated on a district-wide basis and are shown separately in Table 5.15 & Table 5.16.

Table 5.15 – Allied Health Team Human Resource Requirements

PHC Model Component	Type of Worker	FTE's
Allied Health Team	Chiropodist/Podiatrist*	1.00
	Dietitian	4.00
	Occupational Therapist	3.00
	Physiotherapist	6.00
	Rehabilitation Aide	2.00
	Orthotist	1.00
	Respiratory Therapist	0.50
	Speech Language Pathologist	2.00
	TOTAL	19.50

Table 5.16 – Dental Team Human Resource Requirements

PHC Model Component	Type of Worker	FTE's
Dental Health Team	Dentist	10.0
	Dental Hygienist	10.0
	Dental Health Educator	6.0
	Dental Assistant	2.0
	Denturist	1.0
	TOTAL	29.0

Table 5.17 – Gap Analysis for Rehabilitative/ Supportive Care

Rehabilitative / Supportive Services	Population 200			Population 500			Population 1000			Population 2000		
	E	*R*	*G*	*E*	*R*	*G*	*E*	*R*	*G*	*E*	*R*	*G*
Case Manager	0.00	0.25	-0.25	0.00	1.00	-1.00	0.00	1.00	-1.00	0.00	1.50	-1.50
Home Care Nurse	0.00	0.25	-0.25	1.00	0.50	0.50	1.00	1.00	0.00	1.00	2.00	-1.00
Home Support Worker	1.00	0.50	0.50	2.00	1.00	1.00	4.00	2.00	2.00	0.00	4.00	-4.00
Personal Care Worker	0.00	0.50	-0.50	0.00	0.50	-0.50	2.00	1.00	1.00	0.00	2.00	-2.00
Rehabilitation Therapy Aide	0.00	0.25	-0.25	0.00	0.50	-0.50	0.00	1.00	-1.00	0.00	2.00	-2.00
TOTALS	1.00	1.75	-0.75	3.00	3.50	-0.50	7.00	6.00	1.00	1.00	11.50	-10.50

E = Existing *R = Required* *G = Gap*

The existing home care program at the community level is not well-developed nor is there consistent application of program funds to designated services and/or related providers. For example, some communities with a population of 500 have a full-time home-care nurse identified in their current staffing while communities larger than 1000 have no home-care nursing staff. As a result the Gap Analysis does not give a consistent picture across all communities.

Table 5.18, below, shows the gap between the staffing for allied health and dental professionals that exists now and what is required based on the best evidence available.

Table 5.18 – Gap Analysis for Allied Health & Dental Team

Allied Health / Dental Care Component	FTE Requirements		
	E	R	G
Chiropodist/Podiatrist*	0.40	1.00	-0.60
Dietician	0.00	4.00	-4.00
Occupational Therapist	0.00	3.00	-3.00
Physiotherapist	0.00	6.00	-6.00
Rehabilitation Aide	0.00	2.00	-2.00
Orthotist	1.00	1.00	0.00
Respiratory Therapist	0.00	0.50	-0.50
Speech Language Pathologist	0.00	2.00	-2.00
Dentist	4.75	10.0	-5.25
Dental Hygienist	1.60	10.0	-8.40
Dental Health Educator	1.00	6.0	-5.00
Dental Assistant	2.00	2.0	0.00
Denturist	0.00	1.0	-1.0
TOTALS	**10.75**	**48.50**	**-37.75**

E = Existing *R = Required* *G = Gap*

Supporting Assumptions for Rehabilitative/Supportive Care Resource Requirements

Mental Health and Addictions Work

The Primary Health Care Working Group identifies the following as rehabilitation and curative responsibilities in mental health and addictions. In the rehabilitation area it is important to distinguish between mental health and addiction work in smaller to larger communities. These two types of staff have different areas of expertise and action. The list below therefore applies equally to the mental health staff and to addictions staff.

Core services and responsibilities in mental health and in addictions work:

- Assessment, diagnosis and treatment planning for children, youth, adults, elders, families;
- Out-patient addiction treatment services including addicted persons, family members;
- Individual and family counselling;

- Family and individual healing treatment programs in the community (e.g., mobile community addictions treatment; family violence treatment);
- Family violence treatment including coordinating treatment of sexual/emotional/physical abuse victims;
- Client and family intervention;
- Follow-up support and services for those completing in-patient addiction treatment, or in-patient mental health treatment;
- Medication supervision and monitoring, where required;
- Family support;
- Identifying patient/client supports and linking clients and supports;
- Community harm-reduction strategies, activities and programs;
- Healing circles, workshops, peer group work and support;
- Working with pregnant & addicted people as appropriate to level of support, ensure access to spiritual options, translating (culture, language, context);
- Family and community conflict resolution;
- Referrals to other resources including residential addiction treatment; and
- Case management with other PHC Team members & outside resources.

Home and Community Care

There would also be services to address the on-going needs of elders and the disabled as well as the short-term care needs of otherwise well community members. These include a range of services such as case management, home nursing, home support and personal care, palliative care, respite care, continuing care, residential care, long term care and physical therapy services.

Some of these services are funded in many of our communities. However further development of the services is required to meet the continuing care and long-term care needs of the communities.

Allied Health Services

Allied health services comprise most of the visiting supportive and rehabilitation service in our communities. Allied health professionals are those who are trained in a science related to primary care, who share the responsibility for the delivery of health care or related services, including services relating to the identification, evaluation, treatment and prevention of diseases and disorders, dietary and nutrition services, health promotion services, or health systems-management services.

Allied health professionals partner with health care colleagues to promote, maintain and improve health, increase motivation and support lifestyle changes providing effective, integrated treatments that meet the needs of patients. This team approach allows for the provision of modern therapeutic interventions which are underpinned by research and evaluation; all with the same goal: to enable a return to independence.

Allied health professionals also work with all groups of patients to help individuals maintain or regain independence and function following a crisis, accident or hospital stay. They work in the community across primary and secondary care and help provide services that keep people in their own homes, helping people to manage long-term disabling conditions.

The allied health professions include physiotherapists, occupational therapists, respiratory therapists, speech and language therapists, audiologists, chiropodists/podiatrists and dieticians to name a few. Allied health services are preventive, supportive, and rehabilitative. They also supplement other Primary Health Care services.

For example, the man with the new prosthesis in the case example above may need to have assistance from a physiotherapist to learn to walk with crutches, or an occupational therapist to adjust his home and furniture to allow for movement and avoid falls. He may be able to get a prosthesis or false leg. He might also find that he can't get his prosthesis adjusted correctly and need help from an occupational therapist.

Similarly, the people in the snowmobiling case example (in the curative section) may need physical therapy to strengthen muscles and stretch the ligaments for mobility after the fractures have healed. The boy with the head trauma could have speech and motor difficulties, depending on the extent and location of the trauma. He may need the services of the physical therapist, the speech language pathologist, or occupational therapist. If the boy has permanent disabilities, he may need the assistance of the occupational therapist for special equipment and adjustment of his home environment. The occupational therapist could also help the parents and family members learn to assist the boy with equipment and daily activities.

People with stroke, cancer and heart disease can require access to respiratory therapists, occupational therapists and speech language pathologists. Children or adults with asthma or other respiratory problems may require a respiratory therapist.

Due to the lack of current Allied Health services, as well as, the poor availability of morbidity and mortality data projections for Allied Health Service needs are based on a population service model. Our model for allied health services is an outreach model adapted from the Curry model, a successful model used in small, remote communities in Australia.[45] In this model, there are close professional working relationships between doctors and other members of the Primary Health Care Team. Where it has been used, the outreach model has greatly improved recruitment and retention rates for allied health professionals.[46]

The Australian Physiotherapy Association has supported the Curry Model which suggests that there must be a minimum of monthly visits from a physiotherapist to all remote communities with a population of >100. The model also suggests minimum lengths of stay per visit based on community size which are: 1 day visit for communities of 100-300 population; 2 days visit for 300-800; and, 3 day visit for 800-2,000. The model recommends that for each day on-site an equivalent amount of time be allocated for non-clinical service activity such as travel, report writing, equipment ordering, meetings, health education planning, communications etc. In a similar project that looked at benchmarks for allied health services there was recognition that each FTE comprises clinical services, management, teaching, and training and research.

[45] Battye, (2003)
[46] ibid

Population data for the Sioux Lookout area indicates there are 9 communities with populations in the 100-300 range, 11 communities at 300-800 and 10 communities in the 800-2,000 population range. In applying the Curry model of days per month of service per community size and the equivalent time in non-clinical services there is a requirement for 5.6 FTE for physiotherapy. Given that community based service delivery requires a minimum of 5.6 therapists and the additional requirement for some services to be provided at Sioux Lookout the overall requirement is estimated at 6.00 FTE for physiotherapy.

The determination of Occupational Therapy number is much more difficult. There is no outreach model from which service estimates can be determined. However, the Community Care Access Centre (CCAC) for the area employs 5.0 FTE for Occupational Therapy Services. This is the volume required for a caseload of 1,600-1,650 clients. Injury data from the Institute of Clinical Evaluative Sciences (ICES) suggest that 1 in 4 emergency visits in Ontario is injury related. For the Sioux Lookout area in 2004/2005 there were 8,004 emergency room separations suggestive of approximately 2,000 cases that may require rehabilitative services due to injury. Based on this caseload the estimate of 3.0 FTE for Occupational Therapy is a reasonable assumption.

The CCAC also provides Speech Language Pathology services to their population base in the area. The population benchmark for Speech Language Pathology is 1.0 FTE per 14,500 population. Given the First Nations population for the area estimated at 20,000+ and the documented high needs issues with regards to speech and language development in Children the estimate of 2.00 FTE's for speech language pathology is a reasonable assumption.

The high rates of diabetes and its resulting complications are well documented for the Sioux Lookout area. The need for nutrition education, foot care and prosthetic devices is great. Key informants suggest that approximately 3,800 children require nutrition counselling services. The Regional Health Survey suggests that the overall diabetes rate in First Nations is 19.7% indicating that approximately 4,000+ diabetics would also require nutrition counselling and dietetic services. These same diabetic clients would also require chiropody/podiatry and orthotic services. If we assume that each community of 100 population or more receives nutrition services at the community level then 4.00 FTE's would provide 6 days per year of service to communities of 100-300, 15 days per year for 300-800 and 30 days per year for 800-2,000 population. (This is based on the same assumptions in the Curry Model for physiotherapy). Given the high rates of complications for diabetics the assumption of 1.0 FTE each for chiropody/podiatry and orthotics is reasonable.

The service of a Respiratory Therapist is required for clients who receive home oxygen therapy and there is also a need for staff education related to delivering this therapy at the community level. This service maybe available from the vendor who provides home oxygen therapy and the model proposes contracting this service to the maximum of 0.5 FTE's.

Dental Health Services

Information from key knowledge informants and previous research indicates that the oral health needs of the area far outweigh the current resources allocated to dental health services. The current model provides for primarily dental treatment services with limited services for routine preventative oral health care. The current dental contract provides for 3.0 dentist FTEs and the equivalent of an additional 1.75 FTE's for locum dentists. In addition to dentists the dental health team comprises 1.6 FTE's for dental hygiene services, 2.0 FTEs for Dental Assistants and 1.0 FTE for Dental Health Education.

At the present time there are approximately 350 preschool children awaiting dental surgery requiring a general anaesthetic and estimates are that an additional 350 children born over the past year will be added to that list within the next 2-3 years. In 2002-2004 in excess of 2500 clients required transfer to Sioux Lookout or elsewhere for dental services and oral surgery. Key informants also suggested that at any given time in excess of 1500 school age children require extensive dental care. This does not account for any routine oral health care such as bi-annual examinations and cleanings.

Assuming that each person (population of 20,000) receives one annual oral health examination/ cleaning (1.0 hour) per year this would require a minimum of 10.0 FTEs for Dental Hygiene and 2.5 FTE's for Dentists. Assuming a birth rate of 450-500 per year there would be a total of 2,500 children under age 5 at any given time. This is the time when good dental health has the most effect and for this reason Dental Health Educators are required. Assuming each educator can have a target population of 400-450 then 6.0 FTE's are required. Currently dentists are also responsible for providing dentures. In everyday practice this is not a dentists responsibility and the expertise for this rests with Denturists. As this is a standard of care for other Ontarians then so it should be for the communities of the Sioux Lookout area. To meet these needs 1.0 FTE for a Denturist is recommended.

Dentists provide a wide range of services from the routine preventative oral health exams to routine dental treatment and at the opposite end of the spectrum dental surgery. Based on previous assumptions 2.5 FTE's would be the minimum required to meet a target of one preventative examination per person per year. In addition to this the Dental Surgery needs are estimated to require 1.0 FTE assuming 400 procedures per year. The 2,500 urgent dental treatments per year will require an additional 2.5 FTE's. This accounts for 6.0 FTE's for dental services which does not take into account the routine dental treatment required at the community level on an ongoing basis. Using the Curry model once again and assuming days of service per community size at 6 days per year of service to communities of 100-300, 15 days per year for 300-800 and 30 days per year for 800-2,000 population, then an additional 4.0 FTE's are required to meet a minimum standard for dental care services. Dental Services in total are estimated to require a minimum of 10.0 FTE's for dentists.

Conclusion

This chapter attempted to identify the major service delivery components of a comprehensive primary health care system being proposed for the Sioux Lookout area. It gave a brief description of the current service delivery model and presented in more detail the new Primary Health Care service delivery model that is being proposed to better meet the needs of the communities.

There are some limitations to the chapter that should be noted at this time, and they are as follows:

- Final Physician numbers will be determined through the negotiations process with the MOHLTC for a new Physician Contract;
- More detailed work is required on the rehabilitative/supportive service components as they relate to home care and continuing care;
- The number of FTEs required to meet service delivery needs are at best solid assumptions based upon the limited data currently available;

- The required number of FTEs will change as more information becomes available and implementation plans for specific program areas are developed (i.e. nursing, home care); and
- The best practices and subsequent resource requirements for the use of herbalists and *ooweechiwaywin* have yet to be defined.

CHAPTER 6 – Human Resource Management

Key Ideas

- The shortage of health care professionals will make recruitment and retention extremely challenging for First Nations employers
- First Nations will be at a disadvantage when recruiting health care providers if they are unable to offer competitive compensation packages.
- Community-based health care personnel must have the capacity to carry out their responsibilities at the level of skill and competence required for their respective positions.

This chapter will identify the major human resource management services that are required to support the primary health care system being proposed for the Sioux Lookout area.

Recruitment and Retention

Recruitment initiatives identified in this chapter will apply primarily to outside health professionals such as nurses, physicians and other allied health service providers. Retention initiatives will apply to all healthcare providers working within the Anishinabe Health System.

The feedback from the Primary Health Care Working Group, other key stakeholders and informants is that recruitment and retention should be a centralized service carried out by one agency to support all communities. This will avoid issues such as competition for nurses, variations in compensation packages and the burden on the community to recruit its own nurses. It will provide more support and flexibility for relief staffing. Recruitment of local community-based employees will still occur at the community level. However, support in the assessment and selection processes for these employees may be provided by the central agency to that community upon request.

The research literature identifies four recruitment and retention best practice strategies for nursing that can be applied to the Anishinabe Health System. They are education, job satisfaction, service delivery and policy.[47] Employees need the availability of on-site educational opportunities that are funded by the employer. The education programs need to be targeted at the learning needs of the employees in their respective jobs. The program should also include introducing high school students to health careers and have targeted recruitment in to the health professions for Anishinabe students.

The literature also recommends the development and implementation of recognition programs. This will be described in more detail under competitive compensation. Setting standards for recruitment, employment and retention of workers as well as the development of employer certification programs is also related to improved recruitment and retention. Using service delivery mechanisms such as

[47] www.etxahec.org

Telehealth, involving family members in care delivery and developing volunteer programs and services have been determined to improve recruitment and retention in the health care sector. Organizational policies that support professional development, particularly for unskilled health care providers, are also considered effective recruitment and retention strategies.

Shortages of health care providers are more likely to affect rural and remote communities than their urban counterparts. One approach to addressing this issue is the "home grown" strategy whereby Anishinabe communities are proactive in recruiting young people into health careers. A second strategy is career laddering, whereby existing community-based workers are provided with educational/developmental opportunities to expand their skill and knowledge base in the health care sector. As these workers develop over time they are better prepared to take on higher level positions and may even want to seek further education such as nursing, pharmacy etc.

A third strategy involves addressing the issue of the right provider delivering the right service. In the current system nurses are providing many non-nursing services such as laboratory, x-ray and medication-dispensing, to name a few. This approach would identify the services that are traditionally provided by nurses that can be provided by other personnel such pharmacy technicians, phlebotomists (laboratory) and basic radiography workers. Community-based personnel can be trained to provide these services thereby creating a group of ancillary health care providers to support the services delivered by professional nurses, physicians and other allied health providers. This will allow professionals to focus on delivering more advanced care. The application of this strategy is described in Chapter 5 on service delivery.

This is a sampling of the recruitment and retention initiatives that can be developed to support the implementation of the Anishinabe Health Plan. A centralized recruitment and retention service that endorses the initiatives outlined will be essential to ensuring the successful implementation of the Anishinabe Health System.

Competitive Compensation and Wage Parity

At the District Chiefs Meeting in February 2006 the leadership directed SLFNHA to ensure that a competitive and equitable pay and benefits package was developed for all employees. This would include existing First Nations employees, new community-based employees as well as those hired from existing service agencies such as Health Canada.

A key component in implementing the new Primary Health Care system will be the development of a competitive compensation framework to support the recruitment and retention of health staff. The literature on compensation is focused on several core areas: pay synchronization, pay for performance, the use of incentives or reward strategies, and the use of benefit packages.

Pfau & Kay (2002) propose that the practice of synchronizing pay has a positive impact on employees. It puts employees on equal footing, with each contributing to the organization and sharing the risk. Synchronized pay allows the organization to reward all employees, not just the management team. Another benefit is the positive impact on employee morale. The flat pay structure is considered to be supportive to organizations in that it facilitates the recruitment and retention of high-performing employees and it aids in the elimination of wide variances in compensation mechanisms.

Pfau & Kay (2002) also indicate there are rules which must be applied when setting up a synchronized pay structure. These rules stipulate that all employees should receive a salary plus annual and long-term incentives. Secondly, they indicate that special executive perks must be eliminated. Thirdly, the rules indicate that all employees should be held accountable for the same performance measures and everyone including the CEO should be evaluated on their performance.

Santone, Sigler & Britt (1993) indicate that compensation needs to be linked to performance in order for it to work properly and reward employees. Santone et al (1993) also suggest that managing performance through compensation supports overall organizational performance. Howard & Dougherty (2004) indicate that pay for performance strategies are thought to improve productivity as they motivate employees to put more effort into the job.

Howard & Dougherty (2004) identify five different types of reward strategies that can be linked to competitive compensation. These strategies are individual output, group output, human capital, position and market reward. Workers who are usually more in control of their work will be more satisfied with individual rewards as opposed to group rewards. Singh (2002) describes how Southwest Airlines uses a combination of base pay, benefits, incentives and recognition as the make-up of their competitive compensation model. The authors propose Southwest Airlines as a best practice model in that it exemplifies the five core principles that increase the effectiveness of reward strategies.

The first of these strategies is ensuring that the organization connects its rewards to what is most important for it to achieve. Secondly, leadership must be committed to the reward system as it is developed and delivered by the organization. The rewards themselves must have meaning and value for the employees and must be supported within the organizational culture. Finally there must be an on-going process to monitor and evaluate their effectiveness.

The fourth core area for discussion is the use of benefit packages as a compensation mechanism. The literature describes a wide variety of items that are considered within the realm of benefits. They include but are not limited to items such as flex-time, telecommuting and subsidized day-care, which are considered work-life benefits.[48] The traditional benefits are considered the various health-related benefits such as medical, dental and life insurance plans.[49] The literature also includes retirement plans and paid vacation as part of an employee benefits package.[50]

Pfau & Kay (2002) propose that benefits should not be treated as fringe, as they can have a positive impact on organizations if well-planned and administered. Benefit packages can be beneficial but will not improve performance if no one knows how beneficial they are or if they are not linked to the organizational culture.[51] They feel that benefit packages need to be front and centre when recruiting new employees and they need to be kept there to remind employees what they have. It is felt that this will in turn improve recruitment and retention and, ultimately, organizational performance. Employees need to understand the value of their benefit package and this means knowing what is actually included in the package and how much it is costing the organization. This only happens if employers make sure this information is communicated to employees and potential employees.

[48] Anonymous, 2000
[49] McNally, 1992
[50] Ibid
[51] Pfau & Kay, 2002

Benefit packages must also be designed so that they are attractive to potential recruits as well as existing employees. Pfau & Kay (2002) say that packages need to be flexible enough to be cross–generational, attracting generation X and millennial recruits while retaining existing baby boomers (Pfau & Kay, 2002). These same authors suggest that the benefit package can do this by having two ingredients which they call the "must-haves" and the "success differentiators".[52]

The must-haves include medical benefits and a retirement plan that organizations need in order to recruit and retain good employees. Success differentiators are those types of incentives that are often unique to a certain group of employees and strategically linked to a certain aspect of the organization's strategic plan. An example of this may be subsidized education in an organization that comprises a high percentage of young adult workers who want to further their education and their career.

Based upon the review of the literature it is evident that a competitive compensation framework would include some formulation of the four core elements/themes that were identified. According to Singh (2002) Southwest Airlines has a compensation system that has four elements which are: base pay, benefits, incentives and a recognition program. Singh (2002) does suggest that the use of a strategic recognition program to reward employee behaviour can negate the need for a variable pay program. In the not-for-profit sector this would be an appropriate substitution for a pay for performance component in a strategic compensation model.

Given the findings in the literature on the key components of strategic compensation and their adaptation to the not-for-profit sector, a strategic compensation framework as shown in Figure 1 is being proposed for the new primary health care system. The framework consists of the three key components of base pay, incentives and benefits. These are well supported in the literature as key components of any strategic compensation model.

Considering the fact that pay for performance in its intended form in the literature would be difficult to implement in this type of organization it is not included in the framework. In its place employee recognition as per the Southwest Airlines model is added to the framework. According to Singh (2002), these types of programs are very useful in encouraging employee behaviours that align with corporate goals and overall organizational strategy. The four components of base pay, incentives, benefits and employee recognition are combined to form the framework that can be used to develop a competitive compensation model.

Figure 6.1 – Competitive Compensation Framework

Using the framework in Figure 6.1 as a tool to guide the development of the compensation model will enable the process to stay focused, to report on achievements to date, to prepare for the next set of activities and to ensure that none of the key components are missed. Using an analytical framework

[52] Ibid, p.156

to guide the process will not only be helpful in the areas previously mentioned but it will also help the central organization identify any barriers and limitations they may face in the area of staff compensation.

One of the first issues to be faced is determining an appropriate base pay structure for the primary health care program. The new health care system is currently a mixture of a unionized and non-unionized workforce that will be working in a non-union work environment. The current pay structure is determined on an individual basis by each First Nation community, Tribal Council or other organization. Some communities/organizations offer their employees benefit packages and some do not. The pay is not equivalent for similar positions across communities and often not equivalent within the same community/employer.

Staff with relevant education and experience may begin at the same pay rate as those who have no experience in the health care system. There is currently no mechanism to facilitate proper compensation of staff with applicable knowledge and experience. Without the restriction of a union agreement this is one element that can easily be incorporated into the new pay structure.

The current pay rates and grids where they exist can be a supportive tool for developing the new base pay rates for these employees. Any current pay structures within the organization can be used as a guide to developing the new base pay component. As First Nations will be interested in retaining both their current employees as well as existing employees in other organizations (FNIH for example) it would be wise to establish a base pay rate that is not significantly different from the current one so that these employees are more likely to either remain with the organization or move willingly over to the new employer. Powills (1988) indicates that while remuneration is usually not an important factor in retention it is critical in recruitment.

Ochsner (1995) indicates that an organization must be cognizant of two things when looking at altering employee compensation. These two issues are: ensuring the new pay plan is designed and implemented appropriately.[53] Even though some health care providers are not current employees of First Nations and technically the pay plan is a new one for the organization, Ochsner's advice would be well taken in this situation as the employees may be strongly affected by their change in pay if they choose to seek employment with First Nations.

In the literature, incentives are most often ascribed to stock options, profit-sharing, stock purchase plans, bonuses, merit pay and stock dividend payouts, to name a few.[54] The majority of these are not applicable in the not-for-profit sector. A First Nation Home and Community Care Program has developed different incentives that can be applied in the not-for-profit sector.[55] The Cross Lake First Nations Home and Community Care Program has developed a recruitment and retention incentive package for nursing staff which includes an annual retention bonus, allowances for nurses who complete additional specialty and/or post-basic nursing education programs, as well as reimbursement for tuition costs associated with completing these courses (2001). When developing the incentive component of the competitive compensation model it would be useful for First Nations to review this model and others perhaps already in use in similar environments.

When establishing a benefit package, there are numerous options available to organizations. The literature is expansive on the types of benefits available to attract and retain employees. As we learned from the literature, benefits tend to be separated into two distinct categories, which are the

[53] Ochsner, 1995
[54] McNally, 1992, Santone et al, 1993 & Singh, 2002
[55] Cross Lake Band of Indians, 2001

work-life and the traditional types. Work-life benefits are fast becoming a strategic component for their ability to attract new employees.[56]

Benefits can be offered to employees in one of three ways: a no-employee cost, a shared employee-employer cost, or at a 100% employee cost. Federal employees such as nurses currently receive benefits that are a mixture of no-cost and shared-cost for a total package that is worth approximately 22% of the base salary cost per employee. SLFNHA currently offers its existing employees a shared cost benefit package that amounts to 13.4% of base salary cost per employee. A thorough comparative analysis will need to be conducted on both benefit packages to identify the strengths and weaknesses of each. This can be used as a basis upon which to build the new benefit package. First Nations will also need to consider that the new benefit package will also need to be made available to current employees.

The final component of the proposed strategic compensation framework is that of employee recognition. With the exception of the Southwest Airlines model the literature does not give much attention to this aspect of strategic compensation. Both FNIH and SLFNHA currently endorse the concept of using employee recognition programs as a retention mechanism. They each have a committee comprised of both staff and management that oversees the program and is tasked with identifying staff who deserve recognition for their contributions. These current programs should be evaluated for their effectiveness. The one deemed to be effective by the employees could then be expanded to include other First Nation employers or employees.

The analytical framework as described in Figure 1 will provide the framework for designing the strategic compensation model. Ochsner, C. (1995) proposes that competitive compensation not only needs to be designed properly but also needs to be implemented appropriately, and outlines a conceptual framework for doing this. He proposes that an implementation model is developed along two dimensions the strategic level and organizational scope.

First Nations will need to develop performance measures to monitor the progress of implementing the compensation model as it relates to the overall strategic direction of the primary health care system.[57] In monitoring the organizational scope, performance measures need to be developed to help determine the extent to which the model is being implemented across the system.[58]

Hufnagel (1987) also proposes three distinct models that can be used to guide the implementation process. These are the linear, adaptive and interpretative strategic approaches. The three approaches are aligned with organizational strategic planning and as such their usage is dependent on the organization's developmental stage in terms of its overall strategic planning initiatives.

The linear approach is much like a budgeting forecasting exercise, whereby performance in achieving outcomes is based on evaluating the plan against the results achieved.[59] Using the linear approach compensation strategies are often based on budgetary allocations, include short and long-term goals and reward outcomes. This is the type of approach currently used in SLFNHA and most First Nations communities.

The adaptive approach allows for changes to be made rapidly in response to changing environmental conditions such as the availability of personnel.[60] Adaptive approaches are seen as more balanced

[56] Anonymous, 2000
[57] Ochsner, 1995
[58] Ibid
[59] Hufnagel, 1987
[60] Ibid

than the linear approach and are more strategic in nature, allowing for changing goals. This approach is used mostly in the corporate for-profit sector such as the construction industry where there is intense competition for skilled workers.

The third and newest approach is the interpretative approach. It is based on a complete merger of the compensation model into the strategic plan of the system.[61] This approach is not compatible with the other two. The interpretive approach is seen to be system-wide and based on a shared system vision and strategic plan. This approach is not widely used in the not-for-profit sector but rather by large organizations to determine executive and management compensation levels.

Given that this initiative is a system-wide process which does not have a well-developed strategic/implementation plan at the moment, the development and implementation of the competitive compensation model may be inclined to follow the linear approach initially. Using the linear approach will enable First Nations to define the required compensation requirements, identify the necessary budgetary allocations to support the model and to develop the short and long-term goals and/or outcomes it wants to achieve.

The major concern with using the linear approach is that as the primary health care system develops its implementation plan, the compensation model may need to be realigned to fit with the plan. Given the potential disruption this could cause in the organization it is wise for the organization to embark on its strategic planning process as soon as possible and link the development of the compensation model with the overall implementation plan using the interpretative approach.

Professional Supervision

The capacity to manage and deliver both community-based and regional services is essential with the primary health care framework. There are certain supportive types of services that cannot be provided at the individual community level due to the lack of suitable economies of scale. In addition, there are programs and services which require standardization across the whole system. These types of services are often classified as those that fall within the realm of professional supervision and second-level support services. More detail is provided on these in the chapters on governance and management and system roles and responsibilities. This chapter will highlight only those professional supervision activities related to clinical service delivery.

Professional/clinical supervision, support and consultation can be defined by a range of activities. These include but are not limited to the following:

- Consultation and advice on issues relating to the practice of regulated professionals;
- Monitoring and evaluation of professional service delivery;
- Ensuring adherence to their respective standards of care by all professional staff;
- Provision of consultation and support on a wide range of professional practice issues;
- Consultation and advice on issues relating to the practice of unregulated or paraprofessional staff;
- Monitoring and evaluation of all service delivery;

[61] Hufnagel, 1987

- Ensuring adherence to program delivery standards by all staff; and
- Provision of consultation and support on a wide range of service delivery issues.

Insurance Requirements

Liability insurance requirements is an issue that must be taken into consideration for the new primary health care system. First Nations are currently delivering a wide variety of health and social programs under contribution and transfer agreements. Many of these arrangements entail multi-jurisdictional relationships defined by various types of legislation. Appropriate insurance should be in place to protect First Nations (employers) and their staff (employees) from liability for actions or incidents that occur in the course of providing services to clients.

Liability refers to the legal risk that a person or body may be held accountable for if another person or body suffers an injury or loss. It requires that there be some sort of relationship between the person or body who suffered the injury or loss and the person or body being called accountable for it. That injury or loss can arise from an act or a failure to act, or from breach of a term of a contract or duty.[62]

As an employer of health care staff, both professional and paraprofessional First Nations organizations must have the necessary insurance coverage to offset any harm or damage that may occur as a result of its activities or the activities of its employees. Employers can also be held accountable for accidents on their property or in their workplace.

The following types of insurance are recommended for agencies that deliver health care services and employ health care workers:

- Professional staff (regulated workers) should be required to carry their own personal liability and malpractice insurance;
- Employer must carry liability insurance for all other staff;
- Employer must also have general liability insurance coverage;
- Employer is recommended to have property insurance on all work sites inclusive of office space areas; and
- Employer should maintain appropriate vehicular insurance for all vehicles used in the delivery of health services.

Competencies and Skill Mix

Competencies are groups of skills, behaviours, or knowledge that are identified as performance standards for a particular job. Competencies describe behaviours which have been found to lead to job or task success. They are applied to a particular job rather than an individual employee. They are behaviours that can be demonstrated by employees, observed and if necessary measured by others who are evaluating the level of competence displayed.

[62] FNIHCCP Nursing Handbook, 2003

Competencies are also considered the transferable capital that health care providers possess independent of their specific occupation or field. If they possess a strong competency in one field, they can successfully apply it in different professions or fields. For example, a nurse who has strong competencies in the field of communication skills can apply those competencies in public health nursing or in case management. Competencies are typically validated by the employees who are performing the task at least at an acceptable level. This level may also be called a "journeyman" level to distinguish between the entry level and mastery level of the skill.

There are two types of competencies which are classified as knowledge competencies or skill/behaviour competencies. A "knowledge competency" can be measured by an objective test or question. For example, to test the competency Knowledge of the *NIHB Medical Transportation Policy*, a Health Director could answer questions that determine his or her comprehension of the policy. A Skill/Behaviour must be demonstrated or observed. For example, for the competency related to *Giving an Employee Feedback*, the observer might look for the use of a performance evaluation form/tool, whether the Health Director was timely in giving feedback, enhanced the employee's self-esteem or considered the employee's feelings in the conversation.

Some competencies are referred to as core competencies. A core competency is fundamental knowledge, ability, or expertise in a specific subject area or skill set. For example, a core competency in the area of public health would be: *Develops, implements, and evaluates a community public health assessment*. Competencies can be ascribed to program areas as well as to the health care provider. Each program area will require some similar but also different competencies. Health care providers will share some common competencies but will also have some which are unique to their specific discipline.

Capacity Building

Capacity refers to an organization's ability to achieve its mission effectively and to sustain itself over the long term. Capacity also refers to the skills and capabilities of individuals. Capacity building refers to activities that improve an organization's ability to achieve its mission or a person's ability to define and realize his/her goals or to do his/her job more effectively. Capacity itself, capacity building, and organizational effectiveness are all related, but they are not the same.

Organizational effectiveness relates to the capacity of an organization to sustain the people, strategies, learning, infrastructure and resources it needs to continue to achieve its mission. It is a long-term outcome that some capacity building strategies may effect, while others may not (and this is acceptable in the continuum of management support service strategies needed to build capacity). There are many definitions and characterizations of effectiveness, taking into consideration elements such as organizational structure, culture, leadership, governance, strategy, human resources, etc. The various frameworks for measuring organizational effectiveness can be helpful in defining indicators for the success of capacity-building initiatives.

The concept of capacity building in the non-profit sector is similar to the concept of organizational development, organizational effectiveness and/or organizational performance management in the private for-profit sector. Capacity-building efforts can include a broad range of approaches, i.e., granting operating funds, granting management development funds, providing training and development sessions, providing coaching, supporting collaboration with other non-profit agencies, etc. Prominent methods of organizational performance management in private for-profit agencies are

beginning to be mentioned in discussions about capacity building, as well as, for example, the Balanced Scorecard, principles of organizational change, cultural change, organizational learning, etc.

For organizations, capacity building may relate to almost any aspect of its work. Such aspects may include but are not limited to improved governance, leadership, mission and strategy, administration (including human resources, financial management, and legal matters), program development and implementation, fund-raising and income generation, diversity, partnerships and collaboration, evaluation, advocacy and policy change, planning, etc. Capacity building also takes place across organizations, within communities, in whole geographic areas, within the non-profit sector, and across other sectors. It involves individuals and groups of individuals, organizations, groups of organizations within the same field or sector, and organizations and actors from different fields and sectors.

For individuals, capacity building may relate to leadership development, advocacy skills, training/ speaking abilities, technical skills, organizing skills, and other areas of personal and professional development. Capacity is a process by which individuals develop the abilities to enhance and sustain their specific work efforts. The goal is to foster self-sufficiency and the self-sustaining ability to improve program delivery, processes, and outcomes through the application of well-developed skills and abilities. There is a large range of individual capacity-building approaches, a continuum that includes self-learning, peer-to-peer learning, facilitated professional development and training activities, as well as formal academic study.

Within the domain of health service delivery the term "capacity building" has only recently gained prominence. In an article titled Multiplying Health Gains, the authors identify three ways in which the term is used in the health promotion sector.[63] One definition of capacity building in this respect is "the building of infrastructure (staff, skills, resources, structures) across health and other agencies to tackle particular health problems" [64]. Capacity building is also "defined as seeking to develop health promotion skills and resources, and also problem-solving capability, at five levels: the individual; within health care teams; within health organizations; across organizations; and within the community.[65]

According to the New South Wales Health Department (1999, p.3) in their document, *A Framework for Building Capacity to Improve Health*, they define capacity building "as an approach to the development of sustainable skills, structures, resources and commitment to improvement in health and other sectors to prolong and multiply health gains many times over". Aboriginal communities need to develop sustainable skills at the community level so they have the required human resource expertise to develop, deliver and sustain their health programs over the long term. Only with long-term sustainability can they hope to see improvement in their health program deliveries and eventually realize significant gains in their health outcomes.

Cunningham (2002) also stresses that the focus has to be much broader than just training and it must include the "human and social capital dimensions" which he refers to as "capability development" (p. 91). This methodology is highly applicable to community-based primary health care systems, as health care workers do not work in isolation with much work done in teams, requiring relationship-building between team players.

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[63] Hawe, Noort, King & Jordens, 1997
[64] Hawe, King, Noort, Gifford & Lloyd, 1998, p.285
[65] Ibid

Capacity-building agents come in many shapes and sizes. Those that first come to mind are management or training/development consultants who provide expertise, coaching, training and referrals. There also are non-profit consulting organizations, often referred to as management support organizations that provide consulting, training, resources, research, referrals and other services for the non-profit sector. Grant-allocating agencies such as foundations and government organizations often get involved in capacity building either through their grants or sometimes by offering actual training, consulting and resources.

Researchers also play an important role in capacity building by identifying issues and trends, and building knowledge for non-profit agencies and other capacity builders. Universities and other academic centres provide formal training and certification opportunities. They also conduct research and often have resource centres (online and on-site) for non-profit organizations. Intermediaries and umbrella organizations with multiple grantees or chapters usually conduct their own capacity-building activities that respond to specific organizational priorities and needs.

A distinction is sometimes made between capacity building and technical assistance. Often, non-profit organizations hire outside specialists to perform tasks or functions in areas in which they lack capacity. Those services do not necessarily leave behind additional organizational capacity, although they do increase the ability of an organization to achieve its mission.

At the District Chiefs Meeting in February 2006, the leadership indicated that capacity building has to be a major component within the Anishinawbe Health System. The Chiefs said that:

- All workers are qualified and receive continuing education for their jobs;
- Workers have the necessary supports to do their jobs;
- There are adequate resources to support learning (e.g., orientation, mentoring, continuing education, education of youth in math and sciences, etc.); and
- Capacity is built and sustained in community so that we do not become dependent on others.

The feedback from the Primary Health Care Working Group and other key stakeholders and informants is that capacity building is crucial to the successful implementation of the Anishinawbe Health Plan. Specific capacity-building initiatives are integrated in the implementation plan and evaluation framework for the Anishinabe Health Plan.

Conclusion

The intent of this chapter was to provide a high-level overview of the human resource management requirements for the new Anishinabe Health System. This chapter identified six major human resource management services that will be required to support the primary health care system being proposed for the Sioux Lookout area. It focused on the key human resource areas of recruitment and retention, competitive compensation and wage parity, professional supervision, liability and other insurance requirements, competencies, skill mix and capacity building. This list is by no means exhaustive as there are many other human resource issues which will need to be addressed in the Anishinabe Health System.

CHAPTER 7 – Governance and Management

Key Ideas

- Governance is about setting direction and ensuring accountability for performance; management is about following that direction within the limits set while ensuring accountability.
- The quality of governance is linked with success in First Nation development activities. Effective agencies are also linked with success.
- For health services to work best, political governance needs to be separated from the day-to-day service management.
- Increasing capacity for good governance and management within the Anishinabe health system is important.
- To ensure good use of resources, each part of the Anishinabe health system needs to have a clear and distinct role.
- The Chiefs wish to ensure there are ways to work together to improve health.
- Roles will change when the AHP is implemented. The Sioux Lookout First Nations Health Authority will face the greatest changes.

Capacity to Act

To better develop health and encourage needed healing, we as Anishinabe First Nations have a rightful capacity to act on behalf of our people as well as the knowledge and skill to act wisely. We draw on Anishinabe governance and management traditions as well as governance and management ways that have worked elsewhere. We are increasingly successful in changing from the colonial system set up by the Indian Act. We develop our governance, advocacy and management capacities to higher levels. These exist throughout our system: at First Nations, Tribal Councils, the Sioux Lookout First Nations Health Authority, the Nishnawbe-Aski-Nation, and the Assembly of First Nations. We also preserve treaty relationships.

In moving away from the recent past, we base our thinking and actions on Anishinabe values and traditions, use current tools and ideas, and work together because disease knows no borders. We also have needed resources – money, time, people, energy, ideas, and political will – as well as the authority to act. In taking responsibility to govern and manage our health services in the present time, we move toward a new place in history, based on our heritage.

Existing Challenges

According to Key Knowledge people, members of the Primary Health Care Working Group, and First Nations Health Directors, we still have challenges in our health system. Several are important to governance and management.

- Geography makes service delivery much more difficult; using communication technology can help, however, isolation and travel are still issues.
- First Nations now have limited control across the whole system of health care.
- Consistency in service quality is uneven.

"That's a challenge for all First Nations across the country, how to deliver health care that is going to be consistent and as good as people expect it to be. Ensure that there are checks and balances put in place in the communities. And it is ultimately up to the people to hold their Chief and Council accountable for the kind of health care in their community." [66]

  - Continuing education for staff is hard to access.
  - For some staff, qualifications don't match job duties.
  - Limited knowledge of the technical requirements for health staff can make staffing decisions difficult.
  - Political turnover can mean change in direction and staff, and can limit knowledge needed to govern or manage the health service.
  - The differences between governance and management can be confused.

- Services are more reactive than proactive; we play catch-up with outside planning activities.
- Advocacy and funding problems:
  - Differing views on treaty rights to health.
  - It is difficult to do advocacy work based on proof because we don't have good research capacity.
- Tensions over resources: many First Nations want all funding in the community, yet also want help in crisis or in capacity building.
- Working together:
  - Speaking with one voice on behalf of many First Nations is complex; we have less power to make change than we need at times.
  - *"Some communities have 'turn-around' council members. …If the current council says work together, then a new council comes and a younger member says 'let's change all this'. We ourselves create the changes, so we can't move on*[67] *"* (Governance Key Knowledge interviews, 2005).
- Targeted funding can make it difficult to match funding with community priorities.

[66] Governance Key Knowledge interviews, 2005
[67] Governance Key Knowledge interviews, 2005

Governance

Governance means agreement among people on how to make decisions, solve problems and conflicts and work together to achieve goals in their society.[68] It is also about defining a purpose or mission, allocating power, determining decision-making processes, establishing organizational culture, and setting up procedures for performing specific tasks. [69]

To help describe Anishinabe traditions in governance and leadership, Key Knowledge people were asked about what Anishinabe traditions can contribute to our understandings.

> *"What's appropriate is giving people the opportunity and respect to speak; listening; having compassion; …caring, giving…respect is a real big part; acceptance;…knowing the fine line between compassion and enabling".*

> *"…whoever assumes the role of a leader – I think you need to have that vision of the community to carry out the wishes of your constituents, staying in touch with a variety of people, make this a priority that is not set aside, listening and communicating at both formal and informal levels".*

Traditionally, there were different types of leaders for different situations or to meet different needs of the people.

Different Types of Governance

First Nations have a different governance model from Canada and Ontario. In the FN model, the First Nation is the sovereign unit of government. Within this model, the Chief and Council are the political equivalent of the Prime Minister and Cabinet of Canada or the Premier and Cabinet of Ontario. Chiefs and Councils wish to have a peer-to-peer relationship with leaders of other governments. For the Sioux Lookout area, First Nations relationships between the governments are founded on the treaties to which Canada is signatory. For Treaty 9, covering some but not all Sioux Lookout First Nations, Ontario is also signatory to the Treaty. Preserving the treaty relationship and ensuring treaty rights is of great importance to First Nations. Agreements that are made between governments are expected to not derogate or diminish these relationships and rights.

In the First Nations government model, it can be easy to blur the roles of political leaders, governing bodies, and managers. Fundamentally, political leaders exercising **political governance** propose an agenda for action in society. Voters (now) and elders and/or clan members (traditionally) determine which agenda is most desirable and which leaders most capable and trustworthy in a particular situation or at a point in time. Having set the agenda or direction for action, government leaders then assign resources and establish accountability. They may create organizations and delegate certain powers and responsibilities to them.

[68] Cornell, Curtis, Jorgensen. 2004
[69] Wood. 1996. referenced in Kouri. 2003

In First Nations the elected political government representatives are the Chief and Council. Examples of their legislative powers include:

- Establishing by-laws on how affairs on their lands will be organized;
- Setting up boards or committees to run certain organizations, for example an economic development business or a health service; and
- Approving agreements between their First Nations and other organizations or governments.

First Nations acting together gather their Chiefs and make agreements among themselves or with other governments or organizations. Examples include:

- The Nishnawbe-Aski-Nation Chiefs-in-Assembly adopted a Primary Health Care Model to serve as the basic guiding set of ideas for all the First Nations' Health Authorities (Resolution 90/10).
- The Sioux Lookout Chiefs-in-Assembly passed a resolution mandating development of an Anishinabe District Health Plan (Resolution 04/44).
- The Sioux Lookout Chiefs-in-Assembly delegated the responsibility for creating the plan to the SLFNHA, limiting SLFNHA's authority by saying the plan must be presented back to the Chiefs for approval (Resolution 04/44).

In **organizational governance** members in a society or a political government establish an organization with a governing body – a 'board of directors or trustees'. The board holds in trust the organization's resources and reputation, sets direction and assigns resources for that particular institution or organization. The board then establishes a management structure to carry out the work.[70] At times, a board's powers are limited by acts of political governance in enabling legislation or through Chiefs' resolutions, or by the constitution or incorporation articles of the organization. The Board is accountable to the organization's members or shareholders or founding government to follow its own by-laws and policies, as well as any legislation or regulations from the political body.

At times, when an organization such as a regional health authority is established by a higher order government body, it is accountable both to its political masters and to the people it serves. In this approach, the government that delegated powers to the organization usually sets specific limits on authority for that organization, as well as providing a clear mandate of responsibilities. Most regional health authorities in Canada follow this model.

[70] Kouri, 2003

Essentials of Governance

What are the Essentials of Governance?

- Having the authority and responsibility for governing.
- Making and writing down the basic agreements to 'constitute' a society; making a "constitutional foundation for self-rule".
- Making laws that can be either written down, or be unwritten agreements about appropriate behaviour and consequences when behaviour is not appropriate.
- Separating the political and administrative powers, and ensuring each plays its appropriate role.
- Establishing institutions to administer government activities, using competent and qualified staff.
- Making day-to-day decisions on an informed basis and in a timely manner.
- Putting decisions into action using the administration of the government.
- Having fair ways to resolve disputes, making sure that politics doesn't play a harmful role. If the society and the government don't do this, people will mistrust the government, which will then lose legitimacy, causing an array of problems down the road. [71]

Governance Matters

Good governance is one of the factors that make it possible for First Nations to succeed in achieving their goals. In research over 15 years, the Harvard Project on American Indian Economic Development identified factors that were associated with success.[72]

- Real decision-making power.
- Capable governing institutions that can get the work done.
- A good 'fit' between the political culture and the governing institutions.
- *"An ability to think, plan, and act in ways that support a long-term vision of the nation's future; … a strategic orientation."*
- Leadership *that "acts in the nation's interest instead of their own and who can persuade others to do likewise"*[73].

"Developing strong, effective and accountable Aboriginal governments and institutions" was a key factor in successful labour market and economic development programs according to Lessons Learned from many programs funded through Human Resources Development Canada[74]. These lessons can be applied to governing and managing health services as well. In an extensive review, the Centers for Disease Control (U.S.) put leadership and participation first in its list of nine elements that create community capacity, a *"necessary condition"* for health promotion and prevention work.[75]

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[71] Cornell, Curtis, Jorgensen, 2004
[72] ibid
[73] ibid
[74] Human Resources Development Canada. 1999. Pg 3
[75] Goodman, R. et al. (June 1998). Pg. 259

Principles of Good Governance

A principle is a guide for action, usually rooted in basic values of an individual or organization.

Good governance is a concern around the world. The United Nations Development Program has developed fundamental principles, listed below.[76] Many of the principles, such as vision, participation, building consensus, being responsive to community direction, are similar to Anishinabe ideas on leadership.

- ***Strategic Vision:*** Looking carefully at the future, analyzing existing and forecasted forces, and identifying where the organization or society needs to go in the future to gain the greatest benefit for all.
- ***Participation:*** Essential for leaders to know what is important to society members and to share ideas and experiences with members. Members need to feel safe in participating, even if their ideas are different or in conflict with leaders.
- ***Consensus Orientation:*** Governments seek to find areas of common ground, not acting in ways that divide people or groups.
- ***Equity***: Treating people and situations fairly, not just equally. This means understanding the context for events, and putting principles above personalities and family ties.
- ***The Rule of Law:*** All people, including leaders and respected advisors such as elders, are accountable under the same rules. This means that leaders cannot benefit personally from their decisions more than if they were not leaders.
- ***Accountability:*** Leaders are responsible to their people for their decisions and their behaviour. Similarly, society members are accountable to each other in living by the rules to which they have agreed. Accountability means that actions taken can be morally explained. [77]
- ***Transparency:*** Decisions and decision processes are visible. People can see how decisions are made, who benefits or loses by them. Transparency makes it more possible for people to hold their leaders and each other accountable to the rule of law.
- ***Responsiveness:*** Taking direction from the people; paying attention to issues the people find important, changing the government's agenda to better meet the needs of the people.
- ***Effectiveness and Efficiency:*** Using resources well; actions taken have the effects intended; desired outcomes are achieved with the minimum level of resources needed.

[76] United Nations Development Programme Governance and Sustainable Human Development www.undp.org 1999

[77] Kouri D., Democratic Decision-Making for District Health Boards, 1998, HEALNet Centre for Excellence in Regionalization, Saskatoon, SK

Basic principles of good governance are one factor linked to successful economic development. Good governance helps an organization attract and keep good staff. Basic principles of good governance include[78]:

- Leaders make opportunities for community participation and listen to community views and needs; they are responsible back to community; they regularly seek consensus.
- They have long-range vision and are strategic thinkers.
- There are laws or rules in place and they apply to everyone in the same way.
- People are treated fairly; there is no favouritism; the same rules apply to everyone including leaders.
- There is 'transparency' in decisions – ordinary people are fair and reasonable, and can see how decisions are made.
- Resources are used wisely, effectively and efficiently.

Management

Management is different from governance. Governing groups like First Nations Councils or organizational boards set overall direction and define the outcomes that the organization needs to achieve within specified times. Managers follow the direction established and are responsible for achieving the desired outcomes within the limits of budget, labour regulations and other laws, the by-laws and policies of the organization, and the organizational values, principles and culture.

Management in an organization is responsible for the quality and effectiveness of work of the organization. In particular, the chief executive officer or executive director is directly accountable to the board for the organization's performance. Managers need to have a wide variety of thinking, planning, analyzing, communicating, people and financial management skills and knowledge. Some managers are required to be leaders in the organization, including being strategic, innovating, visioning, and being a champion for change so the organization can grow and develop, or be protected from threats inside or outside.

In addition to these skills and knowledge in management staff, an organization needs to have:

- Knowledgeable and skilled staff in each program area, including people with required certifiable skills (such as nursing).
- Good information management and record keeping.
- Fair labour practices, and knowledge of labour regulations.
- Healthy organizational culture, including learning and innovating, open communication and information sharing, trustworthy leaders and staff.

[78] United Nations Development Programme (1999)

Separating Governance and Management

Much difficulty can come from blurring the lines between governing (setting direction) and managing (ensuring direction is accomplished). The chart on the following pages describes the differences between governance and management at three levels in our Anishinabe health system. Feedback from many sources during the AHP planning process recommends separating governance and management, to ensure good health services and system functioning. Other First Nations across Canada have demonstrated that separating governance and management is essential and workable.

Table 7.1 – Chart on System Governance and Management

	Governance	***Management*** *(Directors and Staff)*
FIRST NATION Chief & Council	• Set direction for health service within overall Band strategic plan • Adopt policies, protocols & legislation; ensure policies & legislation respected and followed • Establish standards of performance for First Nation organizations and Council to ensure accountability • Evaluate Council's own performance against its standards and values • Ensure inter-agency work • Hire & supervise Health Director • Review and decide on community health plan, yearly health service plan (including budget); monitor outcomes • Ensure accountability for program performance and resource management through Health Director and Health Committee • Advocate for community health • Role models to community • Work with other FN leaders on inter-community issues • Manage governmental relations with other governments	• Establish community health priorities based on health status and overall Band strategic plan working with Health Committee • Develop and implement community health plan with program plans and staff work plans for accountability, including budget allocation • Deal with funders on program issues • Orient new Chief and Council members, new Health Committee members • Develop policy; upon approval implement and monitor • Establish suitable reporting structure: e.g., work teams in primary care, public health, addictions & mental health, health promotion/community development, • Manage staff and overall program performance: hire, orient, supervise and support program implementation, use of quality assurance, problem solving, conflict resolution, emergency response • Ensure accountability: review with appropriate staff and Health Committee program performance in meeting program objectives 2 x year; report regularly to Health Committee and Chief and Council (at least 4 x year); regular evaluation • Problem solve with staff and Health Committee

	Governance	**Management** *(Directors and Staff)*
Health Committee/ Board & Elders	• Work with Health Director & staff in community health planning • Review and recommend yearly health service plans (including budget); forward to Chief and Council • Advisors to health services on community issues; assist with risk management as appropriate • Regular evaluation • Support to health service and staff in problem-solving on community & health service issues • Represent community in planning activities • Liaise/communicate with community • Act as client service problem-solver with HD & staff	on health service and community health issues • Communicate regularly with community; problem-solve client issues with Health Committee • Ensure quality management & service consistency • Risk management for health service • Liaison with other FN agencies

	Governance	**Management**
TRIBAL COUNCIL Tribal Chiefs	• Set direction within the limits of the council's authority given by member First Nations • Establish strategic plan • Adopt policy and protocols • Hire, supervise support Tribal Council Executive Director • Ensure accountability for program performance, resource management • Ensure regular evaluation of Chiefs' Council • Advocate on TC priorities with funders and other governments	• Executive Director hires, supervises, supports Health Director • Maintain on-going contact with member FNs • Health Director carries out health plan, acting on health priorities set by Health Board and/or Tribal Council Executive Director • Health Director responsible for health program performance including meeting objectives and good stewardship • On-going evaluation • Orientation for member FNs on TC health service responsibilities (new Health Directors, new Chief & Council technical briefing)
Health Board	• (In some TCs, FN Health Directors are Health Board) set direction for the Health Director & programs, establish standards and accountability methods • (In some TCs, Chiefs are Health Board) establish direction and priorities jointly, set standards and identify accountability methods • Regularly reflect on Board performance • Provide support and advice for the Health Director on relationships with member First Nations	

	Governance	***Management***
SLFNHA Board	• Establish strategic plan, collaborating with senior staff • Set direction for health service development and operation within limits set by member First Nations • Adopt policy • Hire, supervise, and support Executive Director • Ensure accountability for overall program performance • Regularly reflect on Board performance using established standards	• Develop strategic plan, collaborating with and supporting Board • Collaborative leadership with FNs & TCs on health system development • Develop and implement operational plans within strategic plan • Orient new HDs and Chiefs and Councils on SLFNHA roles and responsibilities; orient new Board members • Develop policy; implement upon approval • Manage staff and programs, ensuring accountability for performance: on-going evaluation • Liaise, communication - member FNs • Promote quality management and service consistency • Risk management for health services
CCOH	• Advocate on political priorities set by Chiefs in Assembly • Ensure accountability on district-wide special projects as assigned by Chiefs in Assembly (e.g., hospital development, implementation of AHP)	• Technical support available from SLFNHA CCOH Secretariat • Regularly report to CCOH on oversight items (e.g., AHP implementation)
SLO Chiefs in Assembly	• Set direction on district-wide political priorities • Ensure accountability of district-wide organizations and initiatives	• Technical support from agencies responsible for health issues on Chiefs' agenda. • Technical advice on policy items • Policy agenda research and background papers development
NAN	• Treaty protection • Political advocacy on behalf of all NAN FNs	• Technical support from NAN policy staff

Lessons Learned in Working Together in First Nations Health

Based on reviews of existing First Nations health and education organizations that were created by groups of First Nations[79], we can learn the following lessons.

- It is possible for First Nations to create a joint organization to benefit all. Joint organizations can improve system stability, avoid duplicating community work or need for resources. Such a joint organization can enrich First Nation control over system elements, strengthen capacity building, and enhance program functioning. Its agenda needs to be carefully developed. Champions are needed along with highly competent technical staff. On-going political support and oversight are required to ensure a responsive and stable organization.
- Working together is important in health services for good economies of scale. As well, stable organizations with larger numbers of health professionals help ensure group practice and reduce professional isolation while increasing visibility for recruitment.
- Being part of a joint organization is also challenging for First Nations who value their independence very highly and who are new to controlling their own affairs.
- Reviews of joint First Nations organizations link success and longer organization life spans to: clear roles and responsibilities to do together what individual First Nations cannot do alone; good direction; making and keeping good relationships; and on-going accountability.

Governance and Management for Sioux Lookout Anishinabe Health System

Defining a System

A system is *"a set of connected things, parts or institutions"*[80]. One familiar example is our body, made up of many organs, blood vessels, muscles and bones all working together in harmony. When one part breaks down, it puts a strain on the other parts. An injury, bacteria or virus, major stress, emotional loss or spiritual pain can cause the system to break down. Long periods of strain, or having several parts not working at the same time, can create chronic on on-going disease.

For a system to keep functioning, coordination is needed. Parts must have ways to tell each other what is going on, and ask for or provide key resources in a sharing exchange. Usually some parts of a system are widely distributed, bones or blood, while others are highly specialized like eyes or fingers. Constant work is required to keep parts renewed and functioning well. The keys are interconnectedness, interaction and interdependency, with the whole system being able to do things which individual parts cannot do alone.

The health system for our communities extends well beyond our communities and their health staff and services. It includes visiting and specialized staff, hospitals, blood banks, researchers in laboratories looking at health data, planners, advocates, politicians, taxpayers, drug equipment and manufactures teachers, university professors, and medical supplies such as vaccines, airplane pilots,

[79] Leach, P. (2003), McCarthy J. (2001), Cornell, Curtis, Jorgensen (2004)
[80] Barber K. ed. (1998)

translators, hostel workers, and so forth. It is a vast and complex web of roles, responsibilities, relationships and agreements.

It is possible for organizations within a system to be independent, work together, or be centralized. It is useful to think of these choices as a continuous line with independence on one end, working together toward the middle, and centralization on the other end.

What We Need in Our System

The following list summarizes views in Key Knowledge interviews, discussions in the Working Group of the District Health Planning Project, and ideas put forward by First Nations Health Directors in their October health planning workshop.

- Strengthen and use our Anishinabe traditions.
- Speak with one voice when necessary. Be organized for effective advocacy.
- Have evidence to back up our advocacy; ensure health status is monitored.
- Facilitate consistency so that all people get high-quality services.
- Have stable organizations to attract hard-to-recruit staff.
- Political leaders set health service direction based on community health priorities; managers and staff exercise their best professional judgment on service delivery decisions without political interference.
- Have decision-making authority and responsibility as close as possible to where related problems occur.
- Use resources effectively and efficiently, find opportunities to improve services through working together.
- Make arrangements that are flexible to meet individual First Nation needs.
- Build capacity for self-determination.
- Have responsive services that don't create dependency.
- Ensure capacity to do specific tasks exists before moving responsibility to do the work.
- Protect the most vulnerable in our society.
- Respond quickly in major crises by being able to help each other, draw on outside help when necessary.
- Ensure that work goes on in health promotion and disease prevention, even when there are crises.

Mandate for Implementing the AHP

In the Chiefs Meeting (February, 2006) the Chiefs used Resolution 06/04 to "accept the Anishinabe Health Plan report", mandate that SLFNHA "proceed with the development of an implementation plan", and "commence with the implementation of the Anishinabe Health Plan as designed". The

resolution also mandated that "adequate resources be sought to support the plan so that inadequately resourced programs are not offloaded to communities".

Specific Key Directions

Included in the AHP are the following decisions related to governance and management recommended to the Chiefs-in-Assembly by the Chiefs Committee on Health. In accepting the AHP and approving it for implementation, the Chiefs have made the following decisions for the Anishinabe health system.

Use a working together approach for district-wide work while respecting First Nations autonomy. Responsibilities will be different at the First Nations' level, the Tribal Council, the SLFNHA, and NAN. These are described in the Chart on Roles and Responsibilities at end of this chapter.

Ensure overall coordination and oversight of the system.

- Hold annual Chiefs' meetings on health to set overall direction on health development and identify issues to work on together. This becomes the year's priorities for proactive political action by the Chiefs' Committee on Health.
- Continue to have a Chiefs' Committee on Health (CCOH) "accountable back to the Sioux Lookout Zone Chiefs...and tasked with the responsibility for providing direction and monitoring of SLFNHA activities" (Resolution 06/08). The CCOH will have secretariat support from the SLFNHA. CCOH will report regularly to the Sioux Lookout Chiefs using multiple methods: personal contact, TC Chiefs meetings, regularly written updates.
- Chiefs-in-Assembly assign political advocacy issues to the Chiefs' Committee on Health (CCOH). Political oversight on specific projects is also assigned as needed (e.g. implementation of the AHP).
- District-wide response on technical health issues is the responsibility of the SLFNHA, governed by its Board of FN representatives; accountable back to First Nations through their Chiefs.
- Continue work toward the SLFNHA becoming the regional health organization for all Sioux Lookout area First Nations, with district-wide service responsibilities.
- Have capacity for orientation and leadership development throughout the system for new Chiefs and Councils, community Health Boards or Committees, CCOH members, and Board members of the Health Authority.

Two other issues discussed were important to note. Given the current health of Sioux Lookout First Nations members, it is appropriate to receive funding from Ontario as well as Canada. This is based partly on Ontario being signatory to Treaty 9 and having treaty relationships with those First Nations. Capacity building is an important priority for health directors, community health staff, as well as leadership.

One issue the Chiefs did not specifically discuss is a way to help coordinate parts of the system and keep communication flowing among the several agencies. We propose a Primary Health Care Partnership, called that, to emphasize the concept of a gathering of equals who are partners in the system. The group could be made up of representatives from independent First Nations, Tribal

Council Health Directors, SLFNHA (either Executive Director or Associate ED), Meno-Ya-Win, NAN, and the Northwest Health Unit. Its purposes could include:

- keeping communication flowing; to exchange ideas;
- shaping policy background papers for the Chiefs-in-Assembly;
- identifying opportunities to collaborate and co-operate; and
- problem-solving on system-wide challenges.

Dividing the Work

By dividing the work among our various types of organizations – First Nations, Tribal Councils, SLFNHA, and NAN – and maintaining links with others such as the Meno-Ya-Win Health Centre, we can make progress on our health goals more quickly.

First Nation representatives originally developed a division of health service responsibilities in 1997. These possible arrangements were reviewed and revised by the Primary Health Care Working Group in May 2005. In January 2006, First Nations' Health Directors along with the Primary Health Care Working Group reviewed the arrangements. They agreed in principle with the arrangements and wanted to have further clarification about potential overlap, for example in communications or training.

First Nations	Tribal Councils	SLFNHA
• Direct community health staff & programs (except nurses in most FNs)	• Capacity building • Problem solving • Networking • Special services, e.g., home care nursing • Some flow-through funding • IFNA Doctors • Shibogama Transfer arrangements	• Specialized services (e.g., TB, Nodin/CFI) • Advocacy & planning • Health Information System • Regional specialist services • Public Health • Allied Health • Doctors • Nurses
FNIHB	**MOHLTC**	**NAN**
• NIHB • Third level consulting and supervision services (e.g., Medical Officer of Health)	• Pay doctors & Specialists • Fund Lab & x-ray/ ultra-sound ser. • Fund allied health professionals • Hospital funding • Long-term & home care funding	• Advocacy and political work • Region-wide planning and response

The Chiefs Committee on Health endorsed these arrangements, and recommended them to the Chiefs-in-Assembly. The Chiefs-in-Assembly, in accepting the AHP for further implementation work,

agreed with these divisions, wanted to ensure further clarification specified by the Health Directors and others. A revised **detailed description of roles and responsibilities** for different groups within the Anishinabe health system are listed in the Chart on Roles and Responsibilities in Chapter 8. Further clarification may occur during implementation of the AHP.

CHAPTER 8 – System Roles and Responsibilities

A fundamental idea in Primary Health Care is that different types of health care are provided at different points of contact in the system. Primary Health Care is usually defined as the first point of contact which, in our Plan, is in the community. Secondary services are performed by specialist practitioners in district hospitals, for instance. Third-level – or tertiary – services are those offered by large regional hospitals with specialized equipment, staff, and services.

In our Plan, First Nations Primary Health Care services forge links with other partners that support and supplement community services. Direction for various layers ultimately come from the people served. The Anishinabe Health Plan has different roles and responsibilities for each type of organization to increase effective and efficient use of services; to reduce overlap and confusion about destinations; and to accommodate the development and change currently affecting First Nations' health services.

Dividing the Work

By dividing work among various organizations – First Nations, Tribal Councils, SLFNHA, and NAN – and maintaining links with others such as the Meno-Ya-Win Health Centre, we can make progress on our health goals more efficiently.

First Nation community representatives first developed the following division of roles and responsibilities in 1997. The Primary Health Care Working Group and the First Nations Health Directors refined the division. The Chiefs Committee on Health recommended the division to the Chiefs as part of the Anishinabe Health Plan. The Chiefs accepted the report of the Plan in Resolution 06/04 (February 2006).

First Nation representatives originally developed a division of health service responsibilities in 1997. These possible arrangements were reviewed and revised by the Primary Health Care Working Group in May 2005. In January 2006, First Nations' Health Directors along with the Primary Health Care Working Group reviewed the arrangements. They agreed in principle with the arrangements *and* wanted clarification about potential overlap – for example – in communications or training. These changes have been made in the Chart on Roles and Responsibilities at the end of this chapter. The CCOH recommended them to the Chiefs as part of the AHP. The Chiefs accepted the report of the AHP in Resolution.

First Nations	Tribal Councils	SLFNHA
• Direct community health staff & programs (except nurses in most FNs)	• Capacity building • Problem solving • Networking • Special services, e.g., home care nursing • Some flow-through funding • IFNA Doctors • Shibogama Transfer arrangements	• Specialized services (e.g., TB, Nodin/CFI) • Advocacy & planning • Health Information System • Region • specialist services • Public Health • Allied Health • Doctors • Nurses
FNIHB	**MOHLTC**	**NAN**
• Nurses • McMaster Doctors • NIHB • Second & Third level consulting and supervision services (e.g., environmental health, nursing)	• Pay doctors & • Specialists • Fund Lab & x-ray/ ultra-sound ser. • Fund allied health professionals • Hospital funding • Long-term & home care funding	• Advocacy and political work • Region-wide planning and response

The Chiefs Committee on Health endorsed these arrangements, and recommended them to the Chiefs-in-Assembly. The Chiefs-in-Assembly, in accepting the AHP for further implementation work, agreed with these divisions and wanted to ensure further clarification specified by the Health Directors and others. A revised ***detailed description of roles and responsibilities*** for different groups within the Anishinabe health system are listed in the Chart on Roles and Responsibilities at the end of this chapter. Further clarification may occur during implementation of the AHP.

Enhanced Responsibilities

First Nations

First Nations are the fundamental or primary service and support. All other organizations support First Nations in improving the health of our people.

In training, First Nations meet local training needs with Tribal Council and SLFNHA support. They build management capacity to provide consistent services with support from other organizations as needed. It is the first organization to support cultural re-powering and community development.

First Nations manage community health services, including program and staff evaluation. First Nations' health service managers and staff base their work on best practices and Anishinabe ways. Based on community priorities, First Nations identify research priorities and collaborate with others to meet the needs with which they may need assistance.

It is understood that First Nation Chiefs and Councils will continue to exercise political governance over their health care organizations, while typically delegating organizational governance to a health committee or board. This group of community members, usually including Elders, provides regular support and guidance to the Health Director, ensures programs are meeting community needs, acts as the first group to work through patient/client complaints, and provides guidance in staffing. These arrangements will differ between communities, reflecting the independence of First Nations.

A Health Director or a health staff member with responsibilities to act as the health staff leader usually provides health service management. In larger communities, Health Directors often organize staff into major program areas such as primary care, mental health and addictions, mother and child health, community development, etc.

The AHP envisions First Nations having expanded primary health care services, with a mandate and staffing for collaborative community development, and evolving responsibilities for governing and managing enhanced services. Larger teams, more services, and consistent use of a PHC approach will demand enhanced governance and management capacity at the First Nation level.

Nursing services is one example of responsibility that will evolve or grow over time. The Shibogama Tribal Council First Nations already employ their own nurses; Matawa First Nations Management Council is working on a plan to do so. In other First Nations, nurses employed by FNIH will move to First Nations employment within the next two to three years. This will be done in stages with, initially, SLFNHA or TCs taking control. At the community's pace, responsibility for nursing employment and management will move control to First Nations.

First Nations' Health Directors want more networking time and access to capacity building and training. Shibogama Tribal Council First Nations' Health Directors have benefited from their health transfer initiative which provided travel funding at first, with the bonus of the necessity for working together. Even after funds ran out, this approach continued. Enriched capacity of Health Directors has been one result.[81] Matawa Tribal Council invested heavily in formal certified training for its Health Directors. Taking training together over two years helped create a close-knit network. Health Directors rely upon each other for collegial support and advice. As well, they form the Health Board for the Matawa First Nations Council and provide direction to the Health Director there.[82]

The three First Nations with transferred health services already control their services, including nursing. This means that when certain parts of the AHP, such as taking control of nursing, are implemented, there will be less change for these communities. When increased staffing resources are negotiated, all First Nations will share new resources.

Funding for service enrichment related to the AHP is described in Chapter 9. Negotiations for funding will be undertaken by the CCOH, with technical support from the Health Authority.

[81] Key Knowledge interviews, AHP, 2005
[82] Ibid

First Nations' Links to Other Levels and Partners

First Nations collect community data and send it to the information system at SLFNHA. They combine information to analyze local issues, and develop and implement community health policies. With tribal council support as required, they create community health plans and put them into action.

First Nations have a cooperative relationship with tribal councils if they are members. Depending on the level of expertise at the tribal council, First Nations might rely on that expertise for assistance with analyzing information, planning, training, quality assurance as needed and management issues in the health service. Similarly, where the tribal council employs nurses and doctors, First Nations can be involved in joint management of those resources.

First Nations may have direct service links with other providers that meet their specific needs. One example is a First Nation from the Matawa First Nations Council that contracts out for mental health professional service.

First Nations also have direct links to the Sioux Lookout First Nations Health Authority. SLFNHA coordinates the development of whole system's vision and is responsible for public health monitoring and providing expertise. For example, if a community business improperly disposes of sewage and waste, SLFNHA would have the responsibility of working with a First Nation to see that the safety of people is a priority and that public health regulations are met. Similarly, SLFNHA has expertise in training, health planning, quality assurance, information collection and analysis, and provides this service to tribal councils and First Nations who do not yet have that capacity.

Other second-level support includes links to Meno-Ya-Win and other hospitals for emergency and acute care of their community members. Doctors providing primary health care in the communities also provide emergency and in-patient hospital services. They link with primary care nursing by telephone and telehealth to provide patient care advice and support.

Tribal Councils

There are four tribal councils in the Sioux Lookout area: Keewaytinook Okimakanak, Windigo First Nations Council, Shibogama First Nations Council, Pawiidigong Tribal Council, and Matawa First Nations Management (4 of 9 member FNs are considered part of the Sioux Lookout area). Three First Nations make up the Independent First Nations Alliance (IFNA). (There are also four First Nations who do not belong to any tribal council.) Chiefs of member First Nations are the governing body of a tribal council. Management, typically through an Executive Director, is accountable to the Council of Chiefs. Tribal councils have differing responsibilities, however, all have some health responsibilities. Shibogama TC has the most control over its health services, through a transfer agreement between itself, its member First Nations and Health Canada.

Tribal councils are the first source of support for their member First Nations. They work in ways that build capacity, including coordinating training for their member First Nations. Tribal councils support First Nation Health Director interchange, exchange, and networking, and collaborate with others to meet shared training needs.

Tribal councils assist First Nations in gathering information and also use data for tribal council-wide planning.

Some tribal councils provide community health services upon request of their member First Nations. Examples include providing home-care nursing, or nursing supervision. Working with their

members, they also help First Nations to ensure consistency in program quality. In doing this, tribal councils help track measures of service quality and provide support in using tools for best practice and consistency in partnership with SLFNHA.

As part of their support work, tribal councils support community planning and proposal development. They advocate for member First Nations, including partnering with SLFNHA and NAN.

They also provide staff support, including mediation of difficulties, again upon request. In the area of policy analysis and development, tribal councils support First Nation policy development work, and prepare policy analysis for tribal council specific challenges.

At present, some TC Health Directors have core funding; others receive support from program administration funding. Few have sufficient funds for regular travel to their communities to engage in capacity building. In addition to using telehealth technology, it is important for Health Directors to meet face-to-face. Much-needed travel funding presently not provided. Capacity building with member FNs now often uses program administration dollars.

Health Directors and Primary Health Care Working Group members emphasized the importance of having adequate TC level resources – especially for travel – during their joint meeting in January 2006.

Further discussion is needed among the tribal councils and the SLFNHA district health planning project manager to determine the most suitable arrangements for sustaining TC work at the second level. The list below is the necessary basic minimum, based on discussions of the First Nation Health Directors and the PHCWG.

- Full-time TC Health Director with knowledge and skills for mentoring, training coordination, planning support, and policy analysis; more staff may be required by tribal councils with greater numbers of member FNs or wider responsibilities such as nursing employment and supervision.
- Administrative support for the Health Director, along with program overhead costs (office, telecommunications, equipment replacement, professional development, etc.)
- Travel funds to visit communities, to bring FN Health Directors in for meetings, networking, and other capacity building activities.
- Telehealth technology access to enable on-going communication.

Some tribal councils have program staff such as home-care nurses. These arrangements will be continued, guided by member FNs' direction.

Where FNs wish to assign responsibility for nursing services to their tribal councils, arrangements will be needed to have nursing supervision as well as nursing staff at the tribal council. Shibogama has this responsibility now; Matawa is developing its plan for nursing services. It has been agreed that the recruitment and professional support should be the responsibility of the SLFNHA on behalf of all FNs.

Tribal Council Links to Other System Levels and Partners

In addition to the supports and services described above, tribal councils work jointly with First Nations, SLFNHA and other partners to provide safe environments, public health monitoring, quality assurance, information gathering, area information analysis, training, and program development.

They also carry issues and concerns of First Nations to the level in the system where First Nations, individually and collectively can get expertise and assistance.

Tribal councils, when they have the capacity developed, might also have direct service links with service providers. These providers could include nurses, doctors (IFNA) and other health professionals as necessary for their specific area needs. Some tribal councils might prefer to work cooperatively with SLFNHA to provide quality assurance, employment arrangements and professional supervision in cases where they are underdeveloped for these tasks. Others tribal councils might carry out these tasks for their member First Nations.

Where tribal councils have direct service responsibilities, they have links to hospitals and other organizations that provide services to their members.

Independent First Nations

Some First Nations do not belong to a tribal council, preferring to manage all their affairs themselves. These include: Sandy Lake, Mishkeegogamang, Saugeen, and Lac Seul. (Saugeen First Nation also does not belong to Nishnawbe-Aski-Nation.) They have the roles and responsibilities listed above for tribal councils, except for nursing services, and will therefore need to have sufficient resources to carry out these activities. Individual FN decisions are needed on nursing service arrangements.

They work in ways that build capacity, including coordinating training for their members. Independents partner to meet other training needs. Working with their members, they help to ensure consistency in program quality. In doing this, they help track measures of service quality and provide support to their staff in using tools for best practice and consistency in partnership with SLFNHA.

In training, Independents meet local training needs, with SLFNHA support if requested. They build management and capacity to provide consistent services with support from other levels as needed. They are the first level for support of cultural re-powering and community development.

Independents manage community health services, including service planning, implementation, and evaluating programs and staff. Independents' health service managers and staff base their work on best practices and Anishinabe ways. Based on community priorities, Independents identify research priorities and collaborate with others to meet the needs they cannot meet themselves.

As part of their work, they support community planning and proposal development with their members. They advocate as partners with SLFNHA and NAN, for their members. They also provide emergency response planning and coordination for their members.

Independent First Nations Links to Other System Levels and Partners

Independents have all the responsibilities of First Nations as well as the functions of a tribal council. They work jointly with SLFNHA and other partners to provide safe environments, public health monitoring, quality assurance, information gathering, area information analysis, training, and program development. They carry issues and concerns of their members to the level in the system where First Nations, individually and collectively can get expertise and assistance.

Independents, when they have the capacity developed, might also have direct service links with service providers. These providers could include nurses, and other health professionals as necessary for their specific needs. Some Independents might prefer to work cooperatively with SLFNHA to provide quality assurance, employment arrangements and professional supervision in cases where

they do not have fully developed capacity to do these tasks. Others Independents might carry out these tasks for their members.

Where Independents have direct service responsibilities, they have links to hospitals and other organizations that provide services to their members.

Sioux Lookout First Nation Health Authority

The SLFNHA was established by the Sioux Lookout Chiefs-in-Assembly following the Scott-McKay-Bain Report of 1988, with the understanding that it would take on the work that communities could not do themselves. This includes work that First Nations do not wish to do now, and do not wish to assign to their tribal councils, if they belong to one. The SLFNHA is to work on behalf of all First Nations.

The SLNFHA has a Board of Directors, appointed by each member Tribal Council and with seats for independent First Nations. The Board of Directors is responsible for setting SLFNHA's direction, ensuring its adherence to policy and its program achievements and outcomes. The Board is accountable to the Sioux Lookout Chiefs-in-Assembly, and through the Chiefs to First Nation members. Accountability and board processes are described in the existing Policy and Procedures Manual of the SLFNHA.

The Executive Director is accountable to the Board for the SLFNHA's organizational performance, including delivering desired program outputs and outcomes and careful stewardship of resources. The Executive Director is the Board's only employee. The Executive Director then hires and supervises the staff and is accountable for their performance. To ensure that the Board will be able to review SLFNHA's progress on its strategic plan, the Executive Director is responsible for ensuring regular review of the SLFNHA's logic model objectives with senior staff. Program managers and directors are responsible for reporting on progress in achieving these objectives regularly.

The AHP increases SLFNHA's program responsibilities. These changes will occur over time. In some cases, such as the direct employment of nurses, SLFNHA will pass these responsibilities to First Nations or their Tribal Councils as they become ready and wish to take control. SLFNHA will use a collaborative approach to recruiting health professionals, involving community representatives wherever possible.

The role of the SLFNHA is to support tribal councils, independents and other First Nations with program consulting and specialized services. The Health Authority shares its expertise in best practices, planning, training and program design using Anishinabe frameworks.

Where there are region-wide training needs, the SLFNHA coordinates training. Working with Tribal Councils and Independents in a cooperative effort, SLFNHA identifies, plans and organizes training resources and implementation of training plans. In partnership with First Nations, Independents and tribal councils, it engages in system wide vision and planning such as preparing the Anishinabe Health Plan.

In research and information management, the SLFNHA plans and operates a health information system for First Nations, Independents and tribal councils. The Health Authority also has expertise in research and evaluation using Anishinabe culture and values.

The Health Authority takes on primary responsibility for liaison with non-First Nation organizations and agencies in the whole system. This leaves Tribal Councils, Independents and First Nations free

to concentrate on the community level of work. In its role as liaison, the SLFNHA is an advocate for First Nations, Independents and Tribal Councils on system issues. It works closely with NAN on liaison and advocacy.

Physician services, allied health professionals services, and public health services are managed by the SLFNHA, along with nursing service management where requested. It is responsible for recruiting and retention strategies for all Sioux Lookout First Nations. It also provides program consultation services in Primary Health Care development (traditional health, mental health, health promotion, health education resources, human resources, best practices). The focus of these services is to build capacity of First Nations, Independents and Tribal Councils, pass along helpful information from outside systems, and facilitate use of best practices. As well, it has a Client/Patient Advocate,

In policy analysis and development, the SLFNHA has expertise to share with First Nations and Tribal Councils. It concentrates on system-wide issues, coordinating its work with NAN.

Through regular contact with Chiefs, the Chiefs Committee on Health and Chiefs Meetings, it keeps political leadership informed about system issues.

SLFNHA's Responsibilities Under the AHP

- Managing physician services
- Allied health services professionals and capacity building programs for community staff
- Community nursing services (as delegated by First Nations)
- Community health service support unit responsible for recruiting health professionals for all FNs and SLFNHA, retention strategies, orientation, quality assurance, contract management.
- Anishinabe traditional specialist(s) and a program advisor in traditional health
- Public health services including Medical Officer of Health, nurse-epidemiologist(s), community public health nurses (as delegated), environmental health officers, health management information system, research specialist, tuberculosis control program, Canada Prenatal Nutrition Program.
- Program support services including specialists in client/patient advocacy, community development, health promotion and health education, telehealth, special projects
- Nodin/CFI mental health services
- Client services including developing and operating a 100-bed hostel, transportation and translation coordination
- Corporate services of finance, human resources, information technology
- CCOH Secretariat
- Anishinabe Health Careers Secretariat encouraging and supporting increased Anishinawbe participation in health professions including managing a summer student program, internships, and other student support programs.
- A Leadership Development Institute to support continuing education including orientation in leadership, health service governance, health service management for all Sioux Lookout area First Nations.

What is a "Region-Wide" Service?

The Health Authority was created by the Chiefs after the Scott-McKay-Bain Report in 1988. Someone who participated in those discussions describes its original mandate: *"The Health Authority was to be the main repository…for all the services that can't be done at the community. Because of supply of professionals, economies of scale. When we look at health services, we have to take a very close look and determine if they can be done by the community. If so, we'll let them do it. If it involves the whole area, we will know it needs to be done together"* [83]. the SLFNHA, as it grows into the regional health service organization, will take on responsibility for region-wide issues. Some examples include: managing doctors' service arrangements, providing allied health services, facilitating use of quality assurance so program quality is more consistent across First Nations. Other examples would be: coordinating training that is desired by many First Nations, building capacity for management and governance in partnership with First Nations and Tribal Councils, or working toward a permanent solution to birth registration problems with Ontario and Canada.

To undertake new responsibility, growth in governance and management capacity is needed for the SLNFHA Board and staff. Early in AHP implementation, the SLFNHA will have a governance and management review. Based on this more detailed assessment, needed improvements will be made. The planned improvements described below may be revised based on the review.

- Continue using the Board's existing modified policy governance model as described in the existing Policy and Procedures Manual.
- Future appointments to be based on desired knowledge and skills of Board members, using a competencies list to be developed by the SLFNHA Board.
- Establish formal Elder Advisor(s) to the Board, to assist in ensuring Anishinabe ways are being respected and reflected in all the SLFNHA work.
- Formal required orientation for all Board members; on-going orientation availability for new members, using responsibilities as outlined in the existing policy manual.
- On-going leadership development for all Board members including the following, and using methods in the existing policy manual as well as work with the Anishinabe Institute on Health System Governance:
  - Anishinabe governance approaches and methods
  - Governance responsibilities and relevant legal requirements
  - Decision-making processes
  - Fundamental concepts in Primary Health Care and health system operation
  - Using information
- Depending on the Board leadership development and the governance and management review proposed during AHP implementation, the Board reviews its accountability mechanisms and revise as needed.

[83] Key Knowledge Interview, AHP, 2005

- Meeting six times per year; one of these, a meeting with Sioux Lookout Chiefs at the Annual General Meeting. At least one meeting can be by telehealth or teleconference.
- Expand the management team based on evolving responsibilities; be prepared to shrink the management team when responsibilities move to Tribal Councils or First Nations.
- Increase capacity of existing managers; ensure capacity of new managers to undertake management work in a mid-sized First Nations health organization.

Physicians and allied health professionals access clinical space in Sioux Lookout for follow up with clients in space nearby the Hostel and Meno-Ya-Win. A variety of health care professionals use the multi-purpose clinical space. There is an audiology sound booth, as well as exercise and workshop space for physical and occupational therapy.

Health service office space and primary care clinical space is developed separately from Meno-Ya-Win Health Centre, although nearby. Then patients and clients have hostel, follow-up health services, hospital services, and long-term residential care on one large site.

Management

In designing expansion for the Health Authority, three examples of northern Canadian health organizations were used to help determine program management arrangements: Mamawetan Churchilll River Regional Health Authority (SK), Keewatin Yatthe Regional Health Authority (SK), and Weeneebayko Health Ahtuskaywin (ON). All three of these health organizations operate hospitals as well as community health services. As well, other academic and best practice sources were reviewed for guidance.

Mamawetan Churchill River Regional Health Authority (Saskatchewan) serves a population of 21,400 people in 16 communities. It provides hospital services to 11 communities, and 5 communities with primary and community care. It has contract arrangements for physicians serving all communities. It has a total operating budget of $12,500,000 with 184 FTEs. It has a CEO and six department directors (primary health care, acute and continuing care, corporate services, quality initiatives and risk management, human resources, information technology). Department directors have spans of control ranging from 1 – 8. Human resources has 4 FTEs; corporate services has 4 FTEs (responsible for finance, materials & asset management, insurance and contracts, system controls). Both MCRRHA and Keewatin Yatthe RHA share a Population Health Unit with a MHO, unit manager, nurse-epidemiologist, chronic disease nurse, environmental health, and dental health education programs.[84]

Keewatin Yatthe Regional Health Authority (Saskatchewan) serves 11,400 people of whom 94% are Aboriginal ancestry living in 14 communities. KYRHA has a CEO; five directors (finance, corporate services, primary health care, human resources, community health); is responsible for two affiliated hospitals serving the whole region, two nursing stations, additional community health services in three communities, and contract arrangements for physicians in all communities. The budget in 2003-04 was $15,313,925.[85] Finance staff equal 3 FTEs and there are 2 FTEs of human resources staff. Spans of control range from 5 – 9 programs.

Weeneebayko Health Ahtuskaywin (Ontario) is directly responsible for a 50-bed hospital and community primary health care services (exclusive of primary care nurses) for its nine communities

[84] Mamaweta Churchill River Regional Health Authority (2003-04)
[85] Keewatin Yatthe Regional Health Authority. (2003-04)

and about 10,000 people. In addition, it operates three patient hostels (Moose Factory, Timmins, Kingston). It employs 221 people with an annual operating budget of $32 million. It has a senior management team of a CEO and seven program directors (client services & communications, chief of staff, physician and dental services, patient care, corporate services, support services, and human resources). Directors have a span of control of 1-6 programs.[86] It employs a Director of Finance and 5 finance staff, and has 2 staff in human resources.

The recommended span of control for management in an organization varies, based on the innovativeness of the programs, and environmental, organizational and programmatic stability. Generally, a span of 5 – 8 direct reports is considered advisable for program managers and directors.[87] Direct reports have been limited to the lower end due to the newness of programs and the environmental fluidity.

For an organization the size that SLFNHA will become, 2 human resource staff are recommended[88] along with four finance staff.

A new organization chart (Figure 8.1) is shown on the next page, followed by detailed organization charts in the areas of physician services, nurse services, Anishinabe traditional specialists, and mental health. Allied health service teams are multi-disciplinary and are described further in Chapter 5.

An initial Implementation Team is identified; this team will expire within 2-3 years.

[86] Weeneebayko Health Ahtuskaywin (2006)
[87] Robbins, De Cernzo, Condie, Kondo (1998)
[88] Conference Board of Canada (2005)

Figure 8.1 – Sioux Lookout First Nations Health Authority – AHP Implementation Organization Chart (March 2006)

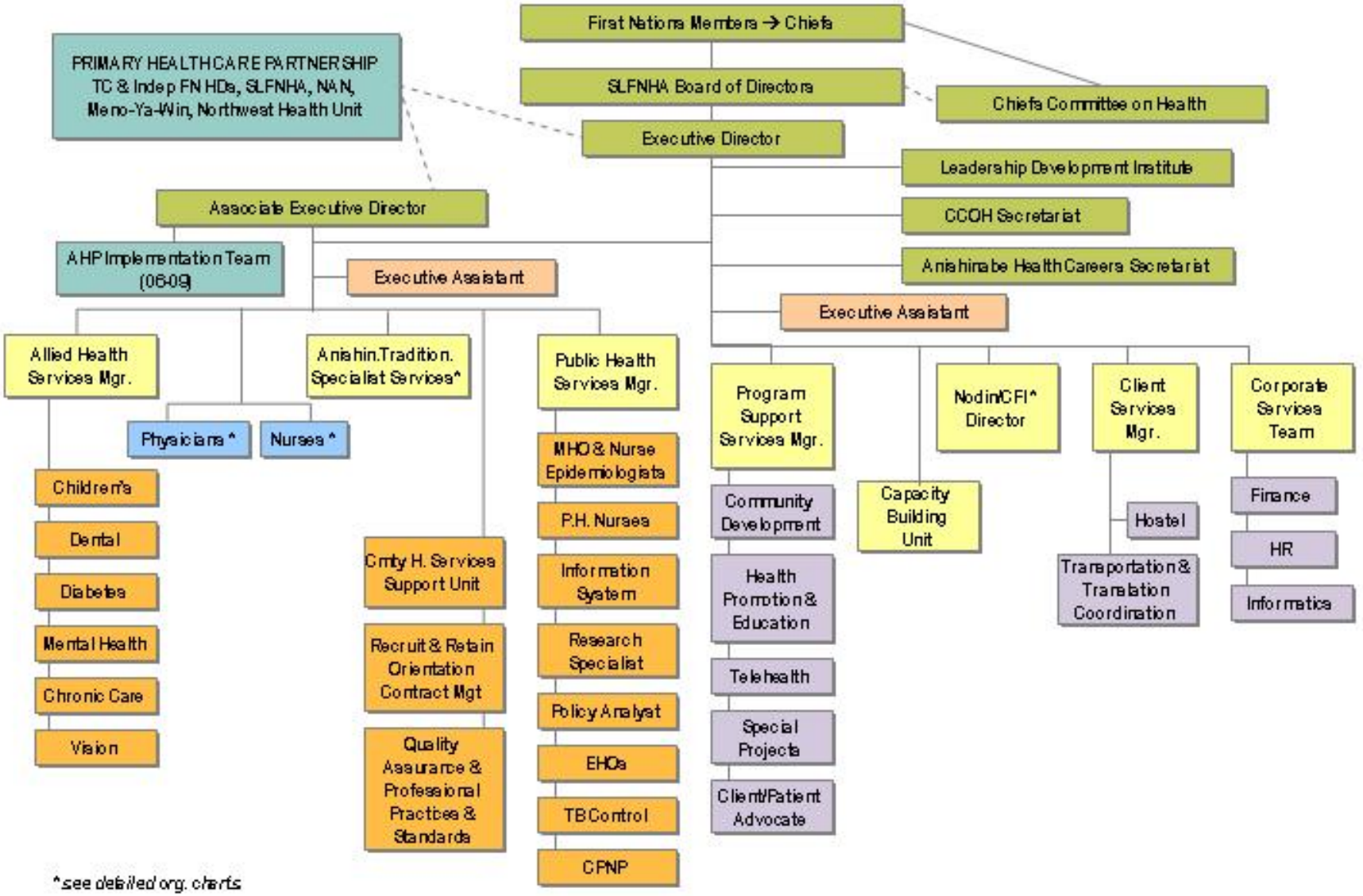

Figure 8.2 – Detailed Organizational Chart

All service managers are expected to ensure risk management, service quality assurance, professional development, and client/patient complaint resolution. ***(March 2006)***

Sioux Lookout First Nation Health Authority Links to Other System Levels and Partners

SLFNHA's first responsibilities are to address region-wide issues in training, policy and advocacy, specialty services including physician services, public health services, and specific mental health services, information management, program consultation and liaison with non-First Nation organizations. It works cooperatively in the system with all partners to achieve the goals of all First Nations. As such, it has links throughout the system and with non-First Nation organizations that have an influence on the health of First Nations. One example would be links with the provincial public health Northwest Health Unit.

SLFNHA has links with tribal councils and independent First Nations in planning, training, quality assurance, professional supervision, information collection and exchange and policy development. It monitors, identifies, analyzes and shares information from non-First Nation organizations that could have an influence on the health status and health development of its partners.

One of the special responsibilities of SLFNHA is to link with Independents and Tribal Councils on public health policy, public health monitoring and public safety issues.

As well, SLFNHA has links with hospitals and health centres that serve its partner First Nations, Independents and Tribal Councils. It works to ensure that policies of these organizations benefit its partners' members. Thus, culturally appropriate service, translation, service access and other policies would be monitored or jointly developed with these non-First Nation organizations to benefit all regional First Nations

Similarly, SLFNHA has links to the Chiefs' Committee on Health through the Board and the CCOH Secretariat, and NAN. These provide information for decision-making and carrying out governance direction from the Chiefs in the development of policy with its partner independent First Nations and tribal councils.

Links with Meno-Ya-Win

Meno-Ya-Win Health Centre was established in 2002 by joining the old 'Zone Hospital' (a federally operated hospital funded mostly by Ontario MOHLTC) and the District Health Centre (a provincially-funded hospital accountable to a local Board). It provides emergency and acute care hospital services to all people living in the Sioux Lookout area. A Board with 2/3 First Nations representatives provides direction for the hospital. It is fully funded by the MOHLTC.

Now, hospital-based services include:

- Emergency room
- Acute inpatient care
- Obstetrics and pregnancy-related hospital care
- Palliative and respite care
- Diagnostics including lab, x-ray, mobile ultrasound, etc.

A new hospital building will be opened in 2009 with expanded services, including 5 detox beds. Clinical space for ambulatory services, it is anticipated, will be included. A new Hostel, operated by the SLFNHA, will be constructed in 2005-06, and will be located next to Meno-Ya-Win. These patients and clients will be a few hundred meters away from hospital and related services.

In our Anishinabe Health Plan, there is a partnership with Meno-Ya-Win. Meno-Ya-Win continues to provide its current and scheduled new services (such as detox). This includes maintaining the extensive integration of physicians serving First Nations with Meno-Ya-Win's emergency and acute services.

Other hospitals at Kenora, Geraldton and Red Lake as well as regional hospitals at Winnipeg and Thunder Bay also provide second and third-level medical services to Sioux Lookout First Nations. The Red Lake Hospital has a special relationship with the Sioux Lookout First Nations providing a base of operations for physicians who have contractual arrangements within the McMaster practice.

Following the AHP, we have an integrated health information system with all these service providers in other locations.

Nishnawbe-Aski-Nation

Nishnawbe-Aski-Nation was established originally as a treaty protection political organization. Deputy Grand Chief Alvin Fiddler, responsible for the health portfolio, is working to return NAN to this original role. This change will take some time. With that goal in mind, it is also important that NAN continue to act as the most influential advocate for all NAN First Nations. To do this, it retains responsibilities in NAN's system-wide policy analysis.

Other roles for NAN include funding advocacy, advocacy on program needs, and political work on health priorities. As part of its advocacy work, NAN engages in liaison and advocacy on direct service issues and programs at the request of Sioux Lookout Chiefs-in-Assembly.

To assist member First Nations, NAN helps to co-ordinate communication and liase with regional training programs.

Our Links to Nishnawbe-Aski-Nation

We continue our relationship with NAN in the development of NAN-wide training, advocacy, and policy development.

Our Links to First Nations' Inuit Health Branch (FNIH), Ontario Region

The Ontario Region of FNIH is the contact point for First Nations health services and issues. Grounded in treaty links with First Nations, FNIH provides most of the funding for First Nations community health services. As well, it is responsible for the Non-Insured Health Benefits Program (NIHB) that includes medical travel benefits.

In our Anishinabe Health Plan, it is responsible for working with First Nations to fund necessary training and education programs. It partners with First Nations to use province-wide and national health information systems to support analysis of health status, using information to improve national program effectiveness and advocate for appropriate health funding and programs.

At a national level, FNIH ensures all health system planning and implementation includes full First Nations' participation.

We continue our relationship with FNIH and seek to improve our partnership through more regular communication and joint decision-making.

Our Links to Ontario Ministry of Health and Long Term Care (MOHLTC)

The Ministry provides funding for and access to publicly-funded health care services for residents of Ontario. Its responsibilities include ensuring First Nations have equitable access to all publicly-funded services.

It funds hospital and physician services, including specialists. It also funds the Aboriginal Healing and Wellness Strategy, which many First Nations use to fund important on-reserve services. Special programs, such as Healthy Mother/Health Baby and the FASD Prevention Program provide funds to some First Nations. More provincial funding is expected in the future as the Chiefs have endorsed its use for health services on reserve. This confirms a policy change that has developed over the past decade.

MOHLTC is also responsible to ensure all health system plans include First Nations' representation.

Our Links to Ontario Ministry of Health and Long Term Care

We work with the Ontario Ministry of Health and Long Term Care in the provision of services assigned to them under the Constitution of Canada. This includes cooperation with the Northwest Health Unit, which is responsible for public health services. A more detailed plan for public health services is to be prepared in the future. Specifics of relationships will be determined at that time.

The MOHLTC is initiating a change to Local Health Integration Networks (LHINs) that will have responsibility for distributing funding for many health services, including hospitals. The Nishnawbe-Aski-Nation Chiefs are deeply concerned about the continued work on establishing LHINs without respectful inclusion of First Nations in the planning and implementation work. Chiefs and the NAN Deputy Grand Chief are engaged in discussions about First Nations relationships with the LHINs. When these discussions have concluded, it will be possible to describe more clearly the relationships and links between LHINs and the Sioux Lookout First Nations.

Assembly of First Nations

- Co-ordinate national training access
- Provide links between jurisdictions
- Advocate for First Nations funds
- National recruiting support
- Links with national professional groups
- National data collection and analysis with reporting to First Nations, Canada and provinces
- Access to national communicable disease control and public safety agencies
- Adaptation of health systems to First Nation needs
- Monitoring and reporting on Non-insured Health benefits

Our Links to the Assembly of First Nations

We link to the Assembly of First Nations through our political organization, the Nishnawbe-Aski-Nation.

Canada – Indian and Northern Affairs, Human Resource Development, Public Health and Safety, Health Canada

- Funding training, capacity building, adapt training in partnership with First Nations
- Emergency response support, including epidemic response planning support and training
- Manage national public health agencies, including communicable disease control
- Report regularly to First Nations and their agencies; summarize program evaluation results into best practices
- Fund planning activities, partner with First Nations on national, regional and local planning activities
- Fund community programs
- Adjust requirements to meet community needs and realities
- Base funding on treaty obligations
- Establish and maintain national communicable disease initiatives
- Maintain on-going policy links with federal agencies
- Advocate on behalf of First Nations' treaties

Our Links to Canada – Indian and Northern Affairs, Human Resource Development, Public Health and Safety, Health Canada

We link to Indian and Northern Affairs, Human Resource Development, Public Health and Safety, Health Canada through our political organizations, starting with First Nations, tribal councils, and the Nishnawbe-Aski-Nation. Technical links are also maintained between these agencies and SLFNHA when appropriate.

Table 8.3 – Roles and Responsibilities

The proposed Anishinabe Health Plan establishes the following division of responsibilities in the health system, based on recommendations from the Primary Health Care Working Group (2005) and on the work of representatives of the Sioux Lookout First Nations at a healthy systems planning workshop in 1997. The Chiefs Committee on Health also recommended these responsibilities; Chiefs-in-Assembly accepted these as part of the AHP, with the provision that any overlap be clarified during implementation. These roles and responsibilities come into being over time; any changes in First Nations' roles at the community's pace. Flexibility in arrangements is possible as First Nations make arrangements most suitable for their situation.

Level of Service / Support	**Type of Support or Service**				
	Capacity Building, Training & Education	***Information, Research & Evaluation***	***Planning***	***Community Health Services***	***Policy Analysis & Development***
FIRST NATION Use culture & language in all cmty activities Note: IFNA FNs have a blend of FN and TC responsible depending on program	• Identify & meet local training needs; collaborate where possible • Evaluate training effectiveness • Training & orientation of all new staff & government members • Build capacity for FN management & service quality consistency • Build leadership capacity • Identify and encourage people interested in health careers; link with Anishinabe Health Careers Dev. Program; • provide internships & summer employment	• Collect & send in information • Use information from district information system • Evaluate programs & staff • Identify research priorities • Use program quality consistency feedback to improve services • Liaise with system research projects	• Create Cmty Health Plan (with TC support as needed) • Develop proposals for improvement or change • Implement Cmty Health Plan & program plans	• Support cmty development, healing & culture re-powering • Seek cmty direction on programs • Cmty health service mgt. • Patient/client advocacy • Nursing employment if desired • Ensure access to traditional specialists as appropriate/needed • Manage emergency response • Ensure consistent service quality • Report to cmty on health & service quality • Identify & collaborate to meet capital needs • Multi-sector/ inter-agency	• Develop & implement local health policy • Identify health public policy opportunities; collaborate with other to create change. • Analyze local issues

Level of Service / Support	**Type of Support or Service**				
	Capacity Building, Training & Education	***Information, Research & Evaluation***	***Planning***	***Community Health Services***	***Policy Analysis & Development***
				collaboration	
INDEPEN. FNS	• Same as above + TC responsibilities below	• Same as above + TC responsibilities below	• Same as above + TC responsibilities below	• Same as above + TC responsibilities below (Cmty Dev Wrkr @ SLFNHA)	• Same as above + TC responsibilities below
TRIBAL COUNCIL	• Support FN capacity building – tutor & mentor • Coordinate TC-wide training • Partner to meet other training needs • Share information on training opportunities • Orient new C&C members & FN HDs to TC health roles • Support use of consistent quality tools • Ensure links with Anishinabe Health Careers Development Program	• Help FNs gather & use information • Use data in TC planning • Track service consistency & provide support • Coordinate TC-wide research	• Support cmty planning & proposal development • TC program planning • Coordinate multi-sector planning at TC • Support FN HDs interchange • Advocacy for FNs • Facilitate use of program consistency & quality tools	• Advocacy for FNs • Program support, advice, capacity building, problem-solving, mediation, system information sharing, support use of consistent quality tools • Service advocacy requested by FNs • Direct services delegated (e.g., nursing) & staff support • Mediation • Delegated flow through funding • Build on existing service models such as IFNA Physicians & Shibogama Nursing	• Support FN policy development & issue analysis • Prepare policy analyses for TC-specific issues

Level of Service / Support	**Type of Support or Service**				
	Capacity Building, Training & Education	***Information, Research & Evaluation***	***Planning***	***Community Health Services***	***Policy Analysis & Development***
SLFNHA	• Expertise in maintaining consistent service quality, planning, training program design using Anishinabe frameworks • Coordinate district training • Keep TCs and independent FNs informed on training opportunities • Support & coordinate professional career education & training; link youth and adults with Anishinabe Health Careers Development Program • Orient new C&C members, & HDs to SLNFHA roles and overall system • Support on-going orientation of SFLNHA staff & board • Assist FNs with orientation materials as needed	• Plan & operate health information system for FNs & TCs; share information to assure health • Coordinate district-wide research projects • Expertise in research & evaluation, including using Anishinabe frameworks • District health status research & reporting • MHO & epidemiology unit	• Expertise in planning using Anishinabe frameworks • Support to TCs and independent FNs • Whole system vision and planning • Liaison with other non-FN organizations in whole system planning • Capital planning support & liaison	• Advocacy on district-wide issues & issues assigned by CCOH or Chiefs-in-Assembly • Regional specialist-consulting services: PHC, MH, cmty dev, comm. disease, H promo, H ed resources, human resources, quality consistency tools • Direct services: small scale specialty programs (e.g., TB, MH, environ health); Public Health support services (MHO, epi, CDC etc.); physician services; nursing services; allied health services • Leadership capacity building • Liaison with non FN second level agencies • Coordinate development of program standards on district-wide programs (e.g., handling medications, standards of primary care)	• Expertise in policy analysis and policy development • Share policy developments with TCs & independ FNs • Key communicator with Chiefs and non-FN governments on district issues

Level of Service / Support	Type of Support or Service				
	Capacity Building, Training & Education	***Information, Research & Evaluation***	***Planning***	***Community Health Services***	***Policy Analysis & Development***
NAN	• Funding advocacy • Coordinate & liaison with regional training programs	• NAN-wide information system • Regional health status assessment, research & reporting • Links with natl. projects	• NAN-wide planning including strategic planning • Advocacy on program needs • Political work on health priorities	• Liaison and advocacy on region-wide issues • Represent region at natl. groups	• Treaty protection • Links between jurisdictions • Review legis. changes & policy implications
MOHLTC	• Certification of training • Set professional registration requirements	• Provide province-wide health status information • Ensure availability of FN community specific data for further research and analysis	• Province-wide planning initiatives with FN participation • Province-wide systems accommodate FN distinct participation	• Constitutional health funding responsibilities: – specific community health services (e.g., crisis, care supports, allied health services, physicians, etc.); hospital services, long term care, allied health professions, etc.	• Ensure FN health issues included in MOHLTC deliberations • Develop policy in inclusive manner • Policy for province-wide issues
AFN	• Coordinate natl. training access • Links between jurisdictions • Advocate for FNs needs • National recruiting support • Links between natl. professionals groups	• Run natl. health information system for FNs; report regularly to FNs and Canada & Provinces	• Leadership in natl. planning activities • Natl. frameworks to adapt health systems to regional FN needs	• Leadership in natl. program changes (e.g., NIHB changes) • National health education materials	• Natl. treaty protection • Natl. political accords • Policy work on natl. issues • National program advocacy • Impacts of natl. policies on FN health status

Level of Service / Support	**Type of Support or Service**				
	Capacity Building, Training & Education	***Information, Research & Evaluation***	***Planning***	***Community Health Services***	***Policy Analysis & Development***
Canada – Health Canada INAC HRDC Pub Health	• Fund training and capacity building • Adapt training in partnership with FNs • Emergency response support including for epidemics	• Run national public health and safety agencies including communicable disease control • Natl. FN health status research & reporting	• Fund national planning activities; ensure FN participation • Ensure inter-sectoral collaboration at federal level	• Fund on-reserve health services • Support FN health services with information, research	• Linking jurisdictions on policy work in FN health

CHAPTER 9 – Financial Planning Process

Key Ideas

- Zero-based budgets will be developed for each aspect of the AHP during implementation.
- There are significant capital and infrastructure requirements that will need to be addressed to support the AHP implementation.
- Additional resources will be required to support the implementation of the AHP.
- Investments in upstream activities will be needed to ensure the success of the AHP in the long term.

Introduction

This chapter will identify the major cost components of the primary health care system (AHP) being proposed for the Sioux Lookout area and the preliminary work that has been completed, most notably in the human resource area.

Functional plans have not been sufficiently developed at this point to prepare detailed budgets for the new AHP. From the overall strategic plan of the organization, detailed functional plans will be developed providing the necessary information to commence the budgeting process.

The information compiled in the functional plans will serve several uses:

- the information will be used in developing budgets;
- the information will be used in assessing whether there are adequate human resources to institute the plan (i.e., the labour management plan); and
- the information will be used in assessing whether there is sufficient capital infrastructure to reach the desired program capacity.

Collectively, the functional plans are considered an overall strategy or plan describing how, when, and where the objectives and goals will be accomplished for each function as well as for the entire project.

As the 'value' enhancing activities are identified from the functional plans, then the attendant costs will be developed.

Zero-based budgets will then be developed in two broad categories: the Operating Budget, sometimes referred to as the "expense" budget, and the Capital Budget (infrastructure requirements).

Development – Functional Plans

Implementation Process

Over the next two (2) years, key elements of implementation of the AHP will take place, based on the following six themes:

- incorporating Anishinabe ways;
- applying good governance and management practices;
- building capacity through continuous learning;
- delivering services through team-based primary health care;
- ensuring adequate infrastructure; and
- continuous monitoring to improve outcomes.

During the first six months of the 2006-07 fiscal year, some foundational work will be done in preparation for the implementation plan to proceed. The second half of the fiscal year (October 2006 – March 2007) will emphasize initiation of the implementation process using the six themes.

During the implementation stage of the project, the organization will continue to align activities, core processes and resources towards supporting mission-related outcomes. The level of performance to be achieved by specific activities or projects will be identified as a program activity in the budget, typically in an objective, quantifiable and measurable form, along with a description of the processes, skills, human and capital assets, and other resources required to meet program goals.

The attached schedule (Table 9.1) prepared by the AHP Working Team sets out details and estimated costs on work to be carried out during the 2006-07 fiscal year on the AHP.

Table 9.1 – Anishinawbe Health Plan Implementation for Fiscal Year 2006-07

Category	Description/Assumptions	Cost
1. Skills development	• Manager-in-training (10 months) • Director of Clinical Services-in-training	$ 55,000 65,000
2. Implementation Plan & Mechanisms	• Detailed 3-year implementation plan with medium and long-range goals & outcomes for approval by Chiefs in September 2006	220,000
3. Negotiations	• Detailed business plan by August 2006 for decision by Chiefs • Secure a negotiator for physician services and complete negotiations by September 2007	28,000 52,500
4. Physician Services	• Medical Director (1.0 FTE) • Recruitment & Retention Coordinator (1.0 FTE) • Interpreters	300,000 60,000 300,000
5. Governance and Management Review	• Detailed governance & management framework by August 2006 • Initial implementation of governance mechanisms, policies and accountabilities (Chiefs & SLFNHA) in October 2006; and implementation of SLFNHA management mechanisms, policies & accountabilities in October 2006	28,000 70,000
6. Communication	• All communication materials, including translation of key materials • Communication specialists (2 individuals @.5 FTE's, including travel)	100,000 160,000
7. Information Management	• Identify information requirements	70,000
8. Capital Planning	• Complete a district capital needs assessment plan by March 2007	250,000
9. Management & Overhead	• Project Manager (1.0 FTE) and Project Assistant (1.0 FTE) • Legal Services • Overhead	140,000 75,000 200,000
10. Evaluation	• Establish mechanisms for data collection and monitoring • Interim evaluation by October 2006 • Annual evaluation	60,000
11. Meetings	• Meetings with Chiefs with video conference updates • 6 PHC Working groups; 3 meetings include Health Directors • 6 CCOH meetings	305,000 240,000 180,000
TOTAL		$ 2,958,500

During the next five (5) years, a clear path for action with goals, objectives and activities will be established through the Anishinabe Health Plan (AHP). The plan will be designed to lay the foundation and build capacity throughout the primary health care system so that both communities

and SLFNHA can assume responsibility for governance, management and service delivery at their pace.

Operating Costs – New AHP

The proposed new primary health care model for the First Nation communities of the Sioux Lookout area will see a shift from the current model that is focused on acute care to a model that will ensure services are delivered to meet the communities' needs in all five areas of action. These areas are curative, promotive, preventive, support and rehabilitative services.

Human Resources

Community Level

The working group has identified the types of health care providers and professionals needed for the new AHP and the numbers required, dependent on community size by population categories. This data has then been extrapolated by population numbers for all communities to be served by the new AHP to provide the total numbers of health care numbers required at the community level.

This data is identified in Table 9.2.

Table 9.2 – Primary Health Community Team Members

Component	Type of Worker	Pop - 200 *FTE's*	Pop - 500 *FTE's*	Pop -1,000 *FTE's*	Pop - 2,000 *FTE's*	Total ALL Pop - 20,491 *FTE's*
Curative	Primary Care Nurse	1.50	2.50	4.00	8.00	91.82
	PHC Nurse Practitioner	0.50	1.00	2.00	4.00	41.44
	On–call First Response	0.00	0.25	1.00	2.50	18.30
	Physician	0.25	0.63	1.25	2.50	25.46
	Medical Translator/Clerk	1.00	1.50	3.00	7.00	68.03
	Pharmacist	0.05	0.10	0.20	0.25	3.53
	Pharmacy Technician	0.25	1.00	1.25	2.00	27.47
	Phlebotomist	0.25	0.50	0.50	1.50	16.01
	Basic Radiography Worker	0.00	0.25	0.25	0.50	6.09
	Ultrasound Technologist	0.00	0.00	0.00	1.00	4.12
	Telehealth Coordinator	0.25	0.50	1.00	1.00	16.60
	Technician	0.00	0.00	0.25	0.50	3.38
	Sub-Total	4.05	8.23	14.70	30.75	325.65

Component	Type of Worker	Pop - 200 *FTE's*	Pop - 500 *FTE's*	Pop -1,000 *FTE's*	Pop - 2,000 *FTE's*	Total ALL Pop - 20,491 *FTE's*
Promotive/ Preventive	Public Health Nurse	0.50	1.00	2.00	4.00	41.24
	MH & Addictions Worker	2.00	4.00	8.00	12.00	149.29
	Environmental Health Tech	0.25	0.50	1.00	1.00	16.60
	Clerk Interpr/Pub Health Aid	0.00	0.50	1.00	2.00	18.96
	Community Health Educator	0.50	1.00	2.00	3.00	37.32
	Community Development worker	0.00	1.00	1.50	2.00	27.03
	Sub-Total	3.25	8.00	15.50	24.00	290.44
Supportive/ Rehab.	Home Support Workers	1.50	2.00	3.00	6.00	72.86
	Personal Care Workers	0.50	1.00	1.50	2.00	30.55
	Sub-Total	2.00	3.00	4.50	8.00	103.42
	TOTAL ALL FTE's	9.30	19.23	34.70	62.75	719.51

Using the numbers and types of health care providers as established by the AHP working group and extrapolating based on the community population numbers (total 20,491) as provided by Lawrence Thompson Consulting, results in a total of 719.51 FTE health care providers required for the new AHP in the communities.

Detailed calculations of FTE's by community can be found in Appendix A, Table I.

In the implementation phase of the new AHP, each community will be assessed individually in terms of its requirement for services and resources.

Table 9.3 is presented following to provide a preliminary calculation for medical health provider salaries at the community level under the proposed new AHP in comparison to what is being incurred under the present health care system.

Table 9.3 – Sioux Lookout Zone Primary Health Care – Medical Service Costs

Community	Population	New PHC Salaries *($000's)*	Act 2005-06 PHC Salaries *($000's)*	Act 2004-05 PHC Salaries *($000's)*
Koocheching	0	0	0	0
Wawakapewin	24	105	0	0
McDowell Lake	39	145	0	0
Wabauskang	80	255	0	0
Saugeen	133	398	0	0
New Slate Falls	186	541	0	13
Wabigoon	200	578	0	4
Muskrat Dam	263	686	153	2
Eagle Lake	300	749	0	0
Neskantaga	335	809	331	225
Nibinamik	367	864	357	319
Wapekeka	367	864	0	0
Poplar Hill	405	929	201	0
North Spirit Lake	416	948	277	0
Kingfisher Lake	426	965	0	0
Cat Lake	521	1,126	513	431
Wunnimun Lake	528	1,138	0	0
Fort Severn	540	1,158	488	519
Keewaywin	540	1,158	147	0
Sachigo Lake	587	1,236	569	440
Bearskin Lake	595	1,249	523	377
Webequie	800	1,568	529	406
North Caribou Lake	813	1,610	705	603
Kasabonika	843	1,659	532	377
Deer Lake	943	1,825	792	704
Big Trout Lake	1,116	2,104	1,095	940
Mishkeegogamang	1,250	2,119	722	653
Eabametoong	1,817	3,223	700	566
Lac Suel	1,890	3,339	0	0
Pikangikum	1,988	3,496	1,321	1,113
Sandy Lake	2,179	3,801	1,215	1,097
Sub-Total	20,491	$ 40,645	$ 11,170	$ 8,789
Physician Salaries		7,637	7,193	7,189
Nursing Salaries – Sioux off		0	2,503	2,606
Sub-Total		$ 7,637	$ 9,696	$ 9,795
TOTAL		$ 48,282	$ 20,866	$ 18,584

Notes:

1. *NEW PHC salaries are calculated on the FTE's as determined by community on attached Appendix A, Table I.*
2. *Actual 2005-06 and 2004-05 salary costs for medical health providers at the communities have been taken from the actual cost summary reports prepared at the Sioux Lookout Zone office.*
3. *The item 'Nursing Salaries – Sioux Off' for the years 2005-06 and 2004-05 represents nursing costs for the communities that were paid directly out of the Sioux Lookout nursing office and not through the community. In the NEW PHC salary costs by community all nursing salaries are included in the community salaries as presented in Table 9.3.*

Allied Health Services

Under the proposed new AHP, allied health teams will provide direct service to the communities in the supportive and rehabilitative areas. Teams of allied health professionals would travel out to the communities to provide services based on the needs of the community. While the supportive and rehabilitative programs and service areas require more developmental work, Table 9.4 provides an indication of the types of specialized professional making up the allied health teams.

Table 9.4 – Allied Health Professionals

Team Member	Proposed FTE's	Annual Salary	Total Salaries
Chiroposists/Podiatrists	1	$ 75,000	$ 75,000
Dentists	10	150,000	1,500,000
Dental Hygienists	10	75,000	750,000
Dental Educators	6	60,000	360,000
Dental Assistants	2	50,000	100,000
Dieticians/Nutritionists	4	50,000	200,000
Occupational Therapists	3	75,000	225,000
Orthotists	1	75,000	75,000
Orthotist Aides	1	50,000	50,000
Physiotherapists	5	75,000	375,000
Speech Language Pathol	1	75,000	75,000
TOTAL ALL – NEW	46		$ 3,785,000
Total AHP – 2005-06			$ 2,079,000
Total AHP – 2004-05			$ 1,884,000

Notes:

1. *Allied Health professional positions and FTE's taken from AHP Chapter 5*
2. *Allied Health professional costs for years 2005-06 and 2004-05 were taken from the actual costs summary reports prepared for those years at the Sioux Lookout Zone office.*

Other Operating Costs

At Community Level

In the implementation phase of the new AHP, each community will be assessed individually in terms of the makeup of their primary health care teams based on their unique requirement for services and resources.

Budgets will have to be established in the following areas once human resource and capital infrastructure requirements are in place at each community:

a) office/administrative staffing numbers and costs;

b) travel costs for PHC team members and admin staff;

c) general administrative costs (i.e., office supplies, telephone, fax, etc.); and

d) general operating budgets (would include utility costs for capital facilities, repairs, etc.)

Existing Health Care Service

In the existing health care model, the emphasis is on urgent/emergency care services with episodic illness and the demand for treatment consuming the majority of the existing health care resources. (I.e., nurses and community based workers who should be delivering public and population health programs are the core providers of primary care. Nurses take the place of physicians due to lack of services at the community level.)

Table 9.5 (following) provides a summary of costs for years 2005 and 2006 by major cost component; Table 9.6 provides a listing of the Contribution Agreement costs for these years.

Table 9.5 – Sioux Lookout Zone – Health Care Costs by Major Cost Components for Fiscal Years 2006 & 2005

Cost Component	Year 2005-06 *($000's)*	Year 2004-05 *($000's)*
Medical Contracts (physicians, nurses, other medical)	22,945	20,468
Medical Travel	1,444	973
Wages & Salaries – service & administrative	3,811	3,358
Medical Supplies	1,249	1,187
Operating Costs – service & administrative	3,393	3,696
OHIP Revenues	(630)	(433)
Non Insured Travel	14,651	9,663
Utility Costs	1,061	1,098
Sub-Total	$ 47,924	$ 40,010
Contribution Agreements (details – Table 9.6)	29,834	25,938
TOTAL ALL COSTS	$ 77,758	$ 65,948

Table 9.6 – Summary of Contribution Agreements for Fiscal Years 2006 & 2005

Contribution Agreements	Year 2005-06 *($000's)*	Year 2004-05 *($000's)*
Brighter Futures	444	470
Central Health Services	4,105	4,729
Non HC Facilities (mainly for small capital/mtce)	3,371	2,788
Non Insured Health Services	2,946	2,847
NADAP (native alcohol & drug abuse program)	779	806
FNIH Health Consultations	3,227	3,140
HIV Aids Program	16	0
Integrate Community Services	9,379	9,105
Mental Health Crisis Management	1,941	1,934
Solvent Abuse	33	38
Environmental Health Program	30	81
FNIH Information Systems	95	0
FNI Drinking Water Safety Program	85	0
Cdn Pre Natal & Nutrition Program	210	0
Aboriginal Head Start Programs on Reserve	1,363	0
Diabetes Strategy	329	0
Tuberculosis	417	0
Health Prevention Programs – injury & illness	1,064	0
TOTAL	$ 29,834	$ 25,938

Attached Appendix A, Tables II and III, provides additional cost details for the cost components presented in Tables 9.5 and 9.6 (previous).

Table 9.7 provides preliminary cost information on medical professional salary costs for the new AHP based on the calculated FTE's as determined in Appendix A, Table I, and are presented alongside actual medical salary costs by community for years 2005 and 2006, (taken from the cost summaries prepared by the Sioux Lookout Zone finance office and have been summarized in Appendix A, Tables II and III).

Other Operating Costs for the new AHP are at a preliminary stage of development and are not presented as part of this report.

Summary – Operations

The implementation plan as proposed by the AHP working group (Table 9.1) provides for a detailed activity plan and business plan for the next three (3) years to be available for review at the September 2006 Chief's meeting.

Using this information, a detailed AHP budget for the 2006-07 fiscal year and a preliminary long-range budget (3 years) could be prepared for the September meeting.

Capital Infrastructure

During the first five (5) years of implementation, work on the AHP will concentrate on building capacity throughout the primary health care system in order that both SLFNHA and the communities can assume the responsibility for governance, and management and service delivery of the new health care system at their pace.

The functional plan to be developed for capital will therefore encompass the entire scope of the new health care system.

The information compiled in the functional plan on capital infrastructure requirements will have several uses:

- the information will be used in assessing whether or not there are adequate resources to institute the proposed new health care system;
- the information will be used in developing budgets; and
- the information will indicate when capital assets are required.

A key theme will be to ensure that adequate infrastructure exists at all locations to proceed with the new health care system. The functional steps of the capital plan will include concrete, specific actions and the time frame for when they are to be performed.

Present Situation at Community Level

Without additional capacity, the new AHP is not deliverable.

A preliminary survey of capital infrastructure completed during 2005 for the Northern communities indicates that present facilities in most communities are insufficient to meet the program needs of the new Primary Health Care program (data set out in Table 9.7).

Table 9.7 – Health Service Infrastructure – Present

Community	Total Office Staff Working at Community	# Offices Available in Community	Health Staff Working at Community	# Offices Available at Nursing Station	Total ALL Staff Working at Community	Total # of All Offices at Community
Koocheching	3	0	0	0	3	0
Wawakapewin	0	0	2	4	2	4
McDowell Lake	0	0	0	0	0	0
Wabauskang	7	2	0	0	7	2
Saugeen	0	0	0	0	0	0
New Slate Falls	10	5	6	3	16	8
Wabigoon	4	3	0	0	4	3
Muskrat Dam	0	0	10	5	10	5
Eagle Lake	4	3	8	8	12	11
Neskantaga	14	8	14	5	28	13
Nibinamik	19	10	8	4	27	14
Wapekeka	0	0	10	0	10	0
Poplar Hill	12	5	9	3	21	8
North Spirit Lake	13	0	13	9	26	9
Kingfisher Lake	0	0	19	7	19	7
Cat Lake	15	8	10	6	25	14
Wunnimun Lake	11	3	9	5	20	8
Fort Severn	1	0	16	3	17	3
Keewaywin	4	2	10	5	14	7
Sachigo Lake	2	2	10	4	12	6
Bearskin Lake	5	8	12	8	17	16
Webequie	6	4	12	6	18	10
North Caribou Lake	4	1	16	11	20	12
Kasabonika	4	4	11	7	14	11
Deer Lake	16	1	5	3	21	4
Big Trout Lake	8	8	9	6	17	14
Mishkeegogamang	24	6	12	5	36	11
Eabametoong	12	13	11	4	23	17
Lac Seul	19	9	10	7	29	16
Pikangikum	0	0	31	12	31	12
Sandy Lake	0	0	20	7	20	7
TOTAL	216	105	302	147	518	252

The lack of facility space at the communities is very evident when the proposed increases in staffing from the new AHP is combined with the existing administrative staffing (Table 9.8).

Table 9.8 – Health Services Infrastructure (With Impact of Proposed Increases in PHC Staffing)

Community	Total Office Staff Working at Community	# Offices Available in Community	Health Staff TO BE Working at Community	# Offices Available at Nursing Station	Total ALL staff TO BE Working at Community	Total # of All Offices at Community
Koocheching	3	0	0	0	3	0
Wawakapewin	0	0	1	4	1	4
McDowell Lake	0	0	2	0	2	0
Wabauskang	7	2	4	0	11	2
Saugeen	0	0	6	0	6	0
New Slate Falls	10	5	8	3	18	8
Wabigoon	4	3	9	0	13	3
Muskrat Dam	0	0	11	5	11	5
Eagle Lake	4	3	12	8	16	11
Neskantaga	14	8	13	5	27	13
Nibinamik	19	10	14	4	33	14
Wapekeka	0	0	14	0	14	0
Poplar Hill	12	5	16	3	28	8
North Spirit Lake	13	0	16	9	29	9
Kingfisher Lake	0	0	16	7	16	7
Cat Lake	15	8	19	6	34	14
Wunnimun Lake	11	3	19	5	30	8
Fort Severn	1	0	20	3	21	3
Keewaywin	4	2	20	5	24	7
Sachigo Lake	2	2	21	4	23	6
Bearskin Lake	5	8	21	8	26	16
Webequie	6	4	28	6	34	10
North Caribou Lake	4	1	28	11	32	12
Kasabonika	4	4	29	7	32	11
Deer Lake	16	1	32	3	48	4
Big Trout Lake	8	8	37	6	45	14
Mishkeegogamang	24	6	37	5	61	11
Eabametoong	12	13	55	4	67	17
Lac Seul	19	9	57	7	76	16
Pikangikum	0	0	60	12	60	12
Sandy Lake	0	0	65	7	65	7
TOTAL	216	105	690	147	906	252

Capital Needs Outside of Communities

Clinical Space

The facilities of the Meno-Ya-Win Health Clinic where Northern physicians 'share' space to provide outpatient care to northern residents are badly outdated, overcrowded and spread over multiple sites. Physicians require the necessary clinical and office space to better service the needs of people from the northern communities.

A new primary health care facility built in close proximity to Meno-Ya-Win and the new hostel is an option for providing the necessary space to support the northern community service.

Additional Administrative Offices

SLFNHA will require additional office space to accommodate the significant manning increases that will result from the impact of the new Primary Health program.

A detailed space analysis will be conducted to determine actual space and equipment requirements.

Functional Plan on Infrastructure

A capital strategy is required that will provide the necessary infrastructure capacity to meet the anticipated program demands of the new health care program.

The capital outlay planning and budgeting process will be linked to program needs, goals and objectives and connected to the organization's strategic planning efforts. Capital assets will be planned for, acquired, and managed according to their ability to contribute to the desired program outputs and outcomes.

Consensus

A key goal of the planning methodology will be to develop consensus amongst the major stakeholders on both project priorities and schedules. The development of consensus must include a complete awareness of existing facilities conditions and program requirements. This gathering of data and information will be conducted simultaneously and linked together in a decision-making process of ranking priorities.

Proposed Methodology

The Implementation Team will perform a comprehensive assessment of existing conditions in all communities to determine priorities for coordination with program requirements.

The assessment of existing infrastructure conditions will be conducted by a facilities audit team. The assessment will include walk-through surveys of existing facilities, review of building drawings and interviews with facility staff at each location.

A standardized electronic reporting format guide will be established for the process.

The implementation team will evaluate the capacity of existing assets at each location for bridging the performance gap between current and planned results. The plan that is developed must be acceptable to all major parties and will provide answers to the following questions:

- What opportunities exist to better utilize current space, equipment and technology?
- How much new space and equipment is required?
- What options will best provide the required capacity increases?
- Will service levels reached the required levels because of the infrastructure changes?

Once it is known how much additional space and equipment are required, the implementation team will identify the options existing to provide the required infrastructure improvements by:

- determining the expansion potential at current locations;
- identifying potential locations for new infrastructure;
- evaluating thoroughly each potential expansion option and selecting the one most appropriate; and
- develop an implementation plan at each location.

Because the required new infrastructure will be brought on stream at various times throughout the implementation process, a carefully prepared plan to monitor progress during the implementation process must be in place. The plan will be time-phased so that the additional capacity is available when needed and when other management decisions and actions are needed.

The implementation plan will provide a critical mechanism to monitor overall progress, effectively utilize the available funding and resources, and take corrective action during the implementation stage if a specific project demand turns out to differ significantly from the originally projected action.

Projects that qualify for the capital outlay budget would include:

- land acquisition;
- site development and improvement;
- acquisition or construction of buildings or other structures;
- additions or expansion to existing facilities;
- installation, extension or replacement of utility systems or major building system components;
- roof replacements;
- hazardous materials abatement; and
- initial equipment and furnishings for new buildings.

Contents of Capital Budget Requests

Each request should contain a detailed project description and justification that includes:

- an analysis of need with corroborative data;
- a reasonable estimate of the date when the project will be needed;
- the project's proposed location;
- the estimated construction cost;
- the cost of equipping and furnishing the project;
- on requests that involve construction of new or additional space, a space utilization plan;
- the cost of opening and operating the facility for the first year;
- the estimated annual operating and maintenance costs of the facility and the method and source of financing; and
- an identification and description of other similar facilities and projects in the given area and an evaluation of their capabilities to meet needs.

Capital budget requests will not include any of the following (covered in operating budget requests):

- repair or renovation projects such as painting, flooring, etc.;
- roof repairs that do not extend the useful life of the roof;
- moveable equipment and furnishings except for that associated with new buildings;
- vehicles of any type;
- repair or renovation of minor building components, such as plumbing fixtures, locks, etc.; or
- regular maintenance materials & supplies.

Summary – Infrastructure

Because of the cross-functional aspects of this project, the Implementation Team will have a broad range of business capabilities, including facilities planning, logistics, financial analysis and human resources. These capabilities will ensure that all relevant options are surfaced and evaluated in a practical manner.

The evaluation of program and departmental space and functional needs will be thoroughly assessed, then tied back to the project's strategic plan.

Future uses of both existing and new buildings will be outlined in a summary program statement.

Consensus must be reached on project priorities and schedules based on a complete awareness of existing facilities conditions and program requirements.

The components of existing infrastructure conditions and program requirements will then be used to prepare the final capital plan.

CHAPTER 10 – System Supports

Conversion to an integrated Primary Health Care system requires several supports. We are committed to keeping what already works well *and* adapting to new ways in the transition to the Anishinabe Health Plan. This chapter describes essential system supports. As implementation proceeds, other system supports may arise.

Information Management System

We *must* have a useful health information management system. This is an *urgent* need. It is very difficult to plan or achieve accountability without proper information. First Nations need to work with others in the larger system to create a joint, useful, user-friendly, networked, electronic health record.

The World Health Organization uses a Geographic Information Systems (GIS) that provides ideal platforms for both disease-specific information and their analyses in relation to population settlements, surrounding social and health services and the natural environment. They are highly suitable for analyzing epidemiological data, revealing trends and interrelationships that would be more difficult to discover in tabular format. Moreover, GIS allows policy-makers to easily visualize problems in relation to existing health and social services and the natural environment, and so more effectively target resources.[89]

Meno-Ya-Win must be networked with the new Information Management System as well as the Sioux Lookout Ambulatory Care Centre, offices of physicians and allied health professionals serving northern First Nations, hospitals at Red Lake, Thunder Bay, and Winnipeg. The new Information Management System must be designed in such a way that post-intake referrals to other health professionals, like allied health and specialists, can be tracked. Compatibility with other regional systems is essential.

The enhanced public health service will also require a comprehensive information system:

> *"In order to properly plan, manage and monitor any public health program, it is vital that up-to-date, relevant information is available to decision-makers at all levels of the public health system. As every disease problem or health event requires a different response and policy decision, information must be available that reflects a realistic assessment of the situation at local, national and global levels. This must be done with best available data and taking into consideration disease transmission dynamics, demographics, availability of and accessibility to existing health and social services as well as other geographic and environmental features."* [90]

It is anticipated that First Nations in-community staff will contribute data to the information system, supported by their tribal councils, as needed. The Sioux Lookout First Nations Health Authority will manage the system, be responsible for returning community data in usable forms to First Nations, share data and information with other organizations as needed to ensure public health and safety and improved health system advocacy.

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[89] World Health Organization, 2006
[90] Ibid

Capital Development of Clinical Space and Clinical Equipment

Communities need new and expanded health service buildings. In many of our communities, staff work in cramped space; some do not have working space that is safe and healthy. For example, in one community the staff have no running water or sanitation facilities.[91] In another, staff cannot carry out funded programs properly due to lack of space.[92] Facility needs require a rapid response. These need to involve all funders and First Nations.

Capital is needed for the development of clinical and accommodation space for allied health professionals. Until such is available, the teams of allied health professionals will not be able to function effectively, and in most cases services will only be offered in a community for a day. This will severely limit health service.

As soon as or where space is currently available, increased supports need to be added: translators, clerks, pharmacy technicians, and paraprofessionals to support allied health services.

Funding and Integration of Traditional Specialists

A key part of the AHP is including ooweechiwaywin or traditional specialists services as a core part of community primary health care. At present, there is no organized funding for ooweechiwaywin services. There is one First Nation whose health staff contributes to a special fund for community members to access such services. NIHB will pay for medical travel to see ooweechiwaywin, however, it is subject to approval conditions. In the AHP, ooweechiwaywin as an essential part of PHC Teams, (in communities where this is acceptable.) It must be adequately fully funded. In communities without a resident ooweechiwaywin, the tribal council or the SLFNHA will arrange access.

It must be kept in mind that individual traditional specialists may not be able to deal with all requests for service in a specific community. Ooweechiwaywin have been gifted with knowledge of how to help individuals and families with specific concerns or conditions. For others, referral on to another traditional specialist may be necessary.[93] In these cases, NIHB support for medical travel is required.

Public Health

The Chiefs' Committee on Health has agreed that the Medical Officer of Health position the public health quality assurance positions and management of the public health information system should be the responsibility of SLFNHA. However, there is an urgent need for the development of a public health plan that will include:

- Public health services detailed design including clinical and technical tasks for each position;
- Information system design (see above);
- Protocols for the development of information recording, gathering and disseminating;
- Capacity building requirements and training plans for those public health workers already in the system; and

[91] Needs Assessment Key Knowledge Interviews, 2005
[92] Fiddler. M., Personal communication. 2006
[93] Key Knowledge interviews (2005).; Notes from Chiefs-in-assembly discussions, (2006)

- Required public health reporting regulations, protocols and agreements with MOHLTC, including comprehensive agreements with the Northwest Health Unit.

Public Health is dependent on an integrated information system (see above). Monitoring and fast response to disease outbreaks are an essential component of any public health system.

A comprehensive design for public health services, as part of the Anishinabe health system, will require additional resources and involve many different organizations in planning discussions. It is anticipated that this planning work will occur in the early months of AHP implementation.

Telehealth Access

Telehealth is an integral part of the Anishinawbe health system. Video conferencing equipment and suitable facilities are needed in every community. In some communities with high use rates, designated staff are required to coordinate and promote the use of service, and problem-solve use of the technology. Without dedicated staff, busy professionals are disinclined to use the equipment.[94] It is proposed that follow-up for allied health professionals' services will be supported by telehealth. The telehealth network also needs to be linked with Meno-Ya-Win Health Centre, the Ambulatory Health Centre in Sioux Lookout, and hospitals at Red Lake, Thunder Bay, Winnipeg, and possibly Toronto. Other jurisdictions have found that telehealth can provide clinical assessment and follow-up support for specialists, particularly in the disciplines of dermatology and mental health.[95] As well, administrators have found it provides significant assistance in networking with colleagues from other communities. Further, health professionals and community staff have found telehealth a useful tool for providing professional development for up-grading skills and for licensing requirements.[96]

Non-Insured Health Benefits

Policy changes in the area of NIHB are required to support the implementation of the AHP. NIHB programs and services need to be more flexible to better meet health needs. Secondly, NIHB needs to support the delivery of service at the community level. While some services will still require the client to travel away from their community it is desirable that whenever and wherever possible services should be delivered at the community level.

Separation of Politics and Management

First Nations Chiefs and health organizations need to make a clear distinction between political direction and health system management. Many First Nations' Health Directors and staff feel that there is a need to separate band politics from the management of the health system.[97] It is important to distinguish between governance and management of the health system. More information about this issue is found in Chapter 7 (Governance and Management). Some key ideas of the separation between governance and management include:

- The quality of governance links to success in First Nation development activities.
- There are differences between political governance (such as a Chief and Council) and organizational governance (a board or committee).

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94 Moore, M.A., Chamberlin, R.B., (2004)
95 Chamberlin, R. B., Moore, M.A. (2002)
96 Saskatchewan Health, 2003
97 Governance Key Knowledge Interviews, 2005

- It is important to keep the governance job (setting direction and ensuring accountability) separate from the management job (carrying out directions and being accountable).
- Each should do what it does best. Hiring staff is a management responsibility. The first line of problem-solving in service access should be handled between the managers, staff, and clients, with no involvement from the political governors.

Time and Funds for a Transition Period

Staff in programs that focus on re-powering Anishinabe culture, community development, health education and promotion will need time and supportive leadership to make these changes. This is hard work. It deserves and needs full support, time and expertise to rethink programs that must be available. For example, much of the mental health work in communities is focused on crisis intervention.[98] Planning to shift some of that focus to health promotion and community development activities is essential to the progression of a strong Primary Health Care system within communities.

Without a transition phase for the new Anishinabe Health System, it would be setting the scene for failure. This must be addressed during negotiations. For change to proceed at the community's pace, a fundamental principle of the AHP, the new health system requires funds and time to see us through a transition period to make the changes.

As well, sufficient funds are required for implementation planning and the further discussions and decisions required to fully implement the AHP. These discussions and the implementation could take two to five years. For example, further discussion with tribal councils and independent First Nations needs to take place about the nursing service and how it will be implemented (see below).

Multi-Year Agreements and Flexible Funding Arrangements

To establish stability in the health system, we need to negotiate multi-year funding agreements with all funders. One and two-year funding agreements mean that long-range planning is not possible.[99]

Similarly, flexible funding agreements and arrangements mean that managers can move or combine funds that allow them to achieve their communities' health plan goals and objectives. First Nations' health organizations would still need to be accountable to the funders to demonstrate that the funds are being spent in a responsible manner and that funding program goals are being achieved.

Streamlining and simplifying reporting requirements is another policy issue that needs to be addressed. At the moment, managers and staff can be required to report on multiple small amounts of money for many programs. This process takes time from managing their health service and achieving their goals and objectives.

[98] Minutes of the Health Directors Workshop, October 2005
[99] Ibid

CHAPTER 11 – Implementation

Key Ideas

- A clear path for action with goals, objectives and related activities is required to make the Anishinabe Primary Health Care Plan (AHP) a reality for our people.
- The implementation plan incorporates the principles affirmed by the Sioux Lookout Chiefs to be community-driven where communities do what they can and others support; where we work together when we can, while respecting First Nations autonomy; where we implement at the pace of the communities, while guided by the wisdom of our Elders; and where we are accountable to each other and always focussed on improving the health of our people.
- The first five years of implementation is designed to lay the foundation and build capacity throughout the primary health care system so that communities and SLFNHA assume responsibility for governance, management and service delivery at their pace.

"The people are the foundation. They are the ones we have to strengthen in order to do this."

"[We] need to go back to the people and grassroots level in order for the system to work and be strong. [We need] to identify ways to include things from our communities."

Introduction

The basis for the Anishinabe Health Plan (AHP) is to set a pathway for improving the health of our people. This means improving access to primary health care in our communities; incorporating Anishinabe ways within the fabric of the system; and delivering services as close to home as possible. We do this work while respecting First Nations autonomy and strengthening our accountability to each other.

Background

The Sioux Lookout First Nations Health Authority (SLFNHA) working with representatives from our First Nation communities, Tribal Councils, physicians, the Ontario Ministry of Health and Long Term Care (OMHLTC), and First Nations and Inuit Health (FNIH), developed the Anishinabe Health Plan (AHP) that is a model of holistic, integrated primary health care service delivery for the region

The Sioux Lookout Zone Chiefs, on February 23, 2006, in Thunder Bay, Ontario, accepted the AHP, and mandated SLFNHA to proceed with implementation. They mandated the Chiefs' Committee on Health (CCOH) be tasked with the responsibility for providing oversight and monitoring of SLFNHA activities (Resolution 06/08), and directed SLFNHA to develop a negotiation framework for the

additional resources required for implementation (Resolution 06/07). The principles confirmed by the Chiefs were:

- Our services are community-driven, reflective of community needs, and delivered as close to home as possible;
- Our communities do what they can and others support;
- We work together where we can, while respecting First Nations autonomy;
- Implementation is a long-term process. It needs to be at the pace of the community, guided by the wisdom of our Elders and mindful of our future generations; and
- We are accountable to each other throughout the system and continuously find ways to strengthen how we work, the services we deliver, and the health of our people.

Assumptions

The implementation plan is designed to:

- Adhere to the principles developed by the Primary Health Care Working Group and Health Directors, and affirmed by the Chiefs;
- Allow progress at the pace of each community;
- Be flexible in responding to each community's priorities;
- Build the service delivery system from inside out (community-based);
- Require collaborative leadership as the mechanism for doing the work; and
- Strengthen capacity for First Nations governance and management.

These assumptions and best practices for operating an effective, efficient health system require multiple activities occurring at the same time and within a prescriptive order. Each goal, objective and activity is essential to building a solid foundation, while achieving tangible impacts within communities. Inattention to any one of the building blocks compromises the strength of the whole. As a result, the plan emphasizes the necessary activities for the next four fiscal years.

Themes

The implementation plan incorporates the principles confirmed by the Chiefs and is based on **seven themes**. They are:

- Incorporating Anishinabe ways
- Applying good governance and management practices
- Building capacity through continuous learning
- Ensuring adequate infrastructure
- Delivering services through team-based primary health care

- Assuring effective communication throughout the primary health care system
- Continuous evaluation program with monitoring to improve outcomes.

Priorities

Implementing the AHP requires a reminder that we can't do everything at once if we are to do anything well. The implementation plan addresses the need for progress and change in primary health care by setting out the goals with objectives and activities designed to build a strong foundation in community and in SLFNHA by honouring Anishinabe ways including Elder guidance, fostering collaboration, supporting leadership and skills training, documenting the need for increased infrastructure to improve service delivery and recognizing the need for continuous quality improvement through evaluation.

First Steps

To help focus efforts in restructuring the primary health care system for the Sioux Lookout area in a systematic way, some foundational work needs to be done in the first six months of the fiscal year 2006/07. This work will enable the implementation plan to proceed. This Phase One work for fiscal year 2006/07 will be accomplished in the time period of April to September 2006. Phase One emphasizes:

- Completing the detailed implementation plan, including a governance and management review framework;
- Hiring managerial, clinical and quality managers-in-training to build organizational capacity;
- Identifying data/information requirements;
- Initiating a capital needs assessment and plan;
- Developing team-based clusters for mental health and addictions;
- Using communication strategies to build consensus for implementation;
- Constructing a negotiations framework that addresses physicians' services, nursing programs, allied health and infrastructure requirements; and
- Building the evaluation program and mechanisms.

The second half of the fiscal year (October 2006 - March 2007) emphasizes initiation of the implementation plan using the seven themes. Effort is placed on essential first steps that are necessary to ensure successful implementation. This includes initiating:

- a governance and management review;
- skills development;
- using communication strategies to support implementation (e.g., translation, stories, etc.); and
- monitoring and refining implementation activities.

Methodology

In initiating the Implementation Plan, it is important to build on the experience of those who participated in the successful development of the AHP. Therefore, the Implementation Plan continues doing the work in the same way as we developed the AHP. This means implementation activities are accomplished through collaboration with the Primary Health Care Working Group (PHCWG) and the Health Directors, with guidance from the CCOH and direction from the Sioux Lookout Zone Chiefs. An Elder and Youth Council is added to assure Anishinabe ways are incorporated within the fabric of the primary health care system. In order to get all the work done, small groups of not more than nine (9) are established to focus on particular activities.

Over the next year, we expect the Chiefs to meet in September 2006 and February 2007. Work leading up to the Chiefs' meetings is supported by the CCOH with presentation to them in August 2006 and January 2007. The PHWG and Health Directors' intend to refine this implementation plan and carry out the activities, while communicating progress.

Implementation Plan

The Implementation Plan has seven (7) Goals. Each goal has objectives applied to them with activities assigned, collaboration identified and timelines established that allow the objectives to be reached and the goal achieved. The Goals are:

GOAL 1 – The primary health care system incorporates **Anishinabe ways** particularly in the areas of traditional specialist, language and communication.

GOAL 2 – The **Governance and Management** of the primary health care system has clear roles and responsibilities at all levels and incorporates the Anishinabe ways and other best practices.

GOAL 3 – A **Continuous Learning System** is in place to assure all the necessary skills are available to support the governance, management and delivery of the primary health care system.

GOAL 4 – Adequate **Infrastructure** will be resourced to allow the appropriate delivery of primary health care services including facilities, equipment, operating systems and communication capacity.

GOAL 5 – The primary health care **Service Delivery** model establishes the same standards of practice across all communities through coordinated (case management), team-based care with support from other levels of service (i.e., this is accomplished through service groupings such as maternal child health, mental illness and addictions and chronic disease management).

GOAL 6 – A **Communications** program is operational and everyone can access current information about the primary health care system

GOAL 7 – A continuous **Evaluation** program is operational within SLFNHA and the communities and includes: quality assurance programs, developing and implementing risk management programs, and adopting an evaluation framework with performance measurements for monitoring progress.

Community Focus

The work of implementation is centred on communities with SLFNHA supporting efforts to allow some early changes in access to primary health care (PHC) and receipt of those services in appropriate Anishinabe ways. These include:

- Having an Elder and Youth Council to guide the use of traditional specialists and work with the education sector for increasing the number of high school graduates choosing health care careers;
- Adding pharmacy technicians to the primary health care teams to allow nurses more time for nursing tasks;
- Establishing a pool of trained translators so that everyone has access to health services in their language;
- Identifying individual community service requirements and refining existing community health plan to address those requirements;
- Developing a mental health and addictions service delivery model that assures the same standard of care across communities with flexibility for each community;
- Identifying both capital needs and infrastructure improvements required in each community; and
- Developing an orientation program for all workers in the PHC system.

The following charts organize the work required by whom and when for each Goal. The activities are focused on moving the AHP forward in all the areas identified while pacing the work in reasonable amounts for successful outcomes. Emphasis is on the early years of implementation. This work helps build the strong foundation required for the AHP while demonstrating change in the communities designed to improve service delivery and increase capacity for First Nation governance of Primary Health Care.

GOAL 1 – Anishinabe Ways

The primary health care system incorporates Anishinabe ways particularly in the areas of traditional specialist, language and communication.

THE USE OF TRADITIONAL SPECIALISTS

Objective 1.1 – Traditional specialists are integrated within the primary health care system.

Outcome – By March 2010, there are consensus definitions for "traditional specialists"; a Code of Ethics; and a defined process for accessing traditional specialists

Activities	*Individual/Joint Action*	*Time Frame*
• 1.0 FTE Policy Analyst	SLFNHA and CCOH	October 2006
• Establishes an Elder and Youth Council	SLFNHA	January 2007
• Develop terms of reference	Elder and Youth Council with support from SLFNHA	February 2007
• Develop a work plan for defining "Traditional Specialists"	Elder and Youth Council with support from SLFNHA	March and April 2007
• Develops a communications plan to keep all parties informed	Elder and Youth Council with support from SLFNHA	April and May 2007
• Complete a literature review on traditional specialists, including definitions, practice standards, code of ethics, operating protocols, funding models, etc.	SLFNHA	June 2007
• Define traditional specialists using the literature review	Elder and Youth Council with support from SLFNHA	October 2007
• Develop a Code of Ethics using the literature review	Elder and Youth Council with support from SLFNHA	January 2008
• Design a process for reviewing, approving, restricting and revoking the activities of traditional specialists using the literature review	Elder and Youth Council with support from SLFNHA	June 2008
• Develop a strategy for funding the use of traditional specialists using the literature review	Elder and Youth Council with support from SLFNHA	June 2008

Medium-Term Outcome – By March 2015, primary health care teams have clinical and funding protocols for accessing traditional specialists.

Long-Term Outcome – By March 2025, traditional specialists are part of the fabric in the delivery of health care services.

THE USE OF LANGUAGE		
Objective 1.2 – Clients receive health information and care in their own language		
Outcome – By March 2010, there are mechanisms in place for clients to access trained translators		
Activities	*Individual/Joint Action*	*Timeframe*
• Undertake a review of job descriptions, salaries and benefits, and skill requirements for translators	Primary Health Care Working Group, Health Directors & SLFNHA Human Resources (the actual work would be done by a small group of not more than nine)	October 2006-February 2007
• Establish a pool of translators	SLFNHA Human resources, Tribal Councils and Health Directors	May 2007
• Contract with a source to provide a medical terminology course for translators and other service providers	SLFNHA	May – June 2007
• Establish a mechanism for accessing trained translators within the case management system	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	June - September 2007
• Identify key documents for translation	SLFNHA	On-going

Medium-Term Outcome – By March 2015, 50% of community members have access to health services in their own language.

Long-Term Outcome – By March 2025, 70% of community members have access to health services in their own language; and health promotion, prevention and protection information is available in the language of preference.

GOAL 2 – Governance and Management

The Governance and Management of the primary health care system has clear roles and responsibilities at all levels and incorporates the Anishinabe ways and other best practices.

GOVERNANCE

Objective 2.1 – Governance throughout the primary health care system is clear, transparent, accountable and reflects Anishinabe ways and best practices

Outcome – By March 2010, Chiefs, CCOH and SLFNHA have implemented the governance review recommendations; 66% of Tribal Councils/communities have completed a governance review, and 33% are initiating approved recommendations

Activities	*Individual/Joint Action*	*Time Frame*
• Conduct literature review & develop a governance framework (e.g., lines of authority, decision-making/processes, terms of reference, resolutions/bylaws, policies, accountability mechanisms, clear roles & responsibilities, etc.) for Anishinabe and best practice governance	SLFNHA	August 2006
• Develop a communications plan for the governance review	SLFNHA	August 2006
• Refine and approve the governance framework with input	PHCWG; CCOH; Chiefs	September 2006
• Conduct a governance review for the Chiefs' oversight of the Anishinabe Health Plan; CCOH roles and responsibilities; and SLFNHA	Chiefs; CCOH; SLFNHA Board and Management	October 2006 - September 2007
• Prepare and present interim report about progress on the governance review	SLFNHA	March 2007
• Approve the governance review recommendations	Chiefs; CCOH; SLFNHA Board and Management	September 2007
• Implement the approved recommendations from the governance review	Chiefs; CCOH; SLFNHA Board and Management	October 2007- March 2010
• Refine/develop bylaws, terms of reference policies and procedures, roles and responsibilities, accountabilities and evaluation	SLFNHA	October 2007- March 2008
• Approval bylaws, terms of reference policies and procedures, roles and responsibilities, accountabilities and evaluation	Chiefs; CCOH; SLFNHA Board and Management	March 2008
• Develop a governance process and template	Chiefs, Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	May–August 2006

GOVERNANCE		
Objective 2.1 – Governance throughout the primary health care system is clear, transparent, accountable and reflects Anishinabe ways and best practices		
Outcome – By March 2010, Chiefs, CCOH and SLFNHA have implemented the governance review recommendations; 66% of Tribal Councils/communities have completed a governance review, and 33% are initiating approved recommendations		
Activities	*Individual/Joint Action*	*Time Frame*
• Refine/develop a sample bylaws, terms of reference policies and procedures, roles and responsibilities, accountabilities and evaluation	Chiefs, Primary Health Care Working Group, Health Directors & SLFNHA (group of nine)	October 2006-January 2007
• Refine and approve governance template and sample bylaws, terms of reference, policies and procedures, roles and responsibilities, accountabilities and evaluation	Chiefs	February 2007
• Conduct bi-annual reviews to monitor progress with implementation	Chiefs, Primary Health Care Working Group, Health Directors & SLFNHA (group of nine)	November and May

Medium-Term Outcome – By March 2015, the Chiefs, CCOH and SLFNHA are operating within established practices and evaluation standards; 80% of Tribal Councils/communities are operating within established practices and evaluation standards

Long-Term Outcome – By March 2025, the governing individuals are continuously learning, innovating and using promising practices for governance

MANAGEMENT		
Objective 2.2 – Management throughout the primary health care system is clear, transparent, accountable and reflects Anishinabe ways and best practices		
Outcome – By March 2010, SLFNHA has implemented the management review recommendations; 66% of Tribal Councils/communities have completed a management review, and 33% are initiating approved recommendations		
Activities	*Individual/Joint Action*	*Time Frame*
• Develop a framework (e.g., lines of authority, decision-making/processes, policies, accountability mechanisms, clear roles & responsibilities, etc.) for Anishinabe and best practice management	SLFNHA	August 2006
• Develop a communications plan for the management review	SLFNHA	August 2006
• Refine and approve the management framework with input		September 2006
• 1.0 FTE Manager-in-training (this person is in training for the first year; and has 50% support the second year)	SLFNHA and CCOH	October 2006
• Conduct a management review with SLFNHA		October 2006-September 2007
• Prepare and present interim report about progress on the management review	SLFNHA Board and Management	March 2007
• Approve the management review recommendations	SLFNHA Board	September 2007
• Implement the approved recommendations from the review	SLFNHA Management	October 2007-March 2010
• Refine/develop policies and procedures, roles and responsibilities, accountabilities and evaluation	SLFNHA Management	October 2007-March 2008
• Approval policies and procedures, roles and responsibilities, accountabilities and evaluation	SLFNHA Board	March 2008
• Develop a Anishinabe and best practice management process and template (includes communication plan)	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	October 2006 – February 2007
• Refine and approve Anishinabe management template	Chiefs	February 2007
• Identify activities within their community health plan to refine management practices and processes in line with the template	Health Directors; Technical support from Tribal Councils and/or SLFNHA	April 2007 – March 2011

MANAGEMENT		
Objective 2.2 – Management throughout the primary health care system is clear, transparent, accountable and reflects Anishinabe ways and best practices		
Outcome – By March 2010, SLFNHA has implemented the management review recommendations; 66% of Tribal Councils/communities have completed a management review, and 33% are initiating approved recommendations		
Activities	*Individual/Joint Action*	*Time Frame*
• Refine/develop policies and procedures, roles and responsibilities, accountabilities and evaluation	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	April 2007-March 2008
• Conduct an annual evaluation of management practices and processes	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	October - November
• Annual review for budget purposes	CCOH	November
• Annual report to Chiefs	Chiefs	February

Medium-Term Outcome – By March 2015, SLFNHA is operating within established practices and evaluation standards; 75% of Tribal Councils/communities are operating within established practices and evaluation standards

Long-Term Outcome – By March 2025, managers are continuously learning, innovating and using promising practices for management

GOAL 3 – Continuous Learning System

A Continuous Learning System is in place to assure all the necessary skills are available to support the governance, management and delivery of the primary health care system.

CONTINUOUS LEARNING SYSTEM

Objective 3.1 – Everyone working in the primary health care system works in a continuous learning environment that assures the necessary skills and supports for the effective governance and management of the system and service delivery.

Outcome – By March 2010, 50% of all workers in the primary health care system are receiving a general orientation; 20% of the communities have their mental health and addictions workers and community health representatives certified; 10% of leaders and managers are certified

Activities	*Individual/Joint Action*	*Time Frame*
• Develop a general orientation program for all workers within the primary health care system that includes: Anishinabe ways; how the system works; who to access; how we continuously improve (consider different media (e.g., DVD, video, etc.) for conducting the orientation)	Elders, Primary Health Care Working Group, Health Directors & SLFNHA (should be a smaller group of not more than 9)	April 2007
• Pilot the general orientation for comment, edit and use	Health Directors, Tribal Council, SLFNHA, Chiefs	October 2007
• Investigate, select and adapt curricula for certifying community mental health and addictions workers, and community health representatives. The investigation includes sustainable funding sources	SLFNHA with Elders, Primary Health Care Working Group, & Health Directors (should be a smaller group of not more than 9)	March 2007
• Pilot the two curricula with volunteer communities, and make any adjustments		April – November 2007
• Train and certify mental health and addictions workers and community health representatives	Education body	Ongoing
• Conduct an annual review of mutually agreed-upon data (e.g., successful certification, learner satisfaction, role models, etc.)	Education body reviewed Elders, Primary Health Care Working Group, Health Directors & SLFNHA (should be a smaller group of not more than 9)	Annual
• Investigate, select and adapt curricula for certifying health care leaders and managers. The investigation includes sustainable funding sources	SLFNHA with Elders, Primary Health Care Working Group, & Health Directors (should be a smaller group of not more than 9)	March 2007
• Pilot the curricula with health care leaders and managers, and make any adjustments		April – November 2008

Medium-Term Outcomes – By March 2015, 90% of all workers in the primary health care system are receiving a general orientation; 60% of the communities have their mental health and addictions workers and community health representatives certified; 50% of leaders and managers are certified

Long-Term Outcomes – By March 2025, 93% of all workers in the primary health care system are receiving a general orientation; 80% of the communities have their mental health and addictions workers and community health representatives certified; 80% of leaders and managers are certified

CONTINUOUS LEARNING SYSTEM		
Objective 3.2 – The primary health care system works with communities and educational institutions to build and sustain First Nations participation in the primary health care system.		
Outcome – By March 2010, the health career plan is implemented with established baseline measures.		
Activities	*Individual/Joint Action*	*Time Frame*
• Develop a plan to encourage youth participation in health careers. Include role model/mentoring program for secondary school credit	Elder and Youth Council; Education and SLFNHA	October 2008
• Establish the data elements and baseline measurements for First Nations participation in health careers	Elder and Youth Council; Education and Health	January 2009
• Conduct a three-year review of progress on plan and baselines	Elder and Youth Council; Education and Health	January 2011

Medium-Term Outcome – By March 2015, X% improvement in high school graduation; X% increase in pursuing health careers; X% increase in First Nations licensed professionals

Long-Term Outcome – By March 2025, 60% licensed professionals are First Nations

GOAL 4 – Infrastructure

Adequate Infrastructure will be resourced to allow the appropriate delivery of primary health care services including facilities, equipment, operating systems and communication capacity.

INFRASTRUCTURE

Objective 4.1 – Develop a capital and equipment plan (including technology), and submit a Treasury Board-ready capital plan document to FNIH, and equipment requirements

Outcome – By March 2010, there is a capital and equipment plan; a Treasury Board-ready document is submitted to FNIH; equipment requirements are submitted

Activities	*Individual/Joint Action*	*Time Frame*
• Prepare a technical document for undertaking a community-by-community and SLFNHA capital and equipment plan and preparation for TB readiness	CCOH and SLFNHA	May – July 2006
• RFP for vendor/team to undertake a community-by-community and SLFNHA capital and equipment plan and preparation for TB readiness	SLFNHA	September 2006
• Select a vendor	CCOH	October 2006
• Orientation of vendor and development of a communication plan for undertaking the work	CCOH and SLFNHA	November 2006
• Identification of immediate opportunities for improvement (capital and/or equipment)	Vendor; CCOH	Ongoing
• Bi-monthly reports on work plan progress from vendor	CCOH and SLFNHA	Ongoing
• Validate the capital and equipment plan	Health Director for their community; SLFNHA	April-June 2009
• Review draft Report with community validation	Vendor, CCOH & SLFNHA	August 2009
• Review and approve recommendations of CCOH	Chiefs	September 2009

Medium-Term Outcome – By March 2015, construction ready in 50% of the communities

Long-Term Outcome – By March 2025, communities have sufficient facilities and equipment for primary health care service delivery

INFORMATION SYSTEM		
Objective 4.2 – Enhance the information system (e.g., health records, surveillance, case management, pharmacy, lab, diagnostics, radiology, human resources, finance) to allow for better, timely decision making		
Outcome – By March 2010, the information system is funded and there is an implementation plan		
Activities	*Individual/Joint Action*	*Time Frame*
• Prepare a technical document that includes: existing inventory; information requirements; hardware and software compatibility between communities and partner system design and cost estimates (include TB readiness specifications)	SLFNHA	September 2006 – April 2007
• Validate the system design	Health Directors, PHCWG; SLFNHA	May – June 2007
• Review the draft system design	CCOH	August 2007
• Review and approve recommendations of CCOH	Chiefs	September 2007
• Submission of system design to TBS	FNIH & Chiefs	January 2008
• Undertake a review of processes and forms to reduce duplication and enhance consistency	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	January 2008 – January 2009
• Fund information system implementation	FNIH	June 2009
• Develop a detailed implementation plan	SLFNHA	October 2009

Medium-Term Outcome – By March 2015, the system is tested and operational

Long-Term Outcome – By March 2025, information from the system is used to inform decisions about health and the health system.

GOAL 5 – Service Delivery

The primary health care Service Delivery model establishes the same standards of practice across all communities through coordinated (case management), team-based care with support from other levels of service (i.e., this is accomplished through service groupings such as maternal child health, mental illness and addictions and chronic-disease management).

SERVICE DELIVERY

Objective 5.1 – Each community completes an assessment for service requirements within the Anishinawbe Health Plan, and addresses the gaps through their individual two-year community health plan

Outcome – By March 2010, every community has met goals identified within their community health plan

Activities	*Individual/Joint Action*	*Time Frame*
• 1.0 FTE Director of Clinical Services (this person is in training for the first year; and has 50% support the second year)	SLFNHA and CCOH	October 2006
• Establish a process for completing each community assessment and gap analysis for service requirements, and identify two-four outcome measures that demonstrate improvement. These outcomes are reviewed in 2015 and 2025	Health Directors, Tribal Council, SLFNHA	October 2007-March 2008
• Use the tool and indicators with each Health Director/Tribal Council to complete a two-year plan that addresses existing gaps, balances urgent/emergent with prevention/promotion, and establishes a baseline for at least two of the indicators	Health Directors, Tribal Council, SLFNHA	April 2008-March 2010
• Update the two-year plan each year	Health Directors, Tribal Council, SLFNHA	Annual

Medium-Term Outcome – By March 2015, each community is meeting its identified outcomes

Long-Term Outcome – By March 2025, each community is meeting its identified outcomes

SERVICE DELIVERY		
Objective 5.2 – At least two communities self-select to test the professional supervision, clinical support and roles and responsibilities model with their primary health care team		
Outcome – By March 2010 there is a professional supervision, clinical support and roles and responsibilities model with their primary health care team. The model is being tested in at least two communities		
Activities	*Individual/Joint Action*	*Time Frame*
• Develop a model for professional supervision, clinical support and roles and responsibilities	Health Directors, Tribal Council, SLFNHA	April – September 2007
• Develop a peer/mentor support network	Health Directors, Tribal Council, SLFNHA	April – September 2007
• Test and evaluate the model in at least two communities	Communities and SLFNHA	September 2007 – March 2008
• Review the findings and make necessary refinements	Health Directors, Tribal Council, SLFNHA	March 2008
• Implement the model	Health Directors, Tribal Council, SLFNHA	April 2008

Medium-Term Outcome – By March 2015, all communities have implemented the professional supervision, clinical support and roles and responsibilities model with their primary health care team

Long-Term Outcome – By March 2025, communities are managing their primary health care team with professional supervision from SLFNHA/Tribal Councils.

SERVICE DELIVERY		
Objective 5.3 – Communities have a strong case management system for team based care		
Outcome – By 2010, the case management model and the mental health and addictions program are ready for implementation		
Activities	*Individual/Joint Action*	*Time Frame*
• The community specifies how the services will be organized (e.g., maternal-child health, mental illness and addictions or chronic disease management per community health plan (this is concurrent with the assessment of service requirements)	Health Directors, Tribal Council and SLFNHA	October 2006 - March 2007
• Complete an environmental scan on promising practices for mental health and addictions prevention, promotion and treatment	SLFNHA	March 2007
• Complete an environmental scan on promising practices for case management and case management in mental health and addiction	SLFNHA	March 2007
• Review promising practices, existing services and refine service delivery, case management, policies and procedures, training requirements	Mental Health & Addictions Working Group	March 2008
• Identify the allied health professionals that support mental health and addictions and clarify roles and responsibilities	Mental Health & Addictions Working Group	March 2008
• Test refinements in at least two communities and with other service providers	Health Directors, Tribal Council and SLFNHA	April – September 2008

Medium-Term Outcome – By March 2015, all communities have implemented the case management system and service groupings are in accordance with community health plan

Long-Term Outcome – By March 2025, all communities have implemented their service groupings

SERVICE DELIVERY		
Objective 5.4 – Allied health services are available to support the primary health care team		
Outcome – By March 2010, allied health professionals are supporting mental health and addictions and nursing (i.e., pharmacy technicians)		
Activities	*Individual/Joint Action*	*Time Frame*
• Identify the specifications for the pharmacist to supply and supervise pharmacy technicians	SLFNHA	September 2006
• Establish a contract with a pharmacist to supply and supervise pharmacy technicians	Pharmacist, SLFNHA	February 2007
• Test proposed service delivery	Health Director(s), Pharmacist, SLFNHA	February – May 2007
• Deploy service with refinements	Health Directors, Pharmacist, SLFNHA	June 2007

Medium-Term Outcome – By March 2015, allied health professionals are supporting maternal and child health (e.g., dentists, speech language, etc.)

Long-Term Outcome – By March 2025, allied health professionals are supporting all service groupings

GOAL 6 – Communications

A Communications program is operational and everyone can access current information about the primary health care system

COMMUNICATION		
Objective 6.1 – Effective communications at all levels of the system		
Outcome – By March 2010, 40% of community members in the Sioux Lookout area report an awareness of the AHP		
Activities	*Individual/Joint Action*	*Time Frame*
• Develop a communication plan (including tools, translation) for the Anishinabe health plan	SLFNHA	June 2006
• Continue community visits	SLFNHA	Ongoing
• Undertake a review of communication processes and forms to reduce duplication and assure timely response.	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	September 2007
• Annual revision of the communication plan	SLFNHA	On-going

Medium-Term Outcome – By March 2015, 60% of community members in the Sioux Lookout area report an awareness of the ADHP. Of those, 20% can identify one change as a result of the AHP

Long-Term Outcome – By March 2025, 80% of community members in the Sioux Lookout area report an awareness of the AHP. Of those, 40% can identify one change as a result of the AHP

GOAL 7 – Evaluation

A continuous Evaluation program is operational within SLFNHA and the communities and includes: quality assurance programs; developing and implementing risk management programs; and adopting an evaluation framework with performance measurements for monitoring progress.

EVALUATION

Objective 7.1 – Everyone in the primary health care system uses evaluation to improve results

Outcome – By 2010, an evaluation program is in place in all communities. The program takes into account the limitations associated with data collection

Activities	*Individual/Joint Action*	*Time Frame*
• Review and refine the evaluation framework with performance measurements	Primary Health Care Working Group, Health Directors & SLFNHA	August 2006
• Approve the evaluation framework with performance measurements	CCOH and Chiefs	September 2006
• 1.0 FTE Evaluation Coordinator (this person is in training for the first year; and has 50% support the second year)	SLFNHA	
• Understanding and applying the principles of evaluation	Primary Health Care Working Group, Health Directors, SLFNHA, CCOH & Chiefs	During governance and management review
• Develop processes and tools to collect data for the evaluation program	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	On-going
• Identify baseline data throughout the primary health care system	SLFNHA	2010-2012
• Monitor the performance measures in accordance with plan	Health Directors, Tribal Councils, SLFNHA, CCOH	As specified

Medium-Term Outcome – By March 2015, the evaluation report is informing program and operational refinements

Long-Term Outcome – By March 2025, the evaluation report indicates the intended progress

EVALUATION		
Objective 7.2 – A continuous quality assurance program is operating throughout the primary health care system		
Outcome – By 2010, there is a plan for implementing the quality assurance program throughout the system		
Activities	*Individual/Joint Action*	*Time Frame*
• Participate in an exchange program for quality assurance operations	Evaluation Coordinator, SLFNHA	September 2007- March 2008
• Understanding and applying the principles and processes of quality assurance	Health Directors, Tribal Councils, SLFNHA, CCOH	September – October 2008
• Develop an implementation plan for the quality assurance program	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	October 2008- February 2009

Medium-Term Outcome – By March 2015, the quality assurance program is operational throughout the primary health care system

EVALUATION		
Objective 7.3 – A continuous risk management program is operating throughout the primary health care system		
Outcome – By 2010, there is a plan for implementing the risk management program throughout the system		
Activities	*Individual/Joint Action*	*Time Frame*
• Establish a contract for developing a risk management program	SLFNHA	September 2007
• Understanding and applying the principles and processes of risk management	Health Directors, Tribal Councils, SLFNHA, CCOH	September – October 2008
• Develop an implementation plan for the risk management program	Primary Health Care Working Group, Health Directors & SLFNHA (the actual work would be done by a small group of not more than nine)	October 2008- February 2009

Medium-Term Outcome – By March 2015, the risk management program is operational throughout the primary health care system

The Evaluation Framework

In order to demonstrate the ways in which implementation of the AHP contributes to the improved health of the Anishinabe people it is necessary to track outcomes from activities of the plan as progress is being achieved. The Evaluation Framework Chapter on the AHP will direct these activities over the yearly implementation plan's short, medium and long-term cycles and will provide tracking mechanisms that can be employed to collect and report the actions from communities and SLFNHA as a First Nations-governed holistic, integrated primary health care system is developed for the region.

CHAPTER 12 – Evaluation Framework

Key Ideas

- A logic model helps us map where we are going, and allows us similar expectations.
- Evaluation provides a regular look at how progress is being made and helps us reflect on how to move forward.
- Evaluation helps us maintain transparency and accountability always keeping in mind the health of our people.

"We need to be humble, take our time to seek guidance and support to have an understanding."

Elder

"We have to remember this is for our future generations."

Chief

Introduction

Implementation of the Sioux Lookout Anishinabe Health Plan (AHP) requires an Evaluation Framework that offers a strategy and on-going mechanisms enabling the Sioux Lookout Zone Chiefs and SLFNHA to monitor and improve its performance toward the implementation of a First Nations-governed holistic, integrated, primary health care service delivery system for the region. This framework enables an assessment of:

- progress and actual results achieved toward the goals set out in the Implementation Plan;
- the relative success of meeting short-term outcomes; and
- the strength of management systems.

This framework includes:

- a profile of the AHP with a perspective on its origin, mandate and the context in which it operates;

- a logic model, a "roadmap" linking goals, objectives, inputs, activities, outputs, and outcomes. It is a visual way to identify the steps that would demonstrate progress toward the intended result (outcome);[100]
- evaluation issue areas and questions. For example, the Treasury Board Secretariat of Canada's Evaluation Policy identifies three primary issue areas and related questions for evaluation. They include:
  - "***Relevance*** – Does the policy, program or initiative continue to be consistent with departmental and government-wide priorities, and does it realistically address an actual need?
  - ***Success*** – Is the policy, program or initiative effective in meeting its intended outcomes, within budget and without negative outcomes? Is the policy, program or initiative making progress toward the achievement of the final outcomes?
  - ***Cost-Effectiveness*** – Are the most appropriate and efficient means being used to achieve outcomes, relative to alternative design and delivery approaches?"[101]
- a performance measurement strategy that includes: performance indicators as signposts indicating whether desired changes are happening or how much progress has been made toward achieving them; data sources and data collection methodologies or the practical information that is needed, including how and how often the data will be collected to determine progress;
- an evaluation plan specifying how the evaluation questions will be answered, including specifying the research instruments along with their respective strengths and limitations; and
- a projection of evaluation timelines and costs.

The following framework works within Health Canada, FNIH, Province of Ontario, Ministry of Health and Long-Term Care and the Treasury Board Secretariat of Canada evaluation requirements.

Program Profile

The 1990 resolution of the Chiefs established the Primary Health Care (PHC) model as the framework for "guiding the delivery of primary health care services within the communities of the Sioux Lookout Zone catchments area". The Sioux Lookout First Nations Health Authority (SLFNHA) is the organization responsible to the Community Chiefs for developing and guiding the delivery of primary health cares services in this catchment area.

This area in northwestern Ontario serves approximately 25,000 individuals , including Sioux Lookout, which is the primary service area and town of about 5,165. It also includes 31 First Nations communities with most accessible only by air.

In April 1997, a Four Party Agreement was signed "by the Nishnawbe-Aski-Nation (NAN), Health Canada, the Province of Ontario and the Town of Sioux Lookout to amalgamate the federal and provincial hospitals into one corporate entity that would be provincially administered under the Public Hospital's Act". The Agreement was also intended:

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[100] http://www.tbs-sct.gc.ca/eval/pubs/RMAF-CGRR/rmafcgrr04_e.asp, September 24, 2005.
[101] Ibid.

- "To improve health and health care services
- To better balance health care services between prevention and treatment of illness
- To strengthen relationships among all the parties"

At the same time NAN and Health Canada entered a Bilateral Agreement on health care relationships that stipulated funding and the use of those funds, including the establishment of a Community Health Reinvestment Plan that would "guide the redeployment of the resources to support and enhance community based primary health care services."

The provincial and federal hospitals amalgamated in 2002 with the establishment of the Meno-Ya-Win Health Centre. Amalgamation-related activities are expected to continue for another four years directly impacting the availability of funds for enhancing community-based primary health care services. As a result, the SLFNHA sought and received funding for two Initiatives – the Sioux Lookout Anishinabe District Health Plan and Health Integration Initiative.

The Province of Ontario through its Primary Health Care Transition Fund funded the Sioux Lookout Anishinabe Health Plan whose primary goal was the development of a "District Health Plan that guides the reinvestment of federal dollars to enhance and improve the current Primary Health Care delivery system. This effort included:

- updating the Participatory Research Project (PRP) conducted in 1995 to assess current health status, issues and priorities for the District;
- a comprehensive review of primary health care service delivery and gaps; and
- incorporation of the evidence within the primary health care service delivery model and District Health Plan.

Health Canada provided funding through its Health Integration Initiative established in 2003. This Initiative was designed to address the "gap in health status between Aboriginal and Non-Aboriginal peoples through better integration of federally funded health systems within First Nations and Inuit communities and those funded through Provincial and Territorial governments". Toward that end, Health Canada funded:

- development of a comprehensive, integrated primary health care model and implementation plan;
- establishment of a District physicians' plan within the integrated primary health care framework;
- development of a nursing services plan; and
- establishment of a mechanism for the governance and management of the primary health care model by First Nations.

These Initiatives, funded through March 2006, were collaborative. The aim was to design a holistic primary health care system model and implementation plan that better coordinates and prepares for the integration of all services under a First Nation governance structure.

The Sioux Lookout First Nations Health Authority (SLFNHA) working with representatives from First Nations communities, Tribal Councils, physicians, the Ontario Ministry of Health and Long Term Care (MHLTC) and the First Nations and Inuit Health Branch (FNIH), Health Canada

developed the Anishinabe Health Plan (AHP) that identifies a model of holistic, integrated health care service delivery for the region.

The Sioux Lookout Zone Chiefs, on February 23, 2006 in Thunder Bay, Ontario, accepted the AHP, and mandated SLFNHA to proceed with implementation. They mandated the Chiefs Committee on Health (CCOH) be tasked with the responsibility for providing oversight and monitoring of SLFNHA activities (Resolution 06/08), and directed SLFNHA to develop a negotiations framework for the additional resources required for implementation of the AHP (Resolution 06/07).

AHP Goals

The implementation plan incorporates and is guided by the following principles confirmed by the Sioux Lookout Zone Chiefs:

- Our services are community-driven, with services reflective of community needs and delivered as close to home as possible.
- Our communities do what they can and others will support.
- We work together where we can, while respecting First Nations autonomy.
- Implementation is a long-term process. It needs to be at the community's pace, guided by the wisdom of our Elders and mindful of our future generations.

We are accountable to each other throughout the system and continuously find ways to strengthen how we work, the services we deliver, and the health of our people

The goals are:

- The primary health care system incorporates Anishinabe ways particularly in the areas of Traditional Specialist, Language and Communication;
- The governance and management of the primary health care system has clear roles and responsibilities at all levels and incorporates Anishinabe ways and other best practices;
- A continuous learning system is in place to assure all the necessary skills are available to support the governance, management and delivery of the primary health care system;
- Adequate infrastructure will be resourced to allow the appropriate delivery of primary health care services including facilities, equipment, operating systems and communication capacity;
- The primary health care service delivery model establishes the same standards of practice across all communities through coordinated (case management), team-based care with support from other levels of service (i.e., this is accomplished through service groupings such as maternal child health, mental illness and addictions and chronic disease management);
- A communications program is operational and everyone can access current information about the health care system; and
- A continuous evaluation program is operational within SLFNHA and the communities and includes: quality assurance programs; developing and implementing risk management programs; and adopting an evaluation framework with performance measurements for monitoring progress.

AHP Partners and Beneficiaries

Sioux Lookout Zone Chiefs and the SLFNHA has partnered with the following organizations to undertake this work:

- Nishnawbe-Aski-Nation (NAN)
- Windigo First Nations Tribal Council
- Shibogama First Nations Tribal Council
- Matawa First Nations Management
- Independent First Nations Alliance
- Keewaytinook Okimakanak (Northern Chiefs)
- Paawidigong First Nations Forum
- Lac Seul First Nation
- Sandy Lake First Nation
- Mishkeegogamang First Nation
- Meno-Ya-Win Health Centre
- Health Canada, First Nations & Inuit Health
- Ministry of Health and Long-Term Care

The primary beneficiaries of this work are First Nations living in northwestern Ontario, which includes 31 First Nations communities.

AHP Funding

Program-funding will take into consideration the amount requested for implementation and the actual amount received from FNIH, Health Canada and the province of Ontario, MOHLTC.

Expected Results

Over the past two years, SLFNHA and its partners developed a primary health care system design and implementation plan and received a consensus decision from the Sioux Lookout Zone Chiefs to initiate implementation. By March 2010, SLFNHA and its partners are expected to:

- establish the foundation for including and funding “traditional specialists” within the primary health care system;
- implement mechanisms for clients to access trained translators;
- implement the governance and management review recommendations for the Chiefs, CCOH and SLFNHA, and complete reviews in 66% of Tribal Councils/communities with 33% initiating approved recommendations;

- build capacity with 50% of all workers receiving a general orientation; 20% of the communities having certified mental health and addictions workers and community health representatives; and 10% of leaders and managers certified;
- implement a First Nations health career plan;
- have a Treasury Board ready document for capital requirements, and a detailed list of equipment requirements submitted to FNIH;
- complete the design and funding requirements for implementation of an information system;
- meet goals set in the AHP implementation plan and within individual community health plans;
- initiate testing of the professional supervision, clinical support and roles and responsibilities model;
- be ready to implement the case management model and the mental health and addictions program;
- have pharmacy technicians supporting service delivery in communities;
- be ready to implement the quality and risk management components of the evaluation program, and have baseline measures established for on-going monitoring; and
- complete an interim (2008) and final evaluation to assess progress on short-term and toward medium and long-term outcomes.

SLFNHA has its challenges in the coming five years, including:

- assuring sufficient funding to transfer governance, build sufficient infrastructure and service delivery systems;
- continuously adjusting the balance in relation to its work and the work of partner organizations;
- assuring effective on-going engagement and communications with First Nations communities;
- adjusting for provincial health reform initiatives under way that could impact implementation;
- addressing jurisdictional issues for integrated health services delivery, as existing policies and programs of federal, provincial and municipal governments could impact implementation;
- strengthening its human resource capacity and management systems and processes within a complex governance and collaborative leadership model. This is complicated when the external environment uses a hierarchical command and control model; and
- focusing its efforts and assisting all in letting go of preconceived notions to affect change. For instance, realizing the relationship is key even while completing deliverables Change occurs when the threads of those efforts are woven together into a stronger whole.

AHP Logic Model

Each of the seven goals has specific objectives, inputs, activities, outputs and medium-term outcomes. Table 12.1 provides a logic model, a visual map, which depicts how SLFNHA will move toward and arrive at its short-term outcomes, while contributing to its medium term outcomes. This map consolidates the information from the AHP and its implementation plan as well as the final evaluation of the planning initiatives.

Table 12.1 – Anishinabe Health Plan Logic Model

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
GOALS					
The primary health care system incorporates **Anishinabe ways** particularly in the areas of Traditional Specialist, Language and Communication	The **governance and management** of the primary health care system has clear roles and responsibilities at all levels and incorporates the Anishinabe ways and other best practices	A **continuous learning system** is in place to assure all the necessary skills are available to support the governance, management and delivery of the primary health care system	Adequate **infrastructure** will be resourced to allow the appropriate delivery of primary health care services including facilities, equipment, operating systems and communication capacity	The primary health care **service delivery model** establishes the same standards of practice across all communities through coordinated (case management), team-based care with support from other levels of service (i.e., this is accomplished through service groupings such as maternal child health, mental illness and addictions and chronic disease management)	A **communications** program is operational and everyone can access current information about the primary health care system
A continuous **evaluation program** is operational within SLFNHA and the communities and includes: quality assurance programs; developing and implementing risk management programs; and adopting an evaluation framework with performance measurements for monitoring progress.					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
OBJECTIVES					
• Traditional specialists are integrated within the primary health care system • Clients receive health information and care in their own language	• Governance throughout the primary health care system is clear, transparent, accountable and reflects Anishinabe ways and best practices • Management throughout the primary health care system is clear, transparent, accountable and reflects Anishinabe ways and best practices	• Everyone working in the primary health care system works in a continuous learning environment that assures the necessary skills and supports for the effective governance and management of the system and service delivery • The primary health care system works with communities and education institutions to build and sustain First Nations participation in the primary health care system	• Develop a capital and equipment plan (including technology), and submit a Treasury Board ready capital plan document to FNIH, and an equipment requirements • Enhance the information system (e.g., health records, surveillance, case management, pharmacy, lab, diagnostics, radiology, human resources, finance) to allow for better, timely decision making	• Each community completes an assessment for service requirements within the AHP, and addresses the gaps through their individual two-year community health plan • At least two communities self-select to test the professional supervision, clinical support and roles and responsibilities model with their primary health care team • Communities have a strong case management system for team-based care • Allied health services are available to support the primary health care team	• Effective communications at all levels of the system
• Everyone in the primary health care system uses evaluation to improve results • A continuous quality assurance program is operating throughout the primary health care system • A continuous risk management program is operating throughout the primary health care system					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
INPUTS					
• Elders • Sioux Lookout Zone Chiefs • Chiefs Committee on Health (CCOH)			• SLFNHA Board of Directors and Personnel • Federal and Provincial Governments • Primary Health Care and Health Director Working Groups		
• Policy Analyst • Elder & Youth Council	• Tribal Councils • Communities • SLFNHA Manager-in-Training	• Elder and Youth Council • Available curricula for mental health and addictions • Available curricula for leadership and management • Adult learning and representatives community-based schools	• Communities • Technical Unit • Informatics expertise	• Communities • SLFNHA Director, Clinical Services • Pharmacist contractor and pharmacist technicians • Community health professionals	• SLFNHA Communication Coordinators
• SLFNHA Evaluation Coordinator • Available exchange programs for quality management • Risk Management contractor					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
ACTIVITIES (HOW WE DID IT)					
• Council Terms of Reference • Literature Review • Communications plan • Review translator job descriptions, salaries, benefits and skill requirements	• Literature review for governance and management frameworks • Communications plan for governance and management process • Governance and management process and template for Tribal Councils and communities	• Pilot general orientation • Curricula review for mental health and addictions • Pilot mental health and addictions training • Curricula review of leadership and management training programs • Pilot curriculum for leadership and management • Plan for youth participation in health careers	• Technical document for undertaking a community-by-community capital and equipment plan • Communication plan • Bi-monthly reports • Community validation of plan • Technical document for information system requirements • Validated information management system design • Forms review	• Community health plans and gap analysis • Two indicators for performance monitoring • Develop professional supervision model • Develop peer/mentor support network • Test professional supervision model • Environmental scan of mental health and addictions promising practices • Environmental scan of case management promising practices • Test mental health and addictions model of care • Pharmacist contract to supply and supervise technicians • Design and test deployment of technicians	• AHP implementation communication plan • Communication processes and protocols at all levels of the primary health care system
• Identify baseline data requirements, develop tools for data collection, and collect data • Participation in exchange program for quality assurance • Training in risk management					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
OUTPUTS (WHAT WE DID)					
• Code of Ethics • Traditional specialists protocols • Traditional specialists funding model • Medical terminology course • Key documents translated • Pool of translators	• Governance and management review for Chiefs, CCOH, SLFNHA, Tribal Councils and communities • Applicable bylaws, policies and procedures, roles and responsibilities, and accountability/evaluation • Annual evaluations	• General orientation program • Mental health and addictions training for certification • Leadership and management training for certification • Baseline of high school graduation; number of licensed First Nations professionals	• Capital and equipment plan for all communities and SLFNHA that is TBS-ready • Information management system design that is TBS-ready • Standard use of forms and review process for new forms across the system	• Two-year community health plans with service organization (e.g., maternal child health, mental health and addictions, etc.) and allied health supports for mental health and addictions • Tool to monitor performance on plan • Professional supervision model • Peer/mentor support network • Deploy pharmacist technicians	• AHP Communication plan • Streamlined communication process, protocols and forms
• Tools for monitoring baseline data • Training completed with an implementation plan for quality assurance program • Training completed with an implementation plan for risk management program					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
SHORT TERM OUTCOMES – 2010					
• There are consensus definitions for "traditional specialists"; a Code of Ethics; and a defined process for accessing traditional specialists • There are mechanisms in place for clients to access trained translators	• Chiefs, CCOH and SLFNHA have implemented the governance review recommendations; 66% of Tribal Councils/communities have completed a governance review, and 33% are initiating approved recommendations • SLFNHA has implemented the management review recommendations; 66% of Tribal Councils/communities have completed a management review, and 33% are initiating approved recommendations	• 50% of all workers in the primary health care system are receiving a general orientation; 20% of the communities have their mental health and addictions workers and community health representatives certified; 10% of leaders and managers are certified • By March 2010, the health career plan is implemented with established baselines measures	• There is a capital and equipment plan; a Treasury Board-ready document is submitted to FNIH; equipment requirements are submitted • The information system is funded and there is an implementation plan	• Every community has met goals identified within their community health plan • There is a professional supervision, clinical support, and roles and responsibilities model with their primary health care team. The model is being tested in at least two communities • The case management model and the mental health and addictions program are ready for implementation • Allied health professionals are supporting mental health and addictions and nursing (i.e., pharmacy technicians	• 40% of community members in the Sioux Lookout area report an awareness of the AHP
• An evaluation program is in place in all communities, and baseline measures are established throughout the system. The program takes into account the limitations associated with data collection • There is a plan for implementing the quality assurance program throughout the system • There is a plan for implementing the risk management program throughout the system					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
MEDIUM TERM OUTCOMES – 2015					
• Primary health care teams have clinical and funding protocols for accessing traditional specialists • 50% of community members have access to health services in their own language	• The Chiefs, CCOH and SLFNHA are operating within established practices and evaluation standards; 80% of Tribal Councils/communities are operating within established practices and evaluation standards • SLFNHA is operating within established practices and evaluation standards; 75% of Tribal Councils/communities are operating within established practices and evaluation standards	• 90% of all workers in the primary health care system are receiving a general orientation; 60% of the communities have their mental health and addictions workers and community health representatives certified; 50% of leaders and managers are certified • X% improvement in high school graduation; X% increase in pursuing health careers; X% increase in First Nations licensed professionals	• Construction ready in 50% of the communities • The system is tested and operational	• Each community is meeting its identified outcomes • All communities have implemented the professional supervision, clinical support and roles and responsibilities model with their primary health care team • All communities have implemented the case management system and service groupings are in accordance with community health plan • Allied health professionals are supporting maternal and child health (e.g., dentists, speech language, etc.)	• 60% of community members in the Sioux Lookout area report an awareness of the AHP. Of those, 20% can identify one change as a result of the AHP
• The evaluation report is informing program and operational refinements. Baseline data is collected through the information system • The quality assurance and risk management programs are operational throughout the primary health care system • Communities, Tribal Councils, SLFNHA, CCOH and Chiefs are meeting established performance requirements • Improved access to timely, quality services					

Anishinabe Health Plan Implementation Evaluation Logic Model					
Anishinabe Ways	*Governance and Management*	*Continuous Learning System*	*Infrastructure*	*Service Delivery Model*	*Communications*
LONG TERM OUTCOMES – 2025					
• Traditional Specialists are part of the fabric in the delivery of health care services • 70% of community members have access to health services in their own language; and health promotion, prevention and protection information is available in the language of preference	• The governing individuals are continuously learning, innovating and using promising practices for governance • Managers are continuously learning, innovating and using promising practices for management	• 93% of all workers in the primary health care system are receiving a general orientation; 80% of the communities have their mental health and addictions workers and community health representatives certified; 80% of leaders and managers are certified • 60% licensed professionals are First Nations	• Communities have sufficient facilities and equipment for primary health care service delivery • Information from the system is used to inform decisions about health and the health system.	• Each community is meeting its identified outcomes • Communities are managing their primary health care team with professional supervision from SLFNHA/Tribal Councils • All communities have implemented their service groupings • Allied health professionals are supporting all service groupings	• 80% of community members in the Sioux Lookout area report an awareness of the AHP. Of those, 40% can identify one change as a result of the AHP
• The evaluation report indicates the intended progress • Improved health status as evidenced by the reduction in gap between First Nations and Canadians living in similar circumstances					

Accountabilities

SLFNHA has five primary accountabilities – to First Nations, SLFNHA Board of Directors, Sioux Lookout Zone Chiefs, FNIH, and province of Ontario, MOHLTC. First Nations trust the investment will ultimately enable better health.

SLFNHA, its Board of Directors, and the Chiefs Committee on Health (CCOH) and personnel, use the Implementation Plan to monitor and report on performance. It does so by:

- Establishing an Evaluation Working Group responsible for monitoring performance indicators and making recommendations for improvement;
- Providing an annual report and audit within 120 days of fiscal year end; and
- Meeting regularly with Health Canada and the province of Ontario, MOHLTC, thereby strengthening the relationships.

Evaluation Questions

Based on the AHP and implementation plan and discussions with the management team, the evaluation issues and questions are as follows (Table 12.2):

Table 12.2 – AHP Evaluation Issues and Questions

ISSUE #1 – Relevance	• How does the work of AHP contribute to Anishinabe ways? • How does the work of the AHP contribute to the work of the Ontario Ministry of Health and Long Term Care and FNIH, Health Canada?
ISSUE #2 – Progress/Success	• What progress has been made toward the accomplishment of short-term outcomes? • How is the AHP making progress toward its medium-term outcomes? • How is the work of AHP contributing to improving the health of First Nations?
ISSUE # 3 – Cost Effectiveness	• Were funds used in accordance with federal and provincial funding contribution agreements? • Does the use of funds reflect promising practices for management of primary health care systems?
ISSUE #4 – Implementation	• Has the AHP been implemented according to plan?

Monitoring and Evaluation

This performance measurement and evaluation plan was constructed with the recognition that:

- On-going performance monitoring is essential for performance improvements and for building system capacity;
- The performance measures must link to the short-term outcomes and measure results; and
- The methods for measuring, monitoring and conducting the evaluation must be relevant and practical.

Performance Measurement Strategy

Table 12.3 delineates the selected performance measurement plan. It specifies the evaluation issues and questions; the related medium-term outcomes and associated indicators; the source, method and frequency of data collection; and who is responsible for collection and analysis of data.

This plan relies on SLFNHA to establish an Evaluation Working Group and systems and processes to monitor and recommend performance improvements. Many of the data elements (Table 12.4) required to monitor performance are currently collected. There are a number of requirements to facilitate the work, including:

- hiring an evaluation coordinator;
- contracting with a risk management consultant;
- training partners and personnel in evaluation;
- developing a worksheet(s) for collecting data; and
- establishing communication mechanisms to embed on-going improvements in work.

SLFNHA projects these requirements will be operational by December 2006, with the first periodic review July 2007.

The plan also relies on the assumption that SLFNHA will continue community site visits and that presentations/conversations in community will include at least one evaluation question. If this is not the case, the Evaluation Working Group will consider a telephone survey for community members in 2005. If this latter approach is used, consideration should be given to include questions that can assist the next steps of implementation.

Finally, the performance measurement plan calls for an environmental scan of promising or best operating practices (e.g., human resource retention, use of funds, etc.) for primary health care systems. The Working Group believes this information is useful to monitoring performance, and may undertake the scan prior to the independent evaluation.

Table 12.3 – Performance Measurement Strategy

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	Data Analysis Method	Frequency of Analysis	Responsibility
RELEVANCE					
How does the work of AHP contribute to Anishinabe ways?	There is a defined process and protocol for accessing traditional specialists There are mechanisms in place for clients to access trained translators Elders are integral to decision processes	Elder and Youth Council reports; annual reports	Work plan monitoring	Semi annual review beginning December 2006	Elder and Youth Council and SLFNHA
		Annual internal performance reports	Documentation Review	Once in 2009	Evaluator
		Elder and Youth Council	Key Informant Survey, Case Study/Story	Once in 2010	Evaluator
How does the work of the AHP contribute to the work of the province of Ontario, MOHLTC and FNIH, Health Canada?	SLFNHA meets the terms and conditions of the Contribution Agreements	Contribution agreement, documents; quarterly activity reports	Work plan monitoring	Semi-annual review beginning December 2006	PHC and Health Director Working Group and SLFNHA
	AHP continues to contribute to federal and provincial health goals	Annual internal performance measurement reports	Documentation Review	Once in 2010	Evaluator
		Federal and provincial representatives		Once in 2010	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	*Data Analysis Method*	*Frequency of Analysis*	*Responsibility*
PROGRESS/SUCCESS					
How is the work of AHP contributing to improving the health of First Nations? How is the AHP making progress toward its medium-term outcomes?	The Evaluator will analyze the results of the Goals in total to answer these evaluation questions			Once in 2010	Evaluator
What progress has been made toward the accomplishment of short-term outcomes? GOAL ONE The primary health care system incorporates Anishinabe ways particularly in the areas of Traditional Specialist, Language and Communication.	There is a defined process and protocols for accessing traditional specialists There is a funding strategy for traditional specialists	Elder and Youth Council Documents	Document Review	Semi-annual Review beginning December 2006 and Interim Evaluation Report in July 2008	Evaluation Working Group
		SLFNHA Document	Document Review	Once in 2009	Evaluator
		Elder and Youth Council	Key Informant Interviews Case Study/Story	Once in 2010	Evaluator
	There are mechanisms in place for clients to access trained translators	List of translators and policies and procedures	Document Review	Semi-annual Review beginning December 2006 and Interim Evaluation Report in July 2008	Evaluation Working Group
		Annual reports	Document Review	Once in 2009	Evaluator
		Health Directors	Key Informant Interviews	Once in 2010	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	***Data Analysis Method***	***Frequency of Analysis***	***Responsibility***
PROGRESS/SUCCESS					
GOAL TWO The governance and management of the primary health care system has clear roles and responsibilities at all levels and incorporates the Anishinabe ways and other best practices.	Chiefs, CCOH and SLFNHA have implemented the governance review recommendations; 66% of Tribal Councils/communities have completed a governance review, and 33% are initiating approved recommendations	Governance reports and work plans	Document Review	Semi-annual Review beginning December 2006 and Interim Evaluation Report in July 2008	Evaluation Working Group
		Governance reports and work plans	Document Review	Once in 2009	Evaluator
		Chiefs, SLFNHA Board and Health Directors	Key Informant Interviews	Once in 2010	Evaluator
	SLFNHA has implemented the management review recommendations; 66% of Tribal Councils/communities have completed a management review, and 33% are initiating approved recommendations	Management reports and work plans	Document Review	Semi-annual Review beginning December 2006 and Interim Evaluation Report in July 2008	Evaluation Working Group
		Management reports and work plans	Document Review	Once in 2009	Evaluator
		Chiefs, SLFNHA Board and Health Directors	Key Informant Interviews	Once in 2010	Evaluator
GOAL THREE A continuous learning system is in place to assure all the necessary skills are available to support the governance, management and delivery of the primary health care system	50% of all workers in the primary health care system are receiving a general orientation	Orientation attendance records	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Annual Reports	Document Review	Once in 2009	Evaluator
	20% of the communities have their mental health and addictions workers and community health representatives certified	Human Resource Certification records	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Annual Reports	Document Review	Once in 2009	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	***Data Analysis Method***	***Frequency of Analysis***	***Responsibility***
PROGRESS/SUCCESS					
	10% of leaders and managers are certified	Human Resource Certification records	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Annual Reports	Document Review	Once in 2009	Evaluator
	Health Career plan implemented with baseline measures	Documents	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Documents, Annual Reports	Document Review	Once in 2009	Evaluator
	Baseline no. of students graduating high school	School records	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
	Baseline no. of First Nations licensed professionals	Human Resource Certification records	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Annual Reports	Document Review	Once in 2009	Evaluator
GOAL FOUR Adequate infrastructure will be resourced to allow the appropriate delivery of primary health care services including facilities, equipment, operating systems and communication capacity	There is a capital and equipment plan; a Treasury Board ready document is submitted to FNIH; equipment requirements are submitted	SLFNHA documents and reports	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		SLFNHA documents and reports	Document Review	Once in 2009	Evaluator
	The information system is funded and there is an implementation plan	SLFNHA documents and reports	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		SLFNHA documents and reports	Document Review	Once in 2009	Evaluator
		Federal and provincial partners	Key Informant Surveys	Once in 2010	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	*Data Analysis Method*	*Frequency of Analysis*	*Responsibility*
PROGRESS/SUCCESS					
GOAL FIVE The primary health care service delivery model establishes the same standards of practice across all communities through coordinated (case management), team-based care with support from other levels of service (i.e., this is accomplished through service groupings such as maternal child health, mental illness and addictions and chronic disease management)	Met goals identified within their community health plan	Community Health Plan	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Interim Evaluation Report	Document Review	Once in 2009	Evaluator
		Health Directors	Key Informant Surveys	Once in 2010	Evaluator
	There is a professional supervision, clinical support and roles and responsibilities model with their primary health care team. The model is being tested in at least two communities	SLFNHA documents and reports	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Interim Evaluation Report	Document Review	Once in 2009	Evaluator
		SLFNHA Clinical Coordinator, PHC, Health Directors	Key Informant Surveys	Once in 2010	Evaluator
	The case management model and the mental health and addictions program are ready for implementation	SLFNHA documents and reports	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Interim Evaluation Report	Document Review	Once in 2009	Evaluator
		SLFNHA Clinical Coordinator, PHC, Health Directors	Key Informant Surveys; Case Study/Story	Once in 2010	Evaluator
	Allied health professionals are supporting mental health and addictions	Interim Evaluation Report	Document Review	Once in 2009	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	*Data Analysis Method*	*Frequency of Analysis*	*Responsibility*
PROGRESS/SUCCESS					
	and nursing (i.e., pharmacy technicians)	Health Directors	Key Informant Surveys	Once in 2010	Evaluator
GOAL SIX A communications program is operational and everyone can access current information about the primary health care system	40% of community members in the Sioux Lookout area report an awareness of the AHP	Community site visit reports	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Interim Evaluation Report	Document Review	Once in 2009	Evaluator
		Community Members	Telephone Survey*	Once in 2010	Evaluator
GOAL SEVEN A continuous evaluation program is operational within SLFNHA and the communities and includes: quality assurance programs; developing and implementing risk management programs; and adopting an evaluation framework with performance measurements for monitoring progress.	An evaluation program is in place in all communities, and baseline measures are established throughout the system. The program takes into account the limitations associated with data collection	Evaluation program and baseline data	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Interim Evaluation Report	Document Review	Once in 2009	Evaluator
	There is a plan for implementing the quality-assurance program throughout the system	Quality Assurance Implementation Plan	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Quality Assurance Implementation Plan	Document Review	Once in 2009	Evaluator
	There is a plan for implementing the risk-management program throughout the system	Risk Management Implementation Plan	Document Review	Interim Evaluation Report in July 2008	Evaluation Working Group
		Risk Management Implementation Plan	Document Review	Once in 2009	Evaluator
	Review of all indicators	Evaluation Coordinator; PHC and Health Director Working Group; CCOH	Key Informant Interviews	Once in 2010	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	***Data Analysis Method***	***Frequency of Analysis***	***Responsibility***
PROGRESS/SUCCESS					
How is AHP making progress toward its medium-term outcomes?	The Evaluator will analyze the results of the Goals in total to answer this evaluation question			Once in 2009	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	***Data Analysis Method***	***Frequency of Analysis***	***Responsibility***
COST EFFECTIVENESS					
Were funds used in accordance with the contribution agreement(s)?	Funds were used in accordance with plan; variances explained	Contribution Agreements; Financial Reports	Financial Monitoring	Quarterly tracking	Finance
			Financial Review	Financial Review in 2009	Evaluator
Does the use of funds reflect promising/best practices for primary health care systems?	Evidence of application of industry promising/best practices to the uses of funds; variances explained	Literature and Industry Experts	Environmental Scan	Once in 2009	SLFNHA
		Chiefs, CCOH, SLFNHA Board and personnel minutes, Annual internal performance measurement reports, and financial reports	Documentation and Financial Review	Once in 2009	Evaluator

Evaluation Categories	Indicators	Data Collection Strategy			
		Data Source	***Data Analysis Method***	***Frequency of Analysis***	***Responsibility***
IMPLEMENTATION					
Has the AHP been implemented according to plan?	All plans relate to AHP implementation plan and contribution agreement requirements	Contribution Agreement, Management Plan, Chiefs, CCOH, SLFNHA, Tribal Councils, community health plans, Annual internal performance measurement reports, and Chiefs, CCOH and SLFNHA Board Minutes	Quality-management monitoring	Semi-annual Review beginning December 2006 and Interim Evaluation Report in July 2008	Evaluation Working Group
	All track actions and record variances				
	Activities have been completed; variances explained				
		Annual internal performance measurement reports, Annual Reports, and Chiefs, CCOH and SLFNHA Board minutes	Documentation Review	Once in 2009	Evaluator
		Chiefs, SLFNHA Board and management, and Primary Health Care and Health Directors working group	Key Informant Interviews	Once in 2010	Evaluator

* *In assessing the use of a telephone survey, consider whether there is sufficient information from reports on community site visits to answer this question, and/or other beneficial uses for furthering work within the implementation plan.*

Table 12.4 – Data Elements and Benchmarks

Data Element	Benchmark	Source
Implementation		
• Annual SLFNHA work plans track to the AHP	80%	Work Plans
• Community health plans track to the AHP	80%	Community Health Plans
• Activities have been completed and variances recorded for SLFNHA and communities	80%	Monthly Activity Reports consolidated
• Funds are expended according to plan and documented variances	80%	Financial Report
• Compliance with funding agreements; annual review with briefing summary	100%	Annual Report to funders

Evaluation Plan

Evaluation provides a periodic look at progress toward outcomes. At this early stage, the focus is on the effectiveness of management issues:

- Program planning and implementation;
- Outputs;
- Resource allocation in accordance with plan; and
- Progress toward achievement of outcomes.

The strategy employed for conducting the periodic look also considers how evaluation capacity can be built through this exercise and on-going monitoring.

Process Evaluation

A process approach examines management planning and implementation; outputs; and resource allocation. It highlights whether there is progress, and what, if any adjustments are necessary to strengthen results. It focuses on work plan activities to determine how things were done and identifies “enablers” and “barriers”.

As the performance measurement plan relies heavily on process evaluation, it is expected the independent evaluation include: a documentation review of work plan and management reporting; a financial review; key informant interviews; and a case study(s). The questionnaire and case study design should relate to the evaluation questions, the related short-term outcomes, and associated indicators (Table 3).

Information from this evaluation component supports and explains findings of the impact assessment and provides program management and partners with tools for continuous improvement.

Impact Evaluation

This component determines the extent to which activities have effected change and produced the desired results. Based on a causal hypothesis testing of the relationship and impact of the processes/activities on the outcomes, the impact assessment provides a systematic analysis of whether SLFNHA has realized its short-term outcomes.

The research instruments aim to produce an estimate of the "net effects' of performance, using instruments that compare information in a variety of circumstances (i.e., pre- and post-interventions). The primary goal is to establish causality between activities and outputs and outcomes achieved, while considering the role of other factors.

The planned methodology includes: the community site visit reports or telephone survey results (secondary data); key informant interviews; and a case study(s). The independent evaluation should assess the methodology, results and conclusions drawn from the site visit reports or survey to assess the increased awareness among First Nations about the AHP. The questionnaire and case study(s) design should specifically relate to the evaluation questions, the related short-term outcomes and associated indicators (Table 12.3).

The reach for the evaluation are the partners, Sioux Lookout Zone Chiefs and health directors who are the primary audience to affect change. First Nation community members are participants in the site visits or survey. The site visit reports or survey have a methodological limitation that is difficult to minimize without the expenditure of significant resources. It is hoped that if SLFNHA uses or participates in surveys a question or two can be designed within the instrument to assist evaluation without adding undo burden.

The on-going performance measurement strategy with the independent evaluation of SLFNHA enables the Chiefs, management and its audiences to gain significant and relevant information on its performance. This will be looked at in terms of achieving its objectives, activities, outputs and impacts – and the testing of the causal assumptions linking these components. Most importantly, the process enables the Chiefs and SLFNHA to consider measures and approaches to strengthen its activities and impacts, and strengthen its organizational effectiveness.

Table 12.5 – Research Instruments

Instrument	*Source*	*# of Interviews*
Documentation and Financial Review	• Contribution Agreements; Sioux Lookout Zone Chiefs, CCOH and SLFNHA Board of Directors minutes and resolutions; the Implementation Plan; financial reports; annual reports; audits; and other relevant documents	

Instrument	Source	# of Interviews
Key Informant Interviews	• Sioux Lookout Zone Chiefs • CCOH • SLFNHA (Board, Management and Staff) • Primary Health Care Working Group	Up to 35 interviews
	• Health Directors • Organizational Partners: • FNIH, Health Canada • Province of Ontario, MOHLTC	Up to 4 interviews
Case Studies	• Two Case Studies. One addresses the inclusion of Anishinabe ways. The second study concerns service delivery, the development of mental health and addictions program with case management. The studies may also incorporate indicators from other goals within the design	Document review and interviews.

Evaluation Work Schedule

Table 12.6 presents a program work schedule, which identifies program activities, timing, and level of effort required to complete the evaluation.

Table 12.6 – Evaluation Work Schedule

Activity	April 2006 – March 2010														
	2006		2007			2008			2009				2010		
	Sep	Dec	Mar	Sept	Dec	Mar	Sep	Dec	Mar	July	Sept	Dec	March	April	July
Development & approval of Evaluation Framework	●														
Development & implementation performance measurement tools		●	●												
Annual reviews		●			●			●				●			
Interim internal check-up							●								
Report to Chiefs				●			●				●				
RFP for Evaluation Contractor									●						
Hire External Evaluator											●				
Conduct evaluation											●	●			
Draft Evaluation Report													●		
Approval by SLFNHA Board, CCOH and Chiefs													●		

Final report for submission to federal and provincial governments													●	
Approval of AHP Evaluation Report													●	
Development of medium-term evaluation framework with baseline data														●

Evaluation Budget

The evaluation budget is in accordance with the program budget for this activity.

Changes to and Approval of the Evaluation Framework

SLFNHA is responsible for evaluation of the initiatives. This evaluation plan was developed in conjunction with the program management team, and reviewed by the Primary Health Care and Health Directors Working Group, and the Chiefs Committee on Health. Final approval has occurred through the Sioux Lookout Zone Chiefs.

Should changes be required to this Framework, SLFNHA will ensure they are reviewed with the working group and CCOH with final approval by the Sioux Lookout Zone Chiefs.

APPENDICES

I – Physician Health Model/Human Resources Data

(Data as per Anishinabe Health Plan Report)

							(factor)	0.120	0.195	0.400	0.665	0.930	1.000
			A	B	C	D				A	A	A	A
PHC MODEL COMPONENT	TYPE of WORKER	(+30%ben) Salary	NUMBER OF REQUIRED FTE'S pop 200	pop 500	pop 1000	pop 2000		Wawakap. 24	Mcdowell 39	Wabausk 80	Saugeen fn 133	New Slate F 186	Wabigoon 200
CURATIVE		*$*	*FTE's*	*FTE's*	*FTE's*	*FTE's*		*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*
100,000	Primary Care Nurse	100,000	1.50	2.50	4.00	8.00		0.18	0.29	0.60	1.00	1.40	1.50
50,000	PHC Nurse Practitioner	50,000	0.50	1.00	2.00	4.00		0.06	0.10	0.20	0.33	0.47	0.50
40,000	On - call First Response	40,000	0.00	0.25	1.00	2.50		0.00	0.00	0.00	0.00	0.00	0.00
300,000	Physician	300,000	0.25	0.63	1.25	2.50		0.03	0.05	0.10	0.17	0.23	0.25
50,000	Medical Translator/Clerk	50,000	1.00	1.50	3.00	7.00		0.12	0.20	0.40	0.67	0.93	1.00
90,000	Pharmacist	90,000	0.05	0.10	0.20	0.25		0.01	0.01	0.02	0.03	0.05	0.05
65,000	Pharmacy Technician	65,000	0.25	1.00	1.25	2.00		0.03	0.05	0.10	0.17	0.23	0.25
65,000	Phlebotomist	65,000	0.25	0.50	0.50	1.50		0.03	0.05	0.10	0.17	0.23	0.25
90,000	Basic Radiography Worker	90,000	0.00	0.25	0.25	0.50		0.00	0.00	0.00	0.00	0.00	0.00
50,000	Ultrasound Technologist	50,000	0.00	0.00	0.00	1.00		0.00	0.00	0.00	0.00	0.00	0.00
50,000	Telehealth Coordinator	50,000	0.25	0.50	1.00	1.00		0.03	0.05	0.10	0.17	0.23	0.25
50,000	Technician	50,000	0.00	0.00	0.25	0.50		0.00	0.00	0.00	0.00	0.00	0.00
	Case Manager		0.00	0.00	0.00	0.00		0.00	0.00		0.00	0.00	0.00
	Sub-Total		4.05	8.23	14.70	30.75		0.49	0.79	1.62	2.69	3.77	4.05
PROMOTIVE/ PREVENTIVE													
100,000	Public Health Nurse	100,000	0.50	1.00	2.00	4.00		0.06	0.10	0.20	0.33	0.47	0.50
50,000	MH & Addictions Worker	50,000	2.00	4.00	8.00	12.00		0.24	0.39	0.80	1.33	1.86	2.00
65,000	Environmental Health Tech	65,000	0.25	0.50	1.00	1.00		0.03	0.05	0.10	0.17	0.23	0.25
50,000	Clerk Interpreter/Public Health Aid	50,000	0.00	0.50	1.00	2.00		0.00	0.00	0.00	0.00	0.00	0.00
50,000	Community Health Educator	50,000	0.50	1.00	2.00	3.00		0.06	0.10	0.20	0.33	0.47	0.50
40,000	Community Development Worker	40,000	0.00	1.00	1.50	2.00		0.00	0.00	0.00	0.00	0.00	0.00
	Sub-Total		3.25	8.00	15.50	24.00		0.39	0.63	1.30	2.16	3.02	3.25
SUPPORTIVE/ REHABILITATIVE													
40,000	Home Support Workers	40,000	1.50	2.00	3.00	6.00		0.18	0.29	0.60	1.00	1.40	1.50
25,000	Personal Care Workers	25,000	0.50	1.00	1.50	2.00		0.06	0.10	0.20	0.33	0.47	0.50
	Sub-Total		2.00	3.00	4.50	8.00		0.24	0.39	0.80	1.33	1.86	2.00
	TOTAL FTE's		9.30	19.23	34.70	62.75		1.12	1.81	3.72	6.18	8.65	9.30
							Physician Total $'s	9,000	14,625	30,000	49,875	69,750	75,000
							Other Total $'s	104,590	144,959	255,300	397,936	540,573	578,250
							TOTAL ALL	113,590	159,584	285,300	447,811	610,323	653,250

(Continued)

							(factor)	0.210	0.333	0.450	0.557	0.557	0.683	0.720	0.753
			A	B	C	D		B	B	B	B	B	B	B	B
PHC MODEL COMPONENT	TYPE of WORKER	(+30%ben) Salary	NUMBER OF REQUIRED FTE'S pop 200	pop 500	pop 1000	pop 2000		Musk Dam 263	Eagle Lake 300	Neskantaga 335	Wapekeka 367	Nibinamik 367	Poplar Hill 405	North Spirit 416	Kingfisher 426
CURATIVE		*$*	*FTE's*	*FTE's*	*FTE's*	*FTE's*		*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*
100,000	Primary Care Nurse	100,000	1.50	2.50	4.00	8.00		1.71	1.83	1.95	2.06	2.06	2.18	2.22	2.25
50,000	PHC Nurse Practitioner	50,000	0.50	1.00	2.00	4.00		0.61	0.67	0.73	0.78	0.78	0.84	0.86	0.88
40,000	On - call First Response	40,000	0.00	0.25	1.00	2.50		0.05	0.08	0.11	0.14	0.14	0.17	0.18	0.19
300,000	Physician	300,000	0.25	0.63	1.25	2.50		0.33	0.38	0.42	0.46	0.46	0.51	0.52	0.53
50,000	Medical Translator/Clerk	50,000	1.00	1.50	3.00	7.00		1.11	1.17	1.23	1.28	1.28	1.34	1.36	1.38
90,000	Pharmacist	90,000	0.05	0.10	0.20	0.25		0.06	0.07	0.07	0.08	0.08	0.08	0.09	0.09
65,000	Pharmacy Technician	65,000	0.25	1.00	1.25	2.00		0.41	0.50	0.59	0.67	0.67	0.76	0.79	0.82
65,000	Phlebotomist	65,000	0.25	0.50	0.50	1.50		0.30	0.33	0.36	0.39	0.39	0.42	0.43	0.44
90,000	Basic Radiography Worker	90,000	0.00	0.25	0.25	0.50		0.05	0.08	0.11	0.14	0.14	0.17	0.18	0.19
50,000	Ultrasound Technologist	50,000	0.00	0.00	0.00	1.00		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
50,000	Telehealth Coordinator	50,000	0.25	0.50	1.00	1.00		0.30	0.33	0.36	0.39	0.39	0.42	0.43	0.44
50,000	Technician	50,000	0.00	0.00	0.25	0.50		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Case Manager		0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Sub-Total		4.05	8.23	14.70	30.75		4.93	5.44	5.93	6.37	6.37	6.90	7.06	7.20
PROMOTIVE/ PREVENTIVE															
100,000	Public Health Nurse	100,000	0.50	1.00	2.00	4.00		0.61	0.67	0.73	0.78	0.78	0.84	0.86	0.88
50,000	MH & Addictions Worker	50,000	2.00	4.00	8.00	12.00		2.42	2.67	2.90	3.11	3.11	3.37	3.44	3.51
65,000	Environmental Health Tech	65,000	0.25	0.50	1.00	1.00		0.30	0.33	0.36	0.39	0.39	0.42	0.43	0.44
50,000	Clerk Interpreter/Public Health Aid	50,000	0.00	0.50	1.00	2.00		0.11	0.17	0.23	0.28	0.28	0.34	0.36	0.38
50,000	Community Health Educator	50,000	0.50	1.00	2.00	3.00		0.61	0.67	0.73	0.78	0.78	0.84	0.86	0.88
40,000	Community Development Worker	40,000	0.00	1.00	1.50	2.00		0.21	0.33	0.45	0.56	0.56	0.68	0.72	0.75
	Sub-Total		3.25	8.00	15.50	24.00		4.25	4.83	5.39	5.89	5.89	6.50	6.67	6.83
SUPPORTIVE/ REHABILITATIVE															
40,000	Home Support Workers	40,000	1.50	2.00	3.00	6.00		1.61	1.67	1.73	1.78	1.78	1.84	1.86	1.88
25,000	Personal Care Workers	25,000	0.50	1.00	1.50	2.00		0.61	0.67	0.73	0.78	0.78	0.84	0.86	0.88
	Sub-Total		2.00	3.00	4.50	8.00		2.21	2.33	2.45	2.56	2.56	2.68	2.72	2.75
	TOTAL FTE's		9.30	19.23	34.70	62.75		11.38	12.61	13.77	14.82	14.82	16.08	16.45	16.78
							Physician Total $'s	98,625	112,500	125,625	137,625	137,625	151,875	156,000	159,750
							Other **Total $'s**	686,033	749,333	809,213	863,959	863,959	928,971	947,790	964,898
							TOTAL ALL	784,658	861,833	934,838	1,001,584	1,001,584	1,080,846	1,103,790	1,124,648

(Continued)

							(factor)	0.042	0.056	0.080	0.080	0.174	0.190	0.600	0.626	0.686	0.886
			A	B	C	D		C	C	C	C	C	C	C	C	C	C
PHC MODEL COMPONENT	TYPE of WORKER	(+30%ben) Salary	NUMBER OF REQUIRED FTE'S pop 200	pop 500	pop 1000	pop 2000		Cat Lake 521	Wunnimum 528	Keewaywin 540	Fort Severn 540	Sachigo 587	Bearskin 595	Webique 800	Round Lake 813	Kasabonika 843	Deer Lake 943
CURATIVE		*$*	*FTE's*	*FTE's*	*FTE's*	*FTE's*		*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*
100,000	Primary Care Nurse	100,000	1.50	2.50	4.00	8.00		2.56	2.58	2.62	2.62	2.76	2.79	3.40	3.44	3.53	3.83
50,000	PHC Nurse Practitioner	50,000	0.50	1.00	2.00	4.00		1.04	1.06	1.08	1.08	1.17	1.19	1.60	1.63	1.69	1.89
40,000	On - call First Response	40,000	0.00	0.25	1.00	2.50		0.28	0.29	0.31	0.31	0.38	0.39	0.70	0.72	0.76	0.91
300,000	Physician	300,000	0.25	0.63	1.25	2.50		0.65	0.66	0.68	0.68	0.73	0.74	1.00	1.02	1.05	1.18
50,000	Medical Translator/Clerk	50,000	1.00	1.50	3.00	7.00		1.56	1.58	1.62	1.62	1.76	1.79	2.40	2.44	2.53	2.83
90,000	Pharmacist	90,000	0.05	0.10	0.20	0.25		0.10	0.11	0.11	0.11	0.12	0.12	0.16	0.16	0.17	0.19
65,000	Pharmacy Technician	65,000	0.25	1.00	1.25	2.00		1.01	1.01	1.02	1.02	1.04	1.05	1.15	1.16	1.17	1.22
65,000	Phlebotomist	65,000	0.25	0.50	0.50	1.50		0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
90,000	Basic Radiography Worker	90,000	0.00	0.25	0.25	0.50		0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
50,000	Ultrasound Technologist	50,000	0.00	0.00	0.00	1.00		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
50,000	Telehealth Coordinator	50,000	0.25	0.50	1.00	1.00		0.52	0.53	0.54	0.54	0.59	0.60	0.80	0.81	0.84	0.94
50,000	Technician	50,000	0.00	0.00	0.25	0.50		0.01	0.01	0.02	0.02	0.04	0.05	0.15	0.16	0.17	0.22
	Case Manager		0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Sub-Total		4.05	8.23	14.70	30.75		8.50	8.59	8.74	8.74	9.35	9.46	12.11	12.28	12.67	13.96
PROMOTIVE/ PREVENTIVE																	
100,000	Public Health Nurse	100,000	0.50	1.00	2.00	4.00		1.04	1.06	1.08	1.08	1.17	1.19	1.40	1.63	1.69	1.89
50,000	MH & Addictions Worker	50,000	2.00	4.00	8.00	12.00		4.17	4.22	4.32	4.32	4.70	4.76	6.40	6.50	6.74	7.54
65,000	Environmental Health Tech	65,000	0.25	0.50	1.00	1.00		0.52	0.53	0.54	0.54	0.59	0.60	0.80	0.81	0.84	0.94
50,000	Clerk Interpreter/Public Health Aid	50,000	0.00	0.50	1.00	2.00		0.52	0.53	0.54	0.54	0.59	0.60	0.80	0.81	0.84	0.94
50,000	Community Health Educator	50,000	0.50	1.00	2.00	3.00		1.04	1.06	1.08	1.08	1.17	1.19	1.60	1.63	1.69	1.89
40,000	Community Development Worker	40,000	0.00	1.00	1.50	2.00		1.02	1.03	1.04	1.04	1.09	1.10	1.30	1.31	1.34	1.44
	Sub-Total		3.25	8.00	15.50	24.00		8.32	8.42	8.60	8.60	9.31	9.43	12.30	12.70	13.15	14.65
SUPPORTIVE/ REHABILITATIVE																	
40,000	Home Support Workers	40,000	1.50	2.00	3.00	6.00		2.04	2.06	2.08	2.08	2.17	2.19	2.60	2.63	2.69	2.89
25,000	Personal Care Workers	25,000	0.50	1.00	1.50	2.00		1.02	1.03	1.04	1.04	1.09	1.10	1.30	1.31	1.34	1.44
	Sub-Total		2.00	3.00	4.50	8.00		3.06	3.08	3.12	3.12	3.26	3.29	3.90	3.94	4.03	4.33
	TOTAL FTE's		9.30	19.23	34.70	62.75		19.87	20.09	20.46	20.46	21.92	22.17	28.31	28.91	29.84	32.94
							Physician Total $'s	195,375	198,000	202,500	202,500	220,125	223,125	300,000	304,875	316,125	353,625
							Other Total $'s	1,126,266	1,137,854	1,157,720	1,157,720	1,235,529	1,248,773	1,568,150	1,609,672	1,659,337	1,824,887
							TOTAL ALL	1,321,641	1,335,854	1,360,220	1,360,220	1,455,654	1,471,898	1,868,150	1,914,547	1,975,462	2,178,512

(Continued)

						(factor)	0.116	0.125	0.817	0.890	0.988	1.179	
			A	B	C	D	D	D	D	D	D	D	
PHC MODEL COMPONENT	TYPE of WORKER	(+30%ben) Salary	NUMBER OF REQUIRED FTE'S pop 200	pop 500	pop 1000	pop 2000	Kitchenum 1116	New Osnab 1250	Fort Hope 1817	Lac Seul 1890	Pikangikum 1988	Sandy Lake 2179	TOTAL ALL
CURATIVE		*$*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*	*FTE's*
100,000	Primary Care Nurse	100,000	1.50	2.50	4.00	8.00	4.46	4.50	7.27	7.56	7.95	8.72	91.15
50,000	PHC Nurse Practitioner	50,000	0.50	1.00	2.00	4.00	2.23	2.25	3.63	3.78	3.98	4.36	41.28
40,000	On - call First Response	40,000	0.00	0.25	1.00	2.50	1.17	1.19	2.23	2.34	2.48	2.77	21.20
300,000	Physician	300,000	0.25	0.63	1.25	2.50	1.40	1.41	2.27	2.36	2.49	2.72	25.38
50,000	Medical Translator/Clerk	50,000	1.00	1.50	3.00	7.00	3.46	3.50	6.27	6.56	6.95	7.72	67.72
90,000	Pharmacist	90,000	0.05	0.10	0.20	0.25	0.21	0.21	0.24	0.24	0.25	0.26	3.56
65,000	Pharmacy Technician	65,000	0.25	1.00	1.25	2.00	1.34	1.34	1.86	1.92	1.99	2.13	26.82
65,000	Phlebotomist	65,000	0.25	0.50	0.50	1.50	0.62	0.63	1.32	1.39	1.49	1.68	16.67
90,000	Basic Radiography Worker	90,000	0.00	0.25	0.25	0.50	0.28	0.28	0.45	0.47	0.50	0.54	7.42
50,000	Ultrasound Technologist	50,000	0.00	0.00	0.00	1.00	0.12	0.13	0.82	0.89	0.99	1.18	4.12
50,000	Telehealth Coordinator	50,000	0.25	0.50	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	16.52
50,000	Technician	50,000	0.00	0.00	0.25	0.50	0.28	0.28	0.45	0.47	0.50	0.54	3.81
	Case Manager		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.06
	Sub-Total		4.05	8.23	14.70	30.75	21.03	21.18	32.11	33.26	34.81	33.62	347.11
PROMOTIVE/ PREVENTIVE													
100,000	Public Health Nurse	100,000	0.50	1.00	2.00	4.00	2.23	2.25	3.63	3.78	3.98	4.36	41.08
50,000	MH & Addictions Worker	50,000	2.00	4.00	8.00	12.00	8.46	8.50	11.27	11.56	11.95	12.72	148.66
65,000	Environmental Health Tech	65,000	0.25	0.50	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	16.52
50,000	Clerk Interpreter/Public Health Aid	50,000	0.00	0.50	1.00	2.00	1.12	1.13	1.82	1.89	1.99	2.18	18.96
50,000	Community Health Educator	50,000	0.50	1.00	2.00	3.00	2.12	2.13	2.82	2.89	2.99	3.18	37.16
40,000	Community Development Worker	40,000	0.00	1.00	1.50	2.00	1.56	1.56	1.91	1.95	1.99	2.09	27.03
	Sub-Total		3.25	8.00	15.50	24.00	16.49	16.56	22.44	23.07	23.90	25.52	289.41
SUPPORTIVE/ REHABILITATIVE													
40,000	Home Support Workers	40,000	1.50	2.00	3.00	6.00	3.35	3.38	5.45	5.67	5.96	6.54	72.39
25,000	Personal Care Workers	25,000	0.50	1.00	1.50	2.00	1.56	1.56	1.91	1.95	1.99	2.09	30.40
	Sub-Total		2.00	3.00	4.50	8.00	4.91	4.94	7.36	7.62	7.96	8.63	102.79
	TOTAL FTE's		9.30	19.23	34.70	62.75	42.42	42.68	61.91	63.94	66.67	67.77	742.23
					Physician	Total $'s	418,500	421,875	681,375	708,750	745,500	817,125	7,637,250
					Other	Total $'s	2,104,357	2,118,719	3,222,978	3,339,468	3,495,851	3,800,639	40,643,680
						TOTAL ALL	2,522,857	2,540,594	3,904,353	4,048,218	4,241,351	4,617,764	48,280,930

II – Cost Summary by Cost Centre and Major Cost Category for Fiscal Year Ending March 31, 2006

	Population #'s	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COMMUNITIES											
Koocheching	0	0	0	0	0	0	0	0	0	0	0
Wawakapewin	24	0	0	0	0	0	0	0	0	3,760	3,760
McDowell Lake	39	0	0	0	0	0	0	0	0	0	0
Wabauskang	80	0	0	1,103	0	0	0	0	0	0	1,103
Saugeen	133	0	0	569	0	0	0	0	0	0	569
New Slate falls	186	0	0	16,172	912	0	0	0	0	0	17,084
Wabigoon	200	0	0	3,793	0	0	0	0	0	0	3,793
Muskrat Dam	263	153,457	0	24,792	59,766	0	0	0	0	3,241	241,256
Eagle Lake	300	0	0	3,044	0	0	0	0	0	0	3,044
Neskantaga	335	331,229	0	35,110	16,703	0	0	0	0	1,697	384,739
Nibinamik	367	357,434	0	33,975	9,075	0	0	0	0	392	400,876
Wapekeka	367	0	0	0	0	0	0	0	0	0	0
Poplar Hill	405	200,901	0	31,435	37,970	0	0	0	0	0	270,306
North Spirit Lake	416	277,282	0	30,913	69,137	0	0	0	0	0	377,332
Kingfisher Lake	426	0	0	33,396	0	0	0	0	0	0	33,396
Cat Lake	521	512,995	0	58,374	23,601	0	0	0	0	3,851	598,821
Wunnimun Lake	528	0	0	30,372	0	0	0	0	0	0	30,372
Fort Severn	540	487,802	0	47,649	14,177	0	0	0	0	696	550,324
Keewaywin	540	146,921	0	32,532	52,073	0	0	0	0	0	231,526
Sachigo Lake	587	569,270	0	56,187	31,352	0	0	0	0	2,299	659,108
Bearskin Lake	595	522,700	0	62,104	24,700	0	0	0	0	1,743	611,247
Webequie	800	529,406	0	40,272	31,432	0	0	0	0	5,209	606,319
North Caribou Lake	813	705,305	0	70,653	59,454	0	0	0	0	801	836,213

	Population #'s	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COMMUNITIES											
Kasabonika	843	531,821	0	34,430	22,698	0	0	0	0	1,999	590,948
Deer lake	943	791,635	0	47,106	26,938	0	0	0	0	585	866,264
Big Trout Lake (Kitch)	1,116	1,094,638	0	88,686	64,793	0	0	0	0	2,689	1,250,806
Mishkeegogamang	1,250	722,095	0	55,479	35,785	0	0	0	0	3,126	816,485
Eabametoong (Ft Hope)	1,817	700,181	0	79,145	43,037	0	0	0	0	1,071	823,434
Lac Seul	1,890	0	0	39,337	0	0	0	0	0	0	39,337
Pikangikum	1,988	1,320,246	0	133,081	95,289	0	0	0	0	-6,718	1,541,898
Sandy Lake	2,179	1,215,023	0	128,687	60,933	0	0	0	0	3,820	1,408,463
Sub-Total (A)	20,491	11,170,341	0	1,218,396	779,825	0	0	0	0	30,261	13,198,823

(Continued)

	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COST CENTRES – MEDICAL										
Basic Radiology	203,038	0	0	46,250	10,243	0	0	0	0	259,531
Zone Dental	1,875,867	11,370	0	0	140,856	0	0	0	0	2,028,093
Zone Med Contracts	7,192,849	0	0	0	42,912	0	0	(630,344)	0	6,605,417
Zone Med Contracts	0	0	0	224,729	173	0	0	0	0	224,902
Relief Nursing	1946253	0	0	0	0	0	0	0	0	1,946,253
Zone Nursing Office	556,229	785,569	0	393,570	113,970	0	0	0	0	1,849,338
Sub-Total (B)	11,774,236	796,939	0	664,549	308,154	0	0	(630,344)	0	12,913,534
TOTAL (A) + (B)	22,944,577	796,939	1,218,396	1,444,374	308,154	0	0	(630,344)	30,261	26,112,357

(Continued)

	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COST CENTRES – ADMIN & SERVICE										
Material Management	0	358,652	0	0	3,604	0	0	0	0	362,256
Hostel Services	0	0	0	0	12,257	0	193,621	0	0	205,878
Inventory control	0	0	0	0	(28,891)	0	0	0	0	(28,891)
Project Manager North	0	64,485	0	0	8,472	0	0	0	0	72,957
Project Manager South	0	71,673	0	0	6,548	0	0	0	0	78,221
Project Manager East	0	95,956	0	0	14,852	0	0	0	0	110,808
Project Manager West	0	12,311	0	0	3,990	0	0	0	0	16,301
Zone Fleet Management	0	0	0	0	27,106	0	0	0	0	27,106
Zone Shipping/ Receiving	0	0	0	0	42,500	0	0	0	0	42,500
Zone Residences	0	0	0	0	190,488	0	0	0	0	190,488
Information Technology	0	0	0	0	3,362	0	0	0	0	3,362
SLZ – Zone Director	0	149,119	0	0	174,238	0	0	0	0	323,357
SLZ – Zone Director	0	0	0	0	320,967	0	0	0	0	320,967
Registry	0	216,660	0	0	96,173	0	0	0	0	312,833
Zone Facilities Manag – office	0	370,442	0	0	434,125	0	0	0	0	804,567
Zone Administration	0	98,377	0	0	498,096	175,140	0	0	0	771,613
Zone Facilities Manag – infrastr	0	104,178	0	0	247,299	0	0	0	0	351,477
SLZ – Non Insured	0	522,505	0	0	68,515	0	14,456,961	0	0	15,047,981
SLZ – Environment	0	470,008	0	0	619,963	0	0	0	0	1,089,971
SLZ – Financial	0	479,944	0	0	12,525	0	0	0	0	492,469
Zone Facilities	0	0	0	0	81,014	0	0	0	0	81,014
Zone Facilities	0	0	0	0	72,399	0	0	0	1,060,989	1,133,388
Sub-Total	0	3,014,310	0	0	2,909,602	175,140	14,650,582	0	1,060,989	21,810,623

(Continued)

		Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
OTHER – CONTRIBUTION AGREEMENTS											
76702	Brighter Futures	0	0	0	0	0	0	0	0	443,540	443,540
76703	CTRL HLT Services	0	0	0	0	0	0	0	0	4,104,353	4,104,353
76704	Non Health Canada Facility	0	0	0	0	0	0	0	0	3,371,244	3,371,244
76705	NIS Health Services	0	0	0	0	0	0	0	0	2,946,368	2,946,368
76706	NADAP	0	0	0	0	0	0	0	0	778,604	778,604
76707	Consult	0	0	0	0	0	0	0	0	3,227,425	3,227,425
76711	Aids	0	0	0	0	0	0	0	0	15,522	15,522
76712	Integrate	0	0	0	0	0	0	0	0	9,379,059	9,379,059
76713	Mental Health	0	0	0	0	0	0	0	0	1,940,888	1,940,888
76714	Solvent Abuse	0	0	0	0	0	0	0	0	32,935	32,935
76718	Environmental Health	0	0	0	0	0	0	0	0	30,000	30,000
76719	FNIH Info System	0	0	0	0	0	0	0	0	95,246	95,246
76721	FNI DWSP	0	0	0	0	0	0	0	0	85,304	85,304
76722	Cnd Pre Nut	0	0	0	0	0	0	0	0	210,107	210,107
76724	Head Start	0	0	0	0	0	0	0	0	1,362,307	1,362,307
76727	Diabetes Strategy	0	0	0	0	0	0	0	0	329,455	329,455
76728	FNIH Tuberculosis	0	0	0	0	0	0	0	0	417,350	417,350
76729	FNIH Hlt Prev Prog	0	0	0	0	0	0	0	0	1,063,886	1,063,886
	Sub-Total	0	0	0	0	0	0	0	0	29,833,593	29,833,593
	TOTAL ALL COSTS	22,944,577	3,811,249	1,218,396	1,444,374	3,217,756	175,140	14,650,582	(630,344)	30,924,843	77,756,573

III – Cost Summary by Cost Centre and Major Cost Category For Fiscal Year Ending March 31, 2005

	Population #'s	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COMMUNITIES											
Koocheching	0	0	0	0	0	0	0	0	0	0	0
Wawakapewin	24	0	0	0	0	0	0	0	0	0	0
McDowell Lake	39	0	0	0	0	0	0	0	0	0	0
Wabauskang	80	0	0	0	0	0	0	0	0	0	0
Saugeen	133	0	0	0	0	0	0	0	0	0	0
New Slate falls	186	12,730	0	0	0	0	0	0	0	0	12,730
Wabigoon	200	4,432	0	0	0	0	0	0	0	0	4,432
Muskrat Dam	263	2,250	0	18,884	23,715	0	0	0	0	5	44,854
Eagle Lake	300	0	0	1,760	0	0	0	0	0	0	1,760
Neskantaga	335	225,011	0	27,313	19,831	0	0	0	0	4,923	277,078
Nibinamik	367	318,944	0	27,743	16,695	0	0	0	0	967	364,349
Wapekeka	367	0	0	0	0	0	0	0	0	0	0
Poplar Hill	405	0	0	23,565	27,790	0	0	0	0	2,644	53,999
North Spirit Lake	416	0	0	13,658	42,108	0	0	0	0	45	55,811
Kingfisher Lake	426	0	0	23,022	0	0	0	0	0	0	23,022
Cat Lake	521	431,168	0	60,491	24,552	0	0	0	0	4,621	520,832
Wunnimun Lake	528	0	0	21,393	0	0	0	0	0	0	21,393
Fort Severn	540	519,224	0	32,648	12,640	0	0	0	0	1,791	566,303
Keewaywin	540	0	0	24,150	26,948	0	0	0	0	21	51,119
Sachigo Lake	587	440,148	0	45,651	10,945	0	0	0	0	3,539	500,283
Bearskin Lake	595	377,134	0	45,195	18,444	0	0	0	0	4,535	445,308
Webequie	800	405,942	0	41,167	22,172	0	0	0	0	2,978	472,259
North Caribou Lake	813	602,893	0	53,269	42,458	0	0	0	0	4,876	703,496
Kasabonika	843	376,778	0	25,666	15,411	0	0	0	0	1,075	418,930
Deer lake	943	703,852	0	45,886	19,710	0	0	0	0	2,542	771,990

	Population #'s	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COMMUNITIES											
Big Trout Lake (Kitch)	1,116	940,327	0	76,599	46,182	0	0	0	0	155	1,063,263
Mishkeegogamang	1,250	652,719	0	45,720	11,362	0	0	0	0	2,285	712,086
Eabametoong (Ft Hope)	1,817	566,230	0	72,186	20,422	0	0	0	0	3,260	662,098
Lac Seul	1,890	0	0	20,821	0	0	0	0	0	0	20,821
Pikangikum	1,988	1,113,383	0	98,183	50,734	0	0	0	0	1,752	1,264,052
Sandy Lake	2,179	1,096,434	0	117,266	46,673	0	0	0	0	5,527	1,265,900
Sub-Total (A)	20,491	8,789,599	0	962,236	498,792	0	0	0	0	47,541	10,298,168

(Continued)

	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COST CENTRES – MEDICAL										
Basic Radiology	164,609	0	250	105,281	0	0	0	0	0	270,140
Zone Dental	1,718,628	0	130,916	0	0	0	0	0	0	1,849,544
Zone Med Contracts	7,188,978	0	43,951	0	0	0	0	(432,892)	0	6,800,037
Zone Med Contracts	0	0	906	164,595	0	0	0	0	0	165,501
Relief Nursing	1,684,610	0	0	0	0	0	0	0	0	1,684,610
Zone Nursing Office	921,774	714,044	0	70,863	303,058	0	0	0	0	2,009,739
Sub-Total (B)	11,678,599	714,044	176,023	340,739	303,058	0	0	(432,892)	0	12,779,571
TOTAL (A) + (B)	20,468,198	714,044	1,138,259	839,531	303,058	0	0	(432,892)	47,541	23,077,739

(Continued)

	Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
COST CENTRES – ADMIN & SERVICE										
Material Management	0	323,930	0	0	4,629	0	0	0	0	328,559
Hostel Services	0	0	0	133,959	17,624	0	0	0	0	151,583
Inventory control	0	0	0	0	105,653	0	0	0	0	105,653
Project Manager North	0	57,948	0	0	9,649	0	0	0	0	67,597
Project Manager South	0	74,111	0	0	4,129	0	0	0	0	78,240
Project Manager West	0	28,677	0	0	1,087	0	0	0	0	29,764
Zone Fleet Management	0	0	0	0	16,029	0	0	0	0	16,029
Zone Shipping/ Receiving	0	0	0	0	21,497	0	0	0	0	21,497
Zone Residences	0	0	0	0	192,915	0	0	0	0	192,915
Information Technology	0	0	0	0	7,462	0	0	0	0	7,462
N SLZ – Zone Director	0	134,283	0	0	55,802	0	0	0	0	190,085
H Registry	0	132,693	0	0	82,483	0	0	0	0	215,176
Zone Facilities Manag – office	0	338,587	0	0	630,980	413,044	0	0	0	1,382,611
H Zone Administration	0	173,211	0	0	556,831	0	0	0	0	730,042
Zone Facilities Manag – infrastr	0	66,616	0	0	226,132	512,482	0	0	0	805,230
N SLZ – Non Insured	0	538,879	0	0	38,073	0	0	0	0	576,952
H SLZ – Environment	0	309,165	0	0	453,348	0	0	0	0	762,513
H SLZ – Financial Se	41,425	425,208	0	0	14,077	0	9,663,140	0	0	10,143,850
O Zone Facilities	0	0	0	0	12,639	16,695	0	0	375,998	405,332
	0	0	0	0	0	0	0	0	2,378,992	2,378,992
Zone Facilities	0	0	0	0	0	0	0	0	1,098,370	1,098,370
Sub-Total	41,425	2,603,308	0	133,959	2,451,039	942,221	9,663,140	0	3,853,360	19,688,452

(Continued)

		Med Wages & Benefits $	Other Wages/ Benefits $	Medical Supplies $	Medical Travel $	Operating Costs $	Minor Capital $	Non-Insured Travel $	OHIP $	Other $	TOTAL ALL $
OTHER – CONTRIBUTION AGREEMENTS											
76702	Brighter Futures	0	0	0	0	0	0	0	0	470,530	470,530
76703	CTRL HLT Services	0	0	0	0	0	0	0	0	4,728,527	4,728,527
76704	Non HC fac	0	0	0	0	0	0	0	0	33,001	33,001
76705	NIS Health Services	0	0	0	0	0	0	0	0	2,847,231	2,847,231
76706	NADAP	0	0	0	0	0	0	0	0	805,579	805,579
76707	Consult	0	0	0	0	0	0	0	0	3,140,000	3,140,000
76711	Aids	0	0	0	0	0	0	0	0	0	0
76712	Integrate	0	0	0	0	0	0	0	0	9,104,884	9,104,884
76713	Mental Health	0	0	0	0	0	0	0	0	1,933,836	1,933,836
76714	Solvent Abuse	0	0	0	0	0	0	0	0	37,831	37,831
76718	Enviro Hlt	0	0	0	0	0	0	0	0	81,560	81,560
76719	FNIH Info System	0	0	0	0	0	0	0	0	0	0
76721	FNI DWSP	0	0	0	0	0	0	0	0	0	0
76722	Cnd Pre Nut	0	0	0	0	0	0	0	0	0	0
76724	Head Start	0	0	0	0	0	0	0	0	0	0
76727	Diabe Strat	0	0	0	0	0	0	0	0	0	0
76728	FNIH Tuberculosis	0	0	0	0	0	0	0	0	0	0
76729	FNIH Hlt Prev Prog	0	0	0	0	0	0	0	0	0	0
	Sub-Total	0	0	0	0	0	0	0	0	23,182,979	23,182,979
	TOTAL ALL COSTS	20,509,623	3,317,352	1,138,259	973,490	2,754,097	942,221	9,663,140	(432,892)	27,083,880	65,949,170

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APPENDIX D – Glossary

Acute care:

> Acute care is health care provided to an ill individual who needs urgent treatment. The care is usually provided in a hospital or clinic under the direction of a primary care nurse and/or physician.

Allied Health Services:

> Allied health professionals are those who are trained in a science related to health care – who share the responsibility for the delivery of health care or related services, including services relating to the identification; evaluation and prevention of diseases and disorders; dietary and nutrition services; health promotion services; or health systems management services. The allied health professions (AHPs) include dental hygienists; dental therapists; diagnostic medical sonographers; dieticians; health educators; medical technologists; physiotherapists; occupational therapists; respiratory therapists; speech and language therapists; audiologists; speech language pathologists; psychologists; chiropodists/podiatrists, prostheticists and orthotists; art, drama and music therapists (usually called arts therapists); radiographers (diagnostic and therapeutic); sonographers and paramedics, among others.

Anishinabe Health Plan (AHP):

> In Resolution 04/44 the Sioux Lookout District Chiefs mandated the Sioux Lookout First Nations Health Authority to prepare a Sioux Lookout Anishinabe Health Plan in cooperation with First Nations and Tribal Councils. The Health Planning Project has been jointly funded by Health Canada through its Health Integration Initiative and the Ontario Ministry of Health and Long Term Care through its Primary Health Care Transition Fund. This Health Plan covers our 31 First Nations in the Sioux Lookout area.

Art Therapy:

> Art therapy is based on psychological theory and research, employing art and other creative modalities in support of the client's goals while taking into consideration thoughts, feelings, behaviours and spirituality within the counselling process. Art therapy can be used to explore issues of relationships, family, loss, life transitions, abuse and development. It may include interventions to: resolve emotional conflict, increase self-awareness and self-esteem, build social skills, change behaviour, increase coping skills and develop strategies for problem solving. Art therapy does not rely on language or verbal skills. It may provide an accessible modality for persons with disabilities. It offers opportunity to access experiences in a controlled way, focuses concentration on a single activity. Shutting out intrusive thoughts, it encourages creative thinking and risk-taking in a safe environment. It may be less intrusive than other therapy forms and yet is capable of releasing strong emotion safely[i].

Audiology:

> The practice of audiology is the assessment of auditory function and the treatment and prevention of auditory dysfunction to develop, maintain, rehabilitate or augment auditory and communicative functions[ii].

Capital development:

> Capital development is the funding of design, planning and building of facilities to house the health service. As well, capital development can include the purchase of equipment, or other tools such as an information system.

CCOH:

> The Chiefs Committee on Health represents, advises and reports to the Sioux Lookout Chiefs in Assembly on matters affecting the health of the First Nations members of the Sioux Lookout Area.

Communication Coordinators:

> Two people hired by the Sioux Lookout First Nations Health Authority to spread the word about the Anishinabe Health Planning process and to ensure that people in each community were informed about proposals and decisions that were being made. They also provided feedback to the planning team from community members about prevalent issues and concerns.

Chiropody:

> The practice of chiropody is the assessment of the foot and the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means.[iii]

Crown:

> Refers to the Queen of England and to Treaties signed by her representatives that guaranteed rights to the Nishnawbe Aski Nations and other First Nations in the treaty areas. The obligations under the treaty fall to the Government of Canada as the Queen's current representative.

Dental Hygiene:

> The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services[iv].

Dentist:

> The practice of dentistry is the assessment of the physical condition of the oral-facial complex and the diagnosis, treatment and prevention of any disease, disorder or dysfunction of same[v].

Denturist:

> The practice of denturism is the assessment of missing some or all teeth and the design, construction, repair, alteration, ordering and fitting of removable dentures[vi].

Dietetics:

> The practice of dietetics is the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition-related disorders by nutritional means[vii].

Elder:

An Elder is an individual with knowledge of traditional ways, gained through lived experience, and with the willingness and ability to teach others[viii]. Another scholar also notes that the term "Elder" refers to any person gifted with an ability to learn new things and to pass them on[ix]. An Elder promotes good health by encouraging traditional ways and language, the practice of ceremony, personal and group healing, applying their wisdom to everyday problems. They also pass along teaching songs and stories, traditional wisdom and knowledge of the how the land supports the people and the consideration of traditional values and beliefs in all aspects of life[x].

Emergent care:

Emergent care is health care to an individual who comes to a hospital, clinic, or other care centre with an undiagnosed condition. A physician or primary care nurse examines the individual and determines if further care is necessary. If a diagnosis indicates that further care is necessary then they are treated or referred for other services.

Episodic Visits:

A sequence of visits, usually unrelated, to a health care centre by one individual.

FASD:

Fetal Alcohol Spectrum Disorder is a disorder caused by a mother's consumption of alcohol during pregnancy. It has multiple symptoms ranging from physical malformations to behaviour and mood disorders.

FNIH:

The First Nations Inuit Health works with First Nations people and Inuit to improve their health. Together with First Nations and Inuit organizations and communities, they work hard to keep people healthy, and prevent chronic and contagious diseases. Health Canada's role in First Nations and Inuit health goes back to 1945, when Indian health services were transferred from Indian Affairs. In 1962, Health Canada provided direct health services to First Nations people on reserve and Inuit in the north. By the mid-1980s, work began to have ensured that First Nations and Inuit communities control over more health services[xi].

FNRLHS:

The First Nations Regional Longitudinal Health Survey (sometimes called RHS) is an on-going research study of the health of First Nations in Canada. The Assembly of First Nations managed the survey administration and its analysis and reporting back. Participation in the study by First Nations is voluntary.

Focus group sessions:

Focus groups are group interviews with usually no more than fifteen participants. The intent of the focus group is to get a diversity of opinion from many people at a time. As well, it is hoped that one person's comment will help another person to a memory or opinion about a similar issue and hence, the discussion becomes richer.

FTE:

Full-time-equivalent is a way of describing the number of working days in a job that would be the equivalent of having one person work full-time in it. It helps with planning, as some positions are not full-time, reported as .15 FTE for example. Other positions can be occupied by one or two or more people working part-time.

Herbalists:

Before contact with Europeans and for some time after that time, many family members understood and had knowledge of plants from the land that were used for healing. Much of "herbal medicine" consisted of "eating right" or eating land food with appropriate ceremonies of gratitude. Land food was used as preventive medicine, staying healthy was seen to be a more valuable practice than curing illness[xii]. Today "herbalists" are people with specialized knowledge of plants that can cure common aliments like infection, coughs, colds, and aches and pains. They assist people recover, with combinations of herbs for specific aliments. Many prescription medicines or over-the-counter medicines like aspirin™ have their roots in the medicinal properties of plants.

Human resource requirements:

The number and types of professionals and community workers required to get a health plan working on the ground in any given health care situation.

Intra-venous therapy:

Fluid, blood or medication given directly into the blood of a patient via a needle into a vein.

Key Informant Interview:

An interview with a knowledgeable person in a community. Key Informants are usually people who can see beyond the daily happenings in a community and have opinions about why things happen.

Liability insurance:

Insurance that covers health practitioners and health organizations against a patient suing for alleged mistakes or negligence.

Midwifery:

The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies; care during normal pregnancy, labour and post-partum period, and the conducting of spontaneous normal vaginal deliveries. (Note: Midwifery is not a funded service in Ontario. However, under Ontario law, aboriginal midwifes are exempt from licensing regulation provided they practice traditional midwifery services and;

(a) use the title "aboriginal midwife", a variation or abbreviation or an equivalent in another language; and

(b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife)[xiii].

MOHLTC:

> The Ontario Ministry of Health and Long Term Care of Ontario is responsible for administering the health care system and providing services to the Ontario public through such programs as health insurance, drug benefits, assistive devices, care for the mentally ill, long-term care, home care, community and public health, and health promotion and disease prevention. It also regulates hospitals and nursing homes, operates psychiatric hospitals and medical laboratories, and co-ordinates emergency health services.
>
> Created by the Public Health Act of 1882 as the first permanent health care administrative body in the province, the Ministry of Health was originally known as the Provincial Board of Health of Ontario and became the Department of Health in 1925. In 1930, the Department of Hospitals was established under the direction of the first Minister of Health; that Department became a division of the Department of Health in 1934. Insured hospital services and insured physicians' services, introduced in 1959 and 1966 respectively, were combined under the Ontario Health Insurance Plan (OHIP) in 1972. The Department of Health became the Ministry of Health in 1971, and then the Ministry of Health and Long-Term Care in June 1999[xiv].

Multi-disciplinary PHC Teams:

> Primary Health Care Teams comprise professionals and community workers from a variety of disciplines. Examples include community mental health, addiction, health education, environmental health, as well as nurses, doctors and allied health professionals.

NAN:

> Nishnawbe-Aski-Nation territory in northwestern Ontario covers a large portion of the province, stretching about seven hundred miles in length and four hundred miles in width; from the Manitoba border on the west to the Quebec border on the north east, from the Hudson's and James Bay watersheds in the north to roughly the Canadian National Railway line in the south. The 49 communities represented by Nishnawbe Aski Nation are scattered throughout this area. The Treaty area includes the districts of Cochrane, Timiskaming, Sudbury, Algoma, Thunder Bay and Sioux Lookout. NAN was created as a political entity by those First Nations to ensure protection of treaty rights[xv].

Nodin:

> Nodin provides mental health services to adults, children and youth. It has an acute care unit providing counseling, stabilization, discharge planning and monitoring; Child and Family Mental Health Services; Community Crisis Response and Adult Community Support Unit providing a crisis response capacity to communities in crises; Specialized Services providing art therapy, psychology, psychiatry and traditional healing services to all people of the Sioux Lookout First Nations. It also employs mental health staff based in six communities. Other mental health staff in Nodin travel to communities. Nodin is managed by the Sioux Lookout First Nations Health Authority.

Obstetrics:

> A specialized branch of medicine that concerns the care of pregnant women.

Occupational Therapy:

> Occupational therapy is the assessment of function and adaptive behaviour and the treatment that supports maintenance, rehabilitation and augmentation of function. This includes the areas of self-care, productivity and leisure[xvi].

Oji-Cree:

> The language spoken by many First Nations people in the Sioux Lookout area. It is a combination of the Ojibwa language and the Cree language and reflects the long association and friendship between these Nations.

Optician:

> Opticians provide, fit and adjustment vision devices such as contact lenses or eyeglasses[xvii].

Optometry:

> The practice of optometry is the assessment of the visual system and the diagnosis, treatment and prevention of; (a) disorders of refraction; (b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and (c) prescribed diseases[xviii].

Palliative care:

> Health care provided to the terminally ill, aimed at relieving symptoms and discomfort.

Physiotherapy:

> The practice of physiotherapy is the assessment of physical function and the treatment, rehabilitation and prevention of physical dysfunction, injury or pain, to develop, maintain, rehabilitate or augment function or to relieve pain[xix].

PHC:

> Primary Health Care (PHC) is an idea first proposed at the Alma Ata Conference in 1978 in Russia[xx]. It's essential health care based on practical, scientifically sound and socially acceptable methods and technology. These were made accessible universally to communities through their full participation, in the spirit of self-reliance and self-determination. It was done at a cost the community and country can afford to maintain at every stage of development.
>
> It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, families and communities with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

PHCWG:

> The Primary Health Care Working Group is a committee established by the Sioux Lookout First Nation Health Authority of all the partners in the delivery of health care in the Sioux Lookout area. This group has sorted through the information and data and made recommendations on establishing a primary health care system, via the Anishinabe Health

Plan, to the Chiefs Committee on Health and the Chiefs-in-Assembly through the Health Authority.

PMSC:

The Project Management Steering Committee is a committee set up by the Sioux Lookout First Nations Health Authority of the funding partners, the First Nations and the Health Authorities representatives to oversee the management of the Anishinabe Health Planning process and to report on progress to its funders. The Committee also was a vehicle for addressing the need for information from the various levels of government.

PRP:

The Participatory Research Project was the needs assessment process of the Anishinabe Health Plan. Participatory research is a method of gathering data that encourages the participation of the people being researched in the design of the research project. Community members play a direct role in the design and conduct of the research study by:

- Bringing community members into the study as partners, not just subjects.
- Using the knowledge of the community to understand health problems and to design activities to improve health care (interventions).
- Connecting community members directly with how the research is done and its results.
- Providing immediate benefits from the results to the community that participated in the study.

In PRP research, community members are also involved in getting the word out about the research and promoting the use of the research findings. This involvement can help improve the quality of life and health care in the community by putting new knowledge in the hands of those who need to make changes[xxi].

Psychology:

The practice of psychology is the assessment of behavioural and mental conditions. It diagnoses neuropsychological disorders and dysfunctions, as well as psychotic, neurotic and personality disorders and dysfunctions. It also works toward the prevention and treatment of behavioural and mental dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning[xxii].

Residential School Syndrome:

An inter-generational condition, characterized by depression, shame and anger, and caused by personal or an ancestor's experience of physical, sexual or emotional abuse in a residential school. The person who experienced residential school didn't learn good parenting, lost their language and traditional ways, and were often abused physically, mentally, or sexually. The purpose of the residential schools was to acculturate First Nations children into the mainstream Euro-centric society. Because of the damage to those children, they have often passed the damaging ways on to their children and grandchildren.

Re-investment Plan:

> The Four Party Agreement that resulted in the amalgamation of the Sioux Lookout District Health Centre and the Federal Hospital stipulated that money saved by the federal government by not operating a hospital was to be re-invested into community services. This agreement was contingent on a plan being developed for how the money was to be spent. Part of the Anishinabe Health planning process brought together all the health directors into two planning sessions totaling six days. The Health Directors developed a plan for the re-investment of the money. The plan was presented to the Chiefs-in-Assembly in February 2006. The plan was not approved. The Chiefs wanted to ensure, however, that all the money went directly to the communities.

Respiratory Therapy:

> The practice of respiratory therapy is the provision of oxygen therapy, cardio-respiratory equipment monitoring and the assessment and treatment of cardio-respiratory and associated disorders to maintain or restore ventilation[xxiii].

Respite care:

> Temporary institutional care of the dependent, elderly, ill or handicapped person, giving rest to the usual caregiver, often a family member.

Scott-McKay-Bain Report:

> A report written by Scott, E., W. McKay, H. Bain. (1989). The report was entitled "From Here to There: Steps Along the Way Report of the Scott McKay Bain Health Panel: Sioux Lookout, ON." The report was prepared for Health Canada because of the poor state of health of the people in the Sioux Lookout Zone. The aim was to improve and promote health among all who live in the Sioux Lookout Zone[xxiv]. The panel was in response to a hunger fast of five people from the Sandy Lake First Nation protesting the poor health of First Nations people, and expressing the frustration of the people at their deteriorating state of health.

Service Model:

> A service model is a representation of a health service in action. It lists the parts and the people and explains how the parts and the people relate to and support each other.

Sioux Lookout District Chiefs:

> The Chiefs of the First Nations of the old Indian Affairs District of Sioux Lookout who meet regularly in Assembly to decide on matters that affect their First Nations jointly and to ensure protection of their treaty rights.

SLFNHA:

> The Sioux Lookout First Nations Health Authority was created by a Chiefs-in-Assembly resolution, in response to a recommendation of the Scott-McKay-Bain Report (1989). It was the only resolution accepted by the Sioux Lookout Chiefs in Assembly. It was, the Chiefs felt, the only recommendation that led toward self-determination and self-government.

Speech Language Pathologist:

> The practice of speech-language pathology is the assessment of speech and language functions and the treatment and prevention of same. The pathologist then works to develop, maintain, rehabilitate or augment oral motor or communicative functions[xxv].

Suturing:

> Using special medical thread, the practitioner sews closed a patient's cut or incision.

Telehealth:

> Technology that allows for consultations with physicians, specialists or other health providers by video-conference. Telehealth systems can be used to transmit images from X-rays and other diagnostic equipment such as pictures of the eye or skin. Telehealth has been used successfully for mental health services, follow-up appointments with certain health providers, dermatology (with limits), and continuing education.

Traditional Specialists:

> Traditional specialists are people who often have the gift of "sight" and receive their specialized knowledge through dreams or visions. They tend to have knowledge of ceremonies, songs and lived experience combined with land "medicine". These traditionalists usually have one or two areas of special knowledge in assisting people to recover from illness of the soul or spirit,[xxvi] as well as illnesses of the body, like skin conditions, heart and lung problems. As well, they can assist people to recover from mental and emotional conditions associated with grief, loss, abuse and addiction. Sometimes, through ceremony and stories they can help people to find a path to 'right thinking" so that they are not confused or so that they have clear minds to approach difficult life tasks, like school examinations[xxvii].

Treaty 9:

> The treaty between the Crown and the First Nations who were signatories. In response to continuous petitions from the Cree and Ojibwa people of northern Ontario, and in keeping with its policy of paving the way for settlement and development, the federal government in 1905-1906 negotiated Treaty 9, also known as the James Bay Treaty. For the first and only time, a provincial government took an active role in negotiations. Together with the area acquired by adhesions in 1929-1930, Treaty 9 covers almost two-thirds of the area that became northern Ontario[xxviii].

Triage:

> When an individual goes to a health centre with an unknown condition a medical provider does an assessment of the person's stated symptoms and makes a decision about the urgency of that person's need. Generally, people with more urgent need are seen first and those with less urgent need are seen later.

Urgent Care:

> Health care provided to an individual who needs immediate attention. Usually urgent care is provided on an emergency basis.

[i] The Ontario Art Therapy Association, 2006.
[ii] Government of Ontario, 1991.
[iii] Government of Ontario, 1991.
[iv] Government of Ontario, 1991.
[v] Government of Ontario, 1991.
[vi] Government of Ontario, 1991.
[vii] Government of Ontario, 1991.
[viii] Wilson, 2002; Medicine, 1983; Stiegelbauer, 1996; Waldram, 1993
[ix] McLeod-Shabogesic, 1998.
[x] Colomeda, Eberhard and Wenzel, 2000.
[xi] Government of Canada (2006), http://www.hc-sc.gc.ca/fnih-spni/index_e.html.
[xii] Devanesen, 2000.
[xiii] Government of Ontario,1991.
[xiv] Government of Ontario (2006), http://www.health.gov.on.ca/english/ public/ministry/about.html
[xv] Knet http://www.knet.ca
[xvi] Government of Ontario, 1991.
[xvii] Government of Ontario, 1991.
[xviii] Government of Ontario, 1991.
[xix] Government of Ontario, 1991.
[xx] Alma Ata Declaration (1978) www.who.int/hpr/NPH/docs/ declaration_almaata.pdf+Alma+Ata&hl=en&gl=ca&ct=clnk&cd=1
[xxi] Agency for Healthcare Research and Quality 2006) Agency for Healthcare Research and Quality, http://www.ahrq.gov/research/cbprrole.htm.
[xxii] Government of Ontario, 1991.
[xxiii] Government of Ontario, 1991.
[xxiv] Scott, McKay, Bain (1989)
[xxv] Government of Ontario, 1991.
[xxvi] Devanesen, 2000.
[xxvii] Caisse, 2004.
[xxviii] Government of Canada (2006), http://www.ainc-inac.gc.ca/pr/trts/trty9_e.html.