Embracing Change

ANNUAL REPORT **2014/2015**

Northern Inter-Tribal Health Authority

Embracing Change

“Don’t fear change - embrace it. ---Anthony J. D’Angelo”

ABOUT US

Chairperson Message 4
Executive Director Address 6
About NITHA 8
Our Vision, Mission, and Principles 9
The Partnership 10
Partnership Communities 11
Board of Chiefs 12
Board of Chiefs Alternates 12
Executive Council 13
Guided by our Elders 14
Organizational Chart 15
2014 Scholorship Recipients 16

COMMUNITY SERVICES UNIT **18**
Mental Health and Addictions Advisor 19
Nurse Program Advisor 21
Capacity Development Advisor 25
Emergency Response Coordinator 34

PUBLIC HEALTH UNIT **38**
Public Health Nurse Advisor 40
Epidemiologist 42
Communicable Disease Control Nurse 49
Environmental Health Advisor 53
Infection Control Advisor 56
Health Promotion Advisor 59
Tobacco Coordinator 65
Tuberculosis Program 67

ADMINISTRATIVE UNIT **75**
Human Resource Advisor 76
eHealth Advisor 80
Finance Manager 83
Audited Financial Statements 85

CHAIRPERSON MESSAGE

I am honoured to introduce the 2014/15 Northern Inter-Tribal Health Authority Annual Report as Chairperson of the NITHA Board of Chiefs. Much change has occurred within the organization over the course of the year. The NITHA Office was relocated, as well we experienced change in the staff complement and within the members of our leadership; thus the theme for this year's report "Embracing Change". To the table of the Board of Chiefs, we welcomed Vice Chief Harold Linklater of the Peter Ballantyne Cree Nation and to the Executive Council table, Hamid Shahzad was welcomed representing the Lac La Ronge Indian Band.

This year we recognized and celebrated the successes NITHA has had to date as we reviewed the Strategic Priorities of the organization. Assisting the Partnership to improve programs and services for the community members continues to be challenging. The Partnership organizations have remained under-resourced with funding levels unreflective of the current (growing) population and the increased cost of living. However, we must continue to acknowledge the work of the Partnership first and second level staff in their strategic approaches in their delivery of programs and services despite the inadequate resources.

This year also provided an opportunity for the NITHA Leadership to define the Third Level of service NITHA as an organization provides:

NITHA 3rd Level Definition

Supporting the Partners to gain control, ownership and management of all First Nations Health Services which are grounded in First Nation philosophy and principles and based on the following 7 Strategic Pillars:

1. *Policy Development/Standards/Protocols/ Procedures*
2. *Data/Statistical Collection & Analysis (year end reports in graph formats)*
3. *Developing Tools and Best Practices*
4. *Research and Analysis*
5. *Engaging Partnership*
6. *Training Second Level / Train the Trainer*
7. *Informing Partnership on new/changing communication and current trends*

In order to be successful we need sustainable infrastructure, capacity and resources to support Partner organizations to move towards First Nations self-government.

The measure of our success in this endeavour is that our community members' health outcomes will be equal to or better than the Canadian Population.

NITHA continues to work with the Federal Government in hopes to strengthen the relationship between the Government of Canada and First Nations People however, we recognize that change is needed. A new approach, one that would encompass a relationship in which Ottawa hears more from the First Nations members, a grass roots approach vs. a top down. A relationship that recognizes the importance that Ottawa hears more from First Nations People, than for First Nations People to hear from Ottawa. Although it is true, we have seen some movement and positive measures as the Federal Government attempts to consult with First Nations, it remains crucial for Ottawa to really listen to what First Nations People need in order to be in better control of our health and well-being. As the Third Level definition reads, ***"the measure of our success in this endeavour is that our community members' health outcomes will be equal to or better than the Canadian Population"***.

This year's annual report theme is truly respective not only of the past year but of the coming year and the hope that we continue to grow and establish a long term plan with the Federal Government in sustainable programs for years to come so that we can achieve equal or better health outcomes when compared to the Canadian Population. Growth means change and change involves risks… stepping from the known to the unknown.

Tiniki,

Chief Tammy Cook-Searson
Chairperson
NITHA Board of Chiefs

EXECUTIVE DIRECTOR ADDRESS

This annual report represents the Northern Inter-tribal Health Authorities activities and results for the fiscal year ending March 31, 2015. It reports on the accomplishments of each position in the organization according to the identified strategic priorities. It also provides an opportunity to assess the accomplishments and challenges in the year, identify the plans for the next fiscal year and identify how to build on past successes for the benefit of the Partnership.

The 2014-2015 fiscal year was my 2nd year as the Executive Director and proved to be exciting and rewarding. We have begun the process of implementing our 5 year Community Health Plan which laid the foundation for the development of annual work plans of the staff within the organization.

During the work of the Community Health Plan the NITHA Executive Council identified 7 pillars that would be the basis for all NITHA work plans as well as a guide focusing on First Nations culturally appropriate and sensitive service delivery. Those 7 Pillars are as follows:

1. Development of policies, procedures, protocols and standards.
2. Collection and Analysis of statistical data.
3. Development of Tool of best practice.
4. Research and analysis.
5. Engaging the Partnership.
6. Training Second level or Train the Trainer.
7. Informing the Partnership on new or changing current trends and communication.

These pillars guided the development of the 5 year operational plan and the 5 year work plans for each position in the organization. As an organization we look forward to the implementation of these plans whilst understanding that as the years move forward they may require adjustment.

GOVERNANCE:

NITHA is guided by the mandate that **"The Chiefs have the ability to speak with one united voice, thereby being stronger and more powerful in our insistence for health services responsive to the needs of our northern communities."** (See NITHA Governance Manual).

The Board of Chiefs are responsible for directing and overseeing the affairs and operations of NITHA, they are involved in both strategic and operational planning for the organization and meet on a quarterly basis.

The Board of Chiefs for the 2014-15 fiscal year are as follows:

- Chairperson – Chief Tammy Cook-Searson, LLRIB
- Vice Chair – Tribal Chief Eric Sylvestre, MLTC
- Member – Grand Chief Ron Michel, PAGC
- Member – Chief Peter A. Beatty, PBCN

The assigned proxy for each meeting for the 2014-15 fiscal year were as follows:

- Vice-Chief Brian Hardlotte, PAGC
- Vice-Chief Dwayne Lasas, MLTC
- Councillor Leon Charles, LLRIB
- Vice-Chief Simon Jobb, PBCN

The council of Elders for each meeting for the 2014-15 fiscal year were as follows:

- Elder Mike Daniels, PAGC
- Elder Vitaline Read, MLTC
- Elder John Cook, LLRIB
- Elder Marilyn Morin, PBCN

The Board of Chiefs are provided with expertise, advice and recommendations from the NITHA Executive Council on the design, implementation and monitoring of the services provided at NITHA, they meet on a quarterly basis. The Executive Council for the 2014-15 fiscal year were as follows:

- Al Ducharme, PAGC
- Flora Fiddler, MLTC
- Sarah Walker-Cavanagh, LLRIB
- Arnette Weber-Beeds, PBCN

The NITHA management team prepares quarterly reports for the NITHA Executive Council, reporting on the progress of the organization according to the identified Strategic Priorities and based on the 7 pillars.

NITHA receives information from the Partner communities through the established working groups for a majority of positions within the organization. These working groups provide a form for a collective approach to discussion, sharing of information, strategizing and action planning. All communities are welcome to send members to each meeting which are hosted quarterly, two times a year face to face and two times via video conference. The requests from these working groups are forwarded to the NITHA Executive Council for consideration.

Achievements:

NITHA has spent considerable time on the offer from FNIHB Regional to assume more roles for Northern Saskatchewan. To begin this process we engaged a researcher to find out how other First Nations have taken on a larger role from FNIHB regional offices and the pro and cons of this process, which was completed January 2015. We are now beginning a process of presenting the information to the Partnership and will be hosting the 1st gathering on June 10th, and 11th, 2015 in Prince Albert. After this large session we will be presenting the information to the Partners in the communities to get feedback on what if anything they would like to see Northern Saskatchewan First Nations or NITHA assume from FNIHB Regional Office.

NITHA is also done some reorganization of positions by dividing the Nurse Epidemiologist position into a Public Health Nurse and an Epidemiologist. This will hopefully increase our ability to provide support to the Public Health Nursing program and to develop a useful Health Status Report for the Partnership.

We have also obtained new office space in order to accommodate all staff in one building, to create a more cohesive team approach to supporting the partners. We have finalized a clear definition of 3rd level for the organization and are working towards a strategy to address the short falls of Transfer Funding agreements.

NITHA has many other achievements that will be identified under each positon throughout the report.

Priorities:

I look forward to the coming year where focus will be on the following:

- Continue working on developing a political advocacy strategy for transfer sustainability.
- Continue working towards rejuvenating the School of Dental Therapy.
- Developing a comprehensive analysis of the shortfalls in NIHB program
- Developing a comprehensive communication plan for the organization
- Develop a Child/youth strategy for the partnership.
- Developing a Traditional Medicine Strategy

Respectfully Submitted,

Mary Carlson
Executive Director

Mary Carlson
Executive DIrector

Heather Gunville
Executive Assistant

ABOUT NITHA

Northern Inter-Tribal Health Authority (NITHA) is the only First Nations Organization of its kind in the country. The organization is comprised of Prince Albert Grand Council, Meadow Lake Tribal Council, Peter Ballantyne Cree Nation, and Lac La Ronge Indian Band and each has extensive experience in health service delivery. The Partners formally joined together in 1998 to create NITHA to deliver a service known as "Third Level".

What is Third Level?

Supporting the Partners to gain control, ownership and management of all First Nations Health Services which are grounded in First Nation philosophy and principles and based on the following 7 Strategic Pillars:

1. Policy Development/Standards/Protocols/ Procedures
2. Data/Statistical Collection & Analysis (year end reports in graph formats)
3. Developing Tools and Best Practices
4. Research and Analysis
5. Engaging Partnership
6. Training Second Level / Train the Trainer
7. Informing Partnership on new/changing communication and current trends

In order to be successful we need sustainable infrastructure, capacity and resources to support Partner organizations to move towards First Nations self-government.

The measure of our success in this endeavour is that our community members' health outcomes will be equal to or better than the Canadian Population.

SERVICES WE PROVIDE

Public Health

- Medical Health Officer Services
- Communicable Disease Prevention and Management
- Notifiable Diseases like:
  - » Tuberculosis (TB)
  - » Human Immunodeficiency Virus (HIV)
  - » Sexually Transmitted Infections (STI)
- Immunization
- Outbreak Management
- Disease Surveillance and Health Status
- Infection Control
- Health Promotion
- Environmental Health

Community Services

- Nursing Support
- Capacity Development
- Mental Health & Addictions
- Emergency Response Planning
- Human Resource Development
- eHealth Planning and Design
- Privacy Education
- Information Technology Support

OUR VISION, MISSION, AND PRINCIPLES

Vision

Partner communities will achieve improved quality health and well-being, with community members empowered to be responsible for their health.

Mission

The NITHA Partnership, a First Nations driven organization, is a source of collective expertise in culturally based, cutting edge professional practices for northern health services in our Partner Organizations.

Principles

NITHA's primary identity is a First Nations health organization empowered by traditional language, culture, values and knowledge.

The NITHA Partnership works to promote and protect the inherent Aboriginal and Treaty Right to Health as signatories to Treaty 6.

NITHA is a bridge between the diversity of our Partners and the external world of different organizations, governments, approaches and best practices.

The NITHA Partnership has representation at the federal and provincial levels.

Partner communities are on the inside track of changes and developments.

Through innovation and experimentation, the NITHA Partnership builds health service models that reflect First Nations' values and our best practices.

NITHA provides professional support, advice and guidance to its Partners.

NITHA contributes to capacity development for our northern First Nations health service system.

NITHA works collaboratively by engaging and empowering.

THE PARTNERSHIP

Prince Albert Grand Council

PO Box 1775
851-23rd Street West
Prince Albert, SK S6V 5T3
Phone: (306) 953-7248
Fax: (306) 764-6272

Meadow Lake Tribal Council

8002 Flying Dust Reserve
Meadow Lake, SK S9X 1T8
Phone: (306) 236-5817
Fax: (306) 236-6485

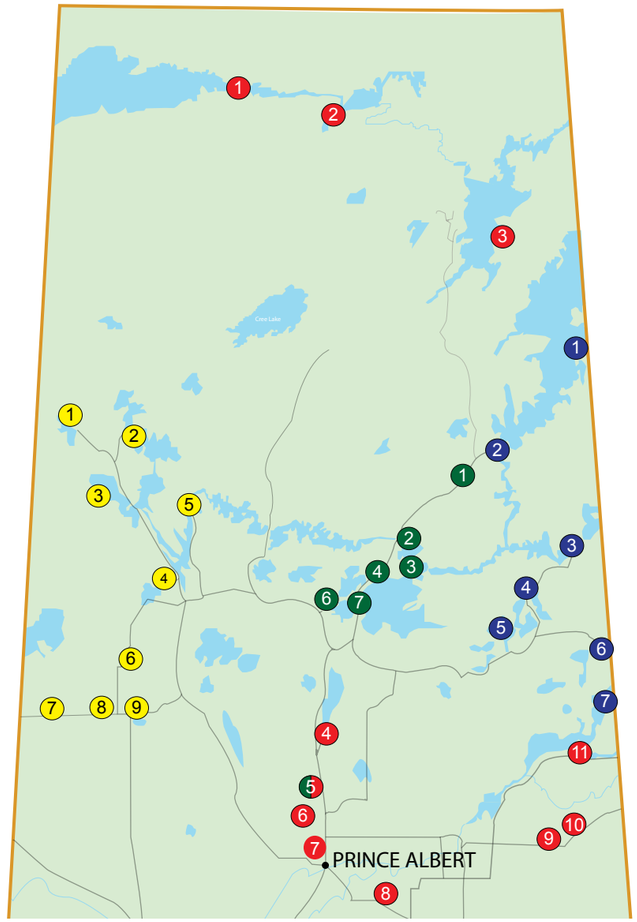
Peter Ballantyne Cree Nation

PO Box 339
2300-10th Avenue West
Prince Albert, SK S6V 5R7
Phone: (306) 953-4425
Fax: (306) 922-4979

Lac La Ronge Indian Band

PO Box 1770
La Ronge, SK S0J 1L0
Phone: (306) 425-3600
Fax: (306) 425-5520

PARTNERSHIP COMMUNITIES



Peter Ballantyne Cree Nation

1. Kinoosao
2. Southend Reindeer Lake
3. Sandy Bay
4. Pelican Narrows
5. Deschambault Lake
6. Denare Beach
7. Sturgeon Landing

Meadow Lake Tribal Council

1. Clearwater River Dene Nation
2. Birch Narrows Dene Nation
3. Buffalo River Dene Nation
4. Canoe Lake Cree Nation
5. English River First Nation
6. Waterhen Lake First Nation
7. Ministikwan Lake Cree Nation
8. Makwa Sahgaiehcan First Nation
9. Flying Dust First Nation

Prince Albert Grand Council

1. Fond du Lac Denesuline First Nation
2. Black Lake Denesuline First Nation
3. Hatchet Lake Denesuline First Nation
4. Montreal Lake Cree Nation
5. Little Red River - Montreal Lake
6. Sturgeon Lake First Nation
7. Wahpeton Dakota Nation
8. James Smith Cree Nation
9. Red Earth Cree Nation
10. Shoal Lake Cree Nation
11. Cumberland House Cree Nation

Lac La Ronge Indian Band

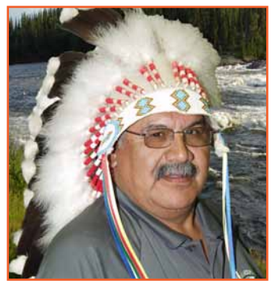
1. Brabant
2. Grandmother's Bay
3. Stanley Mission
4. Sucker River
5. Little Red River - La Ronge
6. Hall Lake
7. Kitsaki

BOARD OF CHIEFS

The Northern Inter-Tribal Health Authority is governed by the Board of Chiefs who is comprised of the following four representatives: PAGC Grand Chief, MLTC Tribal Chief, PBCN Chief and LLRIB Chief. The Board of Chiefs plays both strategic and operational roles in the governance of NITHA in accordance with the Partnership Agreement and the incorporation bylaws. The NITHA Board of Chiefs also appoints one alternate member per Partner; these members are deemed consistent representatives and attend all NITHA Board of Chiefs Meetings.

CHAIRPERSON
CHIEF
TAMMY COOK-SEARSON
Lac La Ronge Indian Band

VICE CHAIRPERSON
TRIBAL CHIEF
ERIC SYLVESTRE
Meadow Lake Tribal Council



GRAND CHIEF
RON MICHEL
Prince Albert Grand Council

CHIEF
PETER A. BEATTY
Peter Ballantyne Cree Nation

BOARD OF CHIEFS ALTERNATES

VICE CHIEF
BRIAN HARDLOTTE
Prince Albert Grand Council

VICE CHIEF
DWAYNE LASAS
Meadow Lake Tribal Council

VICE CHIEF
SIMON JOBB
Peter Ballantyne Cree Nation

COUNCILLOR
LEON CHARLES
Lac La Ronge Indian Band

EXECUTIVE COUNCIL

The NITHA Executive Council (NEC) is comprised of the four Partner Health Directors and the Executive Director who participates as an ex-officio member. The NEC provides operational and strategic direction through recommendations to the Board of Chiefs on the design, implementation and monitoring of third level services. The NEC also provides direction and guidance to the Executive Director.

AL DUCHARME
Prince Albert Grand Council

FLORA FIDDLER
Meadow Lake Tribal COuncil

SARAH WALKER CAVANAGH
Lac La Ronge Indian Band

ARNETTE WEBER-BEEDS
Peter Ballantyne Cree Nation

GUIDED BY OUR ELDERS

ELDER MIKE DANIELS

ELDER VITALINE READ

ELDER ROSE DANIELS

ELDER MARYLYN MORIN

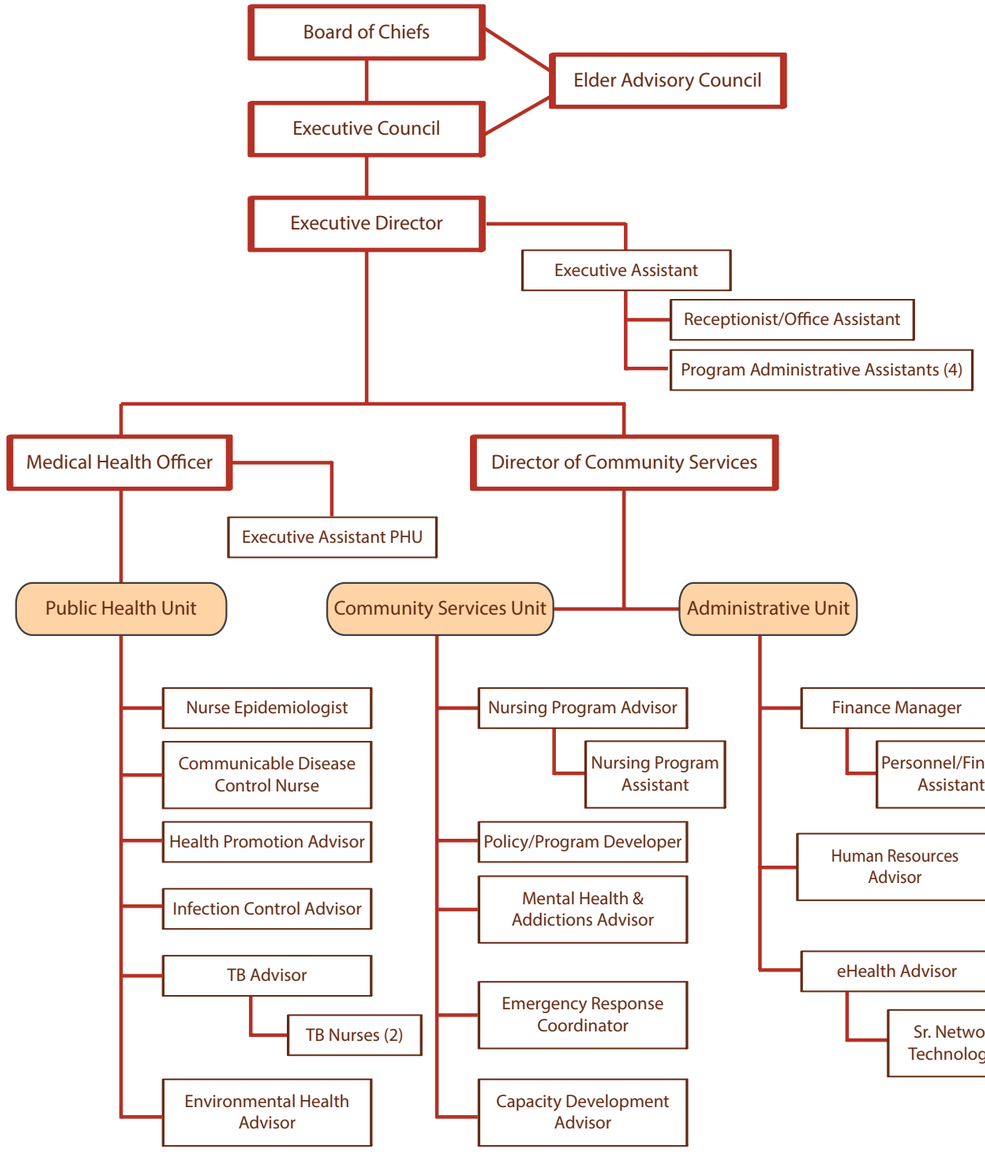
ELDER GERTIE MONTGRAND

ELDER JOHN COOK

Elders play an integral role at the Board of Chiefs and Executive Council Meetings. Four Elders, each representing the Partners is present and engaged at the Board of Chiefs meetings and one elder at Executive Council Meetings. It is through our Elder representation that NITHA remains grounded in its First Nation identity representing our diverse Partnership.

1. The four Partners are unique and make their own decisions.
2. Relationships are principal.
3. Decisions are made based on consensus.
4. Consensus based decisions are informed and supported by the practices of gathering information from various sources, open and timely communication, and supportive learning environments.

ORGANIZATIONAL CHART



CONGRATULATIONS TO OUR 2014 SCHOLARSHIP RECIPIENTS

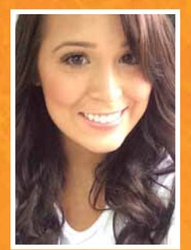
A total of 18 applications were received for the NITHA Scholarship that are awarded to students who are pursuing a health career, 14 of those applicants were successful recipients of the Scholarship. The scholarship receipts will be invited to attend the NITHA Annual General Meeting in the summer of 2015. Congratulations to the recipients and all the best to each of them as they continue to move forward in achieving their goals.

Cara Lynn Bear
LLRIB - La Ronge
Program: BSc Nursing

Sheri-Ann Beatty
PBCN - Deschambeault Lake
Program: BSc Nursing

Tamara Bonoanie
PAGC - Hatchet Lake
Program: BSc Nursing

William A.E. Charles
MLTC - Buffalo River
Program: Practical Nursing



Colleen Daniels
PAGC - Hatchet Lake
Program: BSc Kinesiology

Shay-Anne Daniels
PAGC - Hatchet Lake
Program: Doctor of Medicine

Darcy Diachinsky
MLTC - Buffalo River
Program: BSc Nursing

Mercedes Goulet
PAGC - Cumberland House
Program: BSc Nursing

Kristen Isbister
PAGC - Montreal Lake
Program: BSc Nursing

Janet M. McKenzie
LLRIB - Stanley Mission
Program: BSc Nursing

Kristen McKenzie
LLRIB - La Ronge
Program: BSc Nursing

Cora Mirasty
LLRIB - Little Red River
Program: Doctor of Medicine

Alana Ross
PAGC - Red Earth
Program: BSc Nursing

Brayden Sauve
PAGC - James Smith
Program: Doctor of Medicine

COMMUNITY SERVICES UNIT

Program Overview

The Community Services Unit provides support and knowledge sharing in areas of home care, primary care and community health nursing, capacity development, mental health and addictions, and emergency preparedness. New to the unit this year is the addition of the Federal Tobacco Control Strategy.

The Community Services Unit also provides support to the Partnership through program development, policy and procedure development, capacity building, training and education. The direction for these developments are set by the NITHA Executive Council and reflect the priorities established through the NITHA Board of chiefs. NITHA works with the Partners to build linkages with government and various organizations using a community development approach, based on a set of principles that help to connect the northern people to local opportunities and build and increase capacity.

NITHA's seven pillars serve as a guide for the support and services the unit staff provides the NITHA Partnership. In addition, the NITHA unit staff engages the Partners through coordinated working group meetings with Partner staff, which are held quarterly. These working group meetings are forums for discussing issues affecting the Partner organizations and serve as direction for NITHA unit staff on how to best support and guide them in moving forward.

Grandmother's Bay Staff Retreat, September 2014

Josephine McKay
Director of Community Services

Shianne Mercredi
Program Administrative Assistant

MENTAL HEALTH AND ADDICTIONS ADVISOR

Program Overview

The goal of the Mental Health and Addictions program is to develop models of service delivery encompassing prevention, assessment, education, intervention, treatment, and aftercare within the mental health and addiction services. The mental health and addictions program supports Partner communities who have their own distinctive, home-grown programs and service delivery systems. This support will incorporate models drawn from research literature that are culturally appropriate and create an environment of cultural responsiveness within which healing can occur.

The Mental Health and Addictions Advisor position was vacated in October 2014. However within the 7 months, the Mental Health and Addictions Advisor built relationships with the Partners, clarified roles and responsibilities, reviewed resources and finalized a work plan.

The key areas of third level support in mental health and addictions are:

- Strengthen the capacity of First Nations to deliver culturally appropriate and responsive mental health and addiction services.
- Identify best/wise practices and best fit the Partners community needs;
- Offering educational opportunities and helping access clinical supervision which is responsive to community needs.
- Work with the Partners front line MHA workers and their supervisors/representatives to determine what is needed in their communities.
- Support communities in strengthening processes and improving accountability and outcomes which includes standards, policy and procedure development.

Achievements

Compiled and shared common forms among the Partners to improve policy, procedures and delivery of services in communities. Creating familiarity of the Mental Health Services Act, the Youth Drug Detoxification Stabilization Act, the Canadian Center on Substance Abuse standards and the Canadian Center on Addiction and Mental Health. Provide resource material in regard to current best practices. Researched Diabetes in association with Alcoholism and use of best practices.

NITHA offered the following two, train the trainer programs. The first was Buffalo Riders Early Intervention Training program which was developed and is offered through the National Native Addictions Partnership Foundation (NNAPF). This training enhances and strengthens community-based capacity to provide youth with Early and Brief Interventions and support services to help reduce harmful substance-using behavior. It includes the latest research and culturally specific teachings about youth resiliency, risk and protective factors, and developmental assets-factors which research has identified as critical for young people's successful growth and development.

Michael Woodward
Mental Health & Addictions Advisor

The second training session was by LivingWell Resources called safeTALK. The program prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aide resources. Participants become alert helpers able to provide practical assistance to people at risk of suicide. An alert helper:

- Recognizes when someone might be having thoughts of suicide
- Knows that opportunities to help a person at risk are sometimes missed, dismissed, or avoided
- Wants people with thoughts of suicide to invite them to help
- Engages a person in direct and open talk about suicide
- Know the name and contact information of local suicide intervention resources
- Moves quickly to connect a person at risk with someone who can initiate a suicide intervention

Challenges

One of the major challenges is meeting the common needs given the complexity of the Partners, the organizations, and stakeholders. The level of need for services in the communities can be overwhelming with respect to crisis intervention, making it difficult to develop general mental wellness strategies. An additional challenge continues to be geographic location and the costs associated with providing support services to remote and isolated communities.

Priorities

1. Continue disseminating research in programs and services.
2. Facilitate and support the Partners as they continue to improve their service delivery systems.
3. Establish a process to support continuous quality improvement (CQI).
4. Improve the continuum of mental health and addictions services by drawing linkages between approved stakeholders.
5. Maintain representation on approved committees to advise on issues and program contents that relate to MHA.
6. To coordinate the prevention and intervention efforts across lifespan within human services.
7. To enhance the experience of FN consumers of provincial MHA services.
8. Support Case Management (CM) processes; Examine the opportunities to improve on the effectiveness of CM processes

NURSE PROGRAM ADVISOR

Program Overview

Fay Michayluk
Nurse Program Advisor

The Nursing Program Advisor has played a major role in the activities associated with formalizing a process to deal with the Transfer of Medical Function (TMF), nurse's certification, scope of practice and licensing that is negotiated with and approved by all stakeholders, as described in the five year work plan. In ongoing discussions, meetings and teleconferences with NITHA Nurse Managers and Saskatchewan Registered Nurses Association (SRNA), NITHA has been and will continue to be involved as the SRNA implements the bylaw changes. Ongoing development of the Educational Program and the Prior Learning Assessment Reviews (PLAR) as it relates to the development of the RN with Additional Authorized Practice (AAP) will continue to be a major focus as NITHA works with the Nurse Manager Working Group to ensure northern input into the decisions and developments. The process aims for a seamless transition from the Transfer of Medical Function to the RN with AAP and thus continues to provide safe, accessible and quality nursing care for those living in the north.

NITHA Partner communities are experiencing an increase in the needs for continuing care. The importance of the development of options for long term and special care throughout the NITHA Region has been identified by the NITHA Partners as a major gap in the provision of a continuum of care services. Continuing Care considers care beyond Home Care and looks at meeting the needs of those who can no longer be cared for in their home communities and must seek care and support outside of their home. However, seniors and those with Chronic Conditions who develop increased health issues prefer care that allows them to remain in their home community near family and friends. Many of the required extended care services are not available in the home communities, nor are the services funded by the funding agencies. The NITHA has engaged Horizon Strategic Consultants to assess the current status and the existing and projected needs of NITHA Partner communities for continuing care services including, long term care, personal care, special care homes, palliative care, respite care, and special supports. The project will include six phases: the environmental scan, the needs assessment, a literature review, a recommended plan of action, a feasibility study, and a business plan. The research project is scheduled to be completed in November 2015.

The Orientation Skills Training (OST) sessions were held four times in 2014-15 in June, August, December, and March with a total of 36 participants (newly hired nurses and/or nurses requiring updates). OST consists of two segments of one week skills training followed by a period of onsite preceptor and mentorship with the nurse in their respective communities. The preceptor then recommends further education and training or will meet with Dr. Lanoie for review and possible sign off of Transfer of Medical Function. In order to apply for the PLAR process nurses must have current (within the past two years) Transfer of Medical Function signed off and/or been reviewed by chart audit and skills review.

The preceptor and mentorship of new nurses and nurses requiring updates is arranged by each NITHA Partner. NITHA supports the Partner with the preceptor and mentorship program. NITHA has had Dr. Leo Lanoie on contract for Transfer of Medical Function for many years. Dr. Lanoie continues to provide medical reviews and clinical support for nurses in the field. The teaching materials and procedures are reviewed annually to ensure current practice and updates are incorporated into the teaching modules of the skills training.

Accomplishments

Given the integral importance of nursing to health care in NITHA Partner communities, NITHA is involved at numerous levels on a number internal/external workings groups and committees to ensure current and professional best practices are upheld. These include:

NITHA Working Groups:

- NITHA Nurse Managers – monthly teleconferences, special teleconferences relating to PLAR and AAP are ongoing. Four times a year face to face/video conferencing meetings are held.
- NITHA Home Care Managers – four teleconferences, two face to face/video conferencing meeting are held.
- Collaborative Team Meetings, which includes Primary Care, Community Health and Home Care Nurse Managers held one meeting in 2014 and was well represented. An education session was presented in the afternoon. No further meetings have been scheduled to due the considerable number of other meetings that representatives in this group attend.

Home Care Working Group: work involves planning, policy development, policy review and procedure review at the Regional level and in collaboration with NITHA Partner Organizations. Group meets frequently via teleconference. The group reviews and provides input into the FNIHB work plan.

- FSIN Home Care Working Group (HCWG) meetings held quarterly
- HCWG subcommittee on Palliative Care End of Life Care
- HCWG subcommittee on HIV and Blood Borne Infections
- HCWG subcommittee on chronic disease (hypertension)
- HCWG subcommittee on the development of a new Home Health Aid Manual

FNIHB Regional Community Health Nursing Network Committee: Meets four times a year and provides an opportunity for National updates and program reviews. Involved in review and provide input into the FNIHB work plan this group includes Primary Care and Community Health Nursing Managers.

Pharmacy & Therapeutics Committee: Is an internal working committee that is chaired by the NITHA MHO Dr. Ndubuka. The committee provides support and reviews the Northern Formulary (medications and stock supplies) for northern primary care centers and considers the FNIHB National Formulary. Ensures regulations as they relate to Federal Controlled Drug and Narcotics Act are followed.

Common Table on Continuing Care: SASK MEMORANDUM of UNDERSTANDING ON FIRST NATIONS HEALTH AND WELL BEING as the MOU clearly defines continuing care for First Nations on reserve as a priority item under the MOU. This table provides the opportunity to bring partners together to look for innovative approaches to meet the continuing care needs of First Nations people in the province. Aboriginal and Northern Development Canada (AANDC) will be taking over chairing this committee.

Other Committee involvement:

- Provincial Committee on Lower Extremity Wound Management Pathway Development
- Provincial Screening Committee on Colorectal Cancer
- SRNA Senior Nursing Forum Committee member
- National Home and Community Care Committee

In addition to working group and committee involvement, NITHA also provides an number of professional development opportunities for Health Care staff of our Partner Communities and Saskatchewan Region on behalf of FNIHB. These included:

Community Health Nursing Program Review /Orientation/ Public Health Conference on August 26 - 29, 2014

- Two previously planned workshops for NITHA Partner communities had been planned within six weeks of each other so the decision was made to combine the two into one conference. 21 Community Health Nurses attended.
- The training provided opportunity for new Community Health Nurses as well as a refresher for long term employees.
- The agenda focused on the FNIHB 2013 Community Health Manual which is used to direct the development of the teaching plans. The FNIHB CHN Manual provides the Community Health Nurse with general guidelines, competencies and standards of practice for community health nursing. It is revised and updated every second year.
- In addition, significant reporting was provided by the NITHA Public Health Unit.
- Those attending favored the combining of the two programs and favored the date of late August for the workshop. Supported the session being 4 days and liked the agenda.

Home Care Nursing Program Review / Orientation and Physical Assessment Workshop on August 13 - 15, 2014

- The Physical Assessment portion was funded by FNIHB and hosted by NITHA. 22 Home Care Nurses were in attendance.
- Physical Assessment was presented by Dr. Tony Tung of FNIHB
- The event provided new Home Care Nurses as well as long term employees an opportunity for a refresher to review Policy and Procedures relating to the delivery of Home Care Services in our Communities.

Soap Charting Workshop was offered October 17, 2014

- Funded by FNIHB hosted by NITHA. 14 attended, 7 of which connected via video conferencing
- Dr. Tony Tung facilitated the workshop held at PBCN Board Room
- Excellent review of the documentation program utilized by nursing in the NITHA Partner Communities

End of Life Conference was on March 24 - 25, 2014

- Funded by FNIHB and hosted by NITHA had 35 of possible 55 attended. Unfortunately, 20 registrants had to cancel or just didn't show up.
- Conference held in PA with a full 2 day agenda. Evaluations were very positive and encouraged further workshops with suggestions to include support staff.

Priorities

1. To Continue to offer the Orientation Skills Training, with the intention of supporting all NITHA Partner, to ensure all northern nurses have current Transfer of Medical Function in place and are in a position to apply for the Prior Learning Assessment Review and the RN Additional Authorized Practice certification.
2. Initiate meetings with funding agencies to discuss possible financial support as NITHA Partner Communities continue to support nurses who require additional education to license with AAP.
3. Initiate discussions with NITHA Nurse Managers regarding the reshaping of the Orientation Skills Training; with consideration of the development of an ongoing Skills Lab for skills certification.
4. Continue to work closely with the Partner organizations, the FSIN Home Care Working Group and FNIHB in the development of clear direction for the delivery of Home Care services relating to HIV, Palliative Care and End of Life Care.
5. Meetings, discussions and collaboration with Horizon Strategic Consulting as they proceed with the review of current needs and develop a plan to address the long term and special care needs within NITHA Partner organizations.
6. Facilitate the plans and delivery of two workshops funded by FNIHB, hosted by NITHA. The Home Health Aid Conference planned for fall of 2015. The End of Life Conference planned for January 2016.
7. Work alongside the NITHA Public Health Unit to plan and facilitate a NITHA Nursing Conference for October 2015
8. In collaboration with the NITHA Home Care Working Group, plan a Home Care Nurse Workshop for fall 2015.

COMMUNITY SERVICES UNIT - "EMBRACING CHANGE"

CAPACITY DEVELOPMENT ADVISOR

Program Overview

The function of the Capacity Development Portfolio is to provide opportunities for First Nations People to engage in certified training in health careers utilizing a *learn where you live model* which enables individuals to remain in their communities while they undertake professional training. This not only involves developing support systems, including role models and mentors, for these individuals but it also involves addressing barriers to access. In addition, it requires working collaboratively to develop innovative delivery models that utilize innovative technology, curriculum models, and pedagogies that honour First Nations strengths and are responsive to the needs of Northern and remote First Nations communities' needs. The overall goal is to create a more representative workforce of First Nations Health Care professional who are able to provide culturally competent quality care to enable our clients to feel culturally safe.

Linda Nosbush
Capacity Development Advisor

Priorities

The strategic priorities for 2014-15 were to strengthen the capacity of First Nations to deliver quality health services at the community level as well as strengthen leadership and management functions by working collaboratively with the NITHA Partners, Post-Secondary Institutions, and the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS). The focus this year was on certified programs that lead to national transportable credentials in these priority areas:

- Mental Health and Addictions
- Health Directors/Coordinators/Managers
- Practical Nurses and Nurses
- Dental Therapy
- Cultural Competence

Achievements

There have been a number of exciting achievements in professional training this year that were only realized through the strength of NITHA's internal and external partnerships, and capacity to collaborate. Commitment, persistence, and willingness to work through difficulties together have enabled support of students and assisted them to realize their dreams of becoming certified health care professionals.

The returns on NITHA and her partners in the NLM-HSTS joint investment in training are being realized in increased capacity to retain staff, decisions by those trained in the North to remain living and working in the North which results in a more representative workforce, and a range of benefits to individuals, their families, and their communities. The most recent conservative calculations suggest that for every dollar invested in training there is a $48 net return on that investment.

This past year the joint efforts of NITHA AHHRI Partners and the NLMHSTS have contributed to individuals attaining professional certification. Some programs are provided for **individuals who were already part of their work force**, something frequently referred to as ***upskilling***, were offered this year. This requires students to balance work, home life, and training demands. Upskilling involved two groups of professionals:

Health Directors - 8 NITHA Health Managers received their national designation through the First Nations Health Managers Association (FNHMA). This designation, conferred in Vancouver in September at the FNHMA National Conference, required the completion of five courses (15 credits) and a comprehensive examination. This program was completed over a 22 month period. During 2014-15 students completed their fifth course and wrote their comprehensive examination. This is the first group of Health Managers to attain this designation through the coursework route in Canada.

NITHA Health Directors Achieving FNHMA Designation
From left to right Teena Clarke-Dumais, Marcia Mirasty Ruth Bear, Rose Michel, Kris Keast, Penny Constant, Doris Custer. Missing: , Wilma Roberts
Photo Credit: First Nations Health Managers' Association

A number of career ladders have also been developed that will enable students to pursue a Specialist Certificate at Saskatchewan Polytechnic, a Master's Certificate and a Master's Degree in Organizational Leadership at the University of Regina's Graduate School of Business. Through this work with Post-Secondary Working Group established by NITHA, the FNHMA Certificate was awarded the equivalent of 15 university credits, the first Post-Secondary academic equivalency it has received in Canada.

Mental Health and Addictions Worker Certificate - By the end of June 2015, the 12 students in this program will have completed 41 credits of their 54-credit program (76%). All students were able to PLAR one course and have 8 credits of coursework to complete next year, which will involve four face-to-face meetings. This will be followed by two practicum courses totalling 50 hours of out-of-community placements. All requirements will be completed by September 30, 2016.

This is the first program in Canada that has blended Mental Health and Addictions from a First Nations perspective. Graduates will be accredited nationally through the Canadian Addiction Counsellors Certification Federation (CACCF). Both students and Employers are reporting that learning is being applied in the work place. This type of training is responsive to the needs expressed by NITHA's Executive Council that their front-line staff be able to see individuals when they come to the Health Centre and begin responding to their needs immediately.

Mental Health & Addictions Students with Elders Mike and Rose Daniels and Instructor and Program Head from Saskatchewan Polytechnic Barb Robinson

It is also responsive to the needs expressed by Health Managers, community members and their families, and, Mental Health and Addictions staff. This training also supports the new tiered model for Mental Health and Addictions Services introduced by Saskatchewan Health last spring. This model addresses the whole person, their family, and their community and encourages them to work together to support a client's healing journey.

Some individuals require professional credentials prior to commencing employment. These students study full time and even though they are not yet employed by NITHA, they are members of our communities and require our support. Two professional groups are included in this category of training:

Practical Nurses - June 2015, 4 LPN's will complete their Saskatchewan Polytechnic Diploma Program taken in the Face-to-Face format in Buffalo Narrows through Northlands College. This program requires two years of full-time study since the program was modified by the province in 2006.
The traditional delivery mode for this program has been Face-to-Face - 18 students have been trained in three Face-to-Face cohorts (two in La Ronge - 2009-2011, 2001 - 13 in North graduating 9 and 5 LPNs respectively, and the most recent in Buffalo Narrows with 4 graduates).

The Blended Distance delivery model was developed to respond to two emerging needs: the demand for more LPNs in the North and the need to lessen the disruption to family and community life caused when students moved South for training. To date 10 students have been trained in two cohorts using the Blended Distance Delivery model (the first cohort of 6 involved three PBCN communities in 2007-2009 and the second cohort in 2011-2013 drew from the whole North and graduated 4 LPNs). The Capacity Development Advisor was invited to make a presentation at the Pinning Ceremony in January 2014 for the latter cohort group.

The first 24 graduates are still living and working in the North while the most recent graduates are exploring positions in the North. The LPN Program marked NITHA's first move to work with a Post-Secondary Institutions to develop Blended Distance programming to meet Northern and remote communities' needs and has proven very successful.

Registered Nurses - In May 2015 the first group of 10 RN's to graduate through the College of Nursing, University of Saskatchewan's new Distributed Learning Nursing Degree, which utilizes a *learn where you live* model, will complete their program. Through collaboration with Northlands College, these students have been studying full time in Ile a la Crosse and La Ronge utilizing Remote Presence Technology. The type of Remote Presence Technology they are utilizing in training is now available in Pelican Narrows and Canoe Lake Health Centres. Clients can now access medical and some dental services through this new technology.

Although NITHA AHHRI funds did not contribute to the RN program in a monetary way, NITHA has been involved in supporting the program and has been consulted on its development and evaluation. Not only has this program won a number of awards, including an international award, it is a promising model that enables highly qualified professors to provide high caliber instruction remotely, with the support of on-site nurses as lab instructors. The use of this technology diminishes the distance barrier, renders obsolete the need to find highly qualified nursing instructors in the North, and provides cutting-edge training in technologies that will improve health care and reduce the need to travel outside communities for some services. Reports from their graduation indicate that all 10 plan to live and work in the North.

Other Initiatives

Several other areas received attention this year:

Cultural Competence - For NITHA clients to experience cultural safety in health services, staff ought to be culturally competent. The National Institute of Health provides the following definition:

Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.

COMMUNITY SERVICES UNIT - "EMBRACING CHANGE"

After a literature review, a framework of operation was developed based on the *Stepping Stones Model* of the National Native Addictions Partnership Foundation (NNAPF) Framework which involves seven stepping stones: Cultural Humility, Critical Reflection, Cultural Awareness, Cultural Sensitivity, Cultural Competence, Reciprocity, and Cultural Safety (see graphic to the right). Rather than being linear these stepping stones work in an integrated and nested fashion.

A series of six vignettes have been developed in collaboration with KCDC. They filmed NITHA Elders in their Northern contexts. The first vignette has been translated into both Cree and Dene. To provide further background a number of staff at NITHA took the *Indigenous Cultural Competence* online training through the Provincial Health Services Authority Aboriginal Health Program in British Columbia.

National Native Addictions Partnership Foundation (NNAPF). 1-12. Renewal Stepping Stones to Cultural Safety.

The next step will be to develop a series of power points and a guide. The goal of the series will be to nurture *grand conversations*, built on the *Stepping Stones Model*, to stimulate learning and growth in cultural competence which, in turn, will enhance cultural safety for all those who access health services in the NITHA Partnership.

Dental Therapy - Both the Board of Chiefs and NITHA Executive Council requested that this training gap be addressed. NITHA's Executive Director formed a Working Group to draw together stakeholders to formulate a plan and a proposal. The following resulted:

A **comprehensive literature review** was conducted revealing the Canadian statistics, including those unique to the Aboriginal population; demonstrating need; and highlighting international responses to the need for mid-level Oral Health Providers in their countries. A Canadian Academy of Health Sciences Oral Health Panel report (2014) that highlighted the five A's of challenge facing vulnerable groups as they try to utilize oral health care services is described more fully in the table below. Not only are these challenges significant individually, they also interact with one another to create even more complex issues.

Challenges Facing Vulnerable Groups Trying to Utilize Oral Health Care Services	
Affordability	Do the provider's charges relate to the client's ability to pay for services?
Availability	Does the provider have the requisite resources, such as personnel and technology, to meet the needs of the client?
Accessibility	How easily can the client physically reach the provider's location?
Accommodation	Is the provider's operation organized in ways that meet the constraints and needs of the client?
Acceptability	Is the client comfortable with the characteristics of the provider and vice versa? (p. 2).

A **Proposal and a Business Plan** were presented to the Minister of Advanced Education in December 2014. It provided the data for Saskatchewan, particularly Northern Saskatchewan, revealing that there are only 3 dentists in Meadow Lake, 1 part-time in La Ronge, 14 in North Battleford and 27 in Prince Albert to serve more than half the geographic area of the province of Saskatchewan. Overall, the literature and statistics revealed that vulnerable populations have been disproportionately affected by both the burden and incidence of oral health issues. The alarming rates of Early Childhood Caries in Saskatchewan have resulted in oral surgeries requiring anesthetic for very young children. These statistics are not only problematic and alarming (1,950 children between one and five years of age each year) but also costly (over $4 million per year).

Invitations to become part of the Saskatchewan Oral Health Coalition and the Northern Oral Health Working Group have enabled a more comprehensive understanding of the practical and policy issues in Oral Health and will assist in creating solutions that are more responsive to the needs in the North.
NITHA is also exploring **brokering possibilities** with Post-Secondary Institutions including the university who trains midlevel oral health providers for the Alaska Program.

Bridging Research - Many Northern students have a strong desire to enter the Health Sector Work Force. However, many students lack the prerequisite skills. In the past, our notions of program development were permeated by all or nothing models; that is, students would be required to take all the courses in the program, or not take it at all. Today, we realize that students bring with them a range of capabilities and require only the missing pieces in their bridging/transition programs. In fact, programs in the 21st century might do a disservice to all students by requiring all components; what was intended as a bridge would then become another hurdle or stumbling block for students and would unnecessarily elongate their Post-Secondary experience and, in the long run, could well discourage a number of students from pursuing a specific career ladder and ongoing professional education.

To more fully understand the issue and to mine the literature for wisdom and guidance, a Master of Public Health Student from the University of Saskatchewan worked with the Capacity Development Advisor from May - August 2014 to begin this exploration. While the review identified programs that can assist in bridging the gap between high school and post-secondary training, it was also revealed that non-cognitive skills and their powerful "predictive power that rivals that of cognitive skills" for Post-Secondary and Work Place success (Heckman, Kautz, Diris, Weel, & Borghans, 2014, p. 3) are essential and warrant serious consideration in Bridging Programs. They are "universally valued across all cultures, religions, and societies (p. 10) and are defined as:

> The personal attributes not thought to be measured by IQ tests or achievement tests. These attributes go by many names in the literature, including soft skills, personality traits, non-cognitive and socio-emotional skills. …. Both cognitive and non-cognitive skills can change and be changed over the life cycle, but through different mechanisms and with different ease at different ages (p. 14).

They include openness to experience, conscientiousness, assertive and self-confident as well as energetic, agreeableness, and emotional stability.

Collaboration

The work for this portfolio depends on internal and external collaborative relationships and working groups. The Capacity Development Advisor is grateful for **internal** willingness to collaborate and for the support she has received from NITHA and the Partners.

Externally, she has been consulted and invited to be part of committees (Advisory Committee on Addictions), has become part of provincial and regional coalitions and working groups in Oral Health, and has become colleagues with all the Program Heads for the programs that NITHA students are taking. The external partners' wisdom and willingness to work in a collaborative manner is greatly valued.

Through the external Evaluation of all AHHRI Program over the past years, the Capacity Development Advisor was able to work closely with Laurence Thompson. Through the cultural competency work she was able to work with Marty Ballentyne at KCDC. Through the latter, she was given the opportunity to explore how complex concepts can be communicated using multimedia techniques. The Capacity Development Advisor was also able to orchestrate a meeting between Donavan Mutschler at FNIHB and Marion Crowe at FNHMA to discuss NITHA programs and possibilities for the future. The Capacity Development Advisor is grateful for all her colleagues' contributions and their willingness to work together to discern solutions to complex issues; it has been a privilege to work with all these colleagues.

In many ways, the **NLMHSTS** functions as an ***incubator*** of ideas and processes that nurture collaborative and responsive fiscal management, program development and implementation, and program evaluation. It nurtures consensus building and democracy that is *of* the people, *by* the people, and *for* the people of the North. Rather than focussing on what was lacking in the North, this group focused on its strengths and how it might **harness these strengths** to respond to the Health Human Resource needs in Northern and remote communities. They explored ways that technology could bring us closer together all the while acknowledging the importance of relationship in North endeavours. As a result, a Blended Distance model with different variants for each type of Health Sector Training Program was developed. Throughout the process collective achievements were celebrated, and future areas for growth were identified by dialoguing with all NITHA's partners, participants, employers, as well as past and present students. In this way, it was an ongoing learning process and the programs were refined as they proceeded.

Elders have been powerful sources of wisdom, knowledge, and support in both the training and working group meetings. Ceremonies and Prayer are part of all training sessions. Elders have modelled good listening behaviour and, how to encourage living and respecting others 'in a good way.' They have guided students to be all the Creator intended them to be personally and professionally. Elder Mike Daniels notes that "the inner child needs to be blessed" so that individuals can understand and respect who they are as human beings. He cautions students to let go of grudges and learn how to forgive. He reminds them to look *within* and not *outside* to learn about self and the world. NITHA is also privileged to have Elder Rose, a 'grandmother,' be with the training groups and share her wisdom.

Elders open each day of training in thanksgiving and invite the Creator into the day to guide the actions and learning of the group; at the close of each day they offer thanksgiving and ask for the wisdom gained to guide practice in students' communities. Elders are an integral part of NITHA training, and guide students as they apply their learning in culturally appropriate ways that promote the well-being of the whole person and healing in communities.

The Capacity Development Advisor on behalf of students and instructors expresses deepest gratitude and appreciation for these powerful relationships.

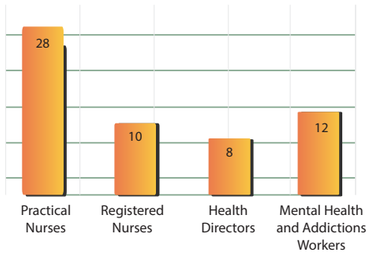
AHHRI

There has been a longstanding **shortage of Aboriginal Health Care Professionals** in NITHA communities which resulted in increasing recruitment and retention efforts that resulted in recruiting professionals from outside NITHA communities. The need for more Aboriginal Health Care Providers has been identified as far back as 1996, when the *Royal Commission on Aboriginal Peoples* recommended that government and educational institutions train 10,000 First Nations, Inuit, and Métis health and social services workers by 2006.

As a result, in 2005 the Federal Government introduced the **Aboriginal Health Human Resources Initiative (AHHRI)** to ensure that First Nations, Inuit, and Métis people have access to the Health Care Providers that they need now, and in the future. AHHRI was developed in two five-year cycles: 2005-2010 and 2010-2015. This part of the report will summarize the work accomplished in the last five years with particular emphasis on the 2014-15 year. Overall, AHHRI had **three goals:**

Increase the number of Aboriginal people working in health careers - In 2008 the Health Human Resource Study indicated that the Northern Work Force was 62% Aboriginal; in 2012 another cycle of this study revealed that the representativeness had

Certified Professionals Trained



grown to 73% and was representative in all professions except those requiring a degree or more of preparation. With 58 professionals now certified as a result of the NLMHSTS and AHHRI work (28 LPN's, 12 Mental Health and Addictions Workers [by the fall of 2016], 8 Health Directors, and 10 RN's), significant progress has been made across a number of health professions. To date all those who have graduated from these programs have remained living and working in the North.

Retain health care workers in Aboriginal communities - To date all those who have graduated from these programs have remained living and working in the North. The 2012 Health Human Resource Study indicated that the retention rates in First Nations communities had increased slightly. With over 1,414 positions in the Health Sector across the North in First Nations and Regional Health Authorities and an estimate of 293 new hires per year required each year, there is great demand for Health Professionals in the North. Through the NLMHSTS, there has been encouragement to engage in **Opportunity Training** - what Premier Wall terms matching the focus of training to the demand in the Labour Force. This has been possible through the collaborative efforts of all involved in the NLMHSTS and the utilization of an accurate data base provided by the Health Human Resource Studies (2008, 2012).

Change educational curricula to yield health care providers that are culturally competent in providing health care services to Aboriginal people - New programs (for Mental Health and Addictions, Health Directors, and hopefully soon Dental Therapists) have been developed based on DACUMs conducted by NITHA; new delivery systems have been devised, including a variety of blended distance models that continue to evolve; innovative uses of technology have been incorporated in both training and the workplace (remote presence technology); and, an overall willingness of Post-Secondary Institutions to include of Aboriginal perspectives, and to develop of pedagogies that capitalize of First Nations strengths, have moved the North forward. The development of Career Ladders for Health Directors, Mental Health and Addictions Workers, LPNs who want to become RNs, have also created opportunities for students and knit Saskatchewan's Post-Secondary Institutions and Employers in the North into a powerful group that is changing the future of Northern Saskatchewan.

Priorities

1. **Mental Health and Addictions** - Complete *Mental Health and Addictions Certificate Worker Program* and explore how basic addictions and mental health competencies can be addressed through Community-Based Worker Training;
2. **Dental Therapy** - Pursue an infrastructure and working relationships that will enable training of Dental Therapists;
3. **Cultural Competence** - Develop training materials that can be used for new and existing employees in the Partnership;
4. **Health Human Resources Study** - for NITHA Partners only;
5. **Management and Leadership Skills Training** - Explore what is available;
6. **Community-Based Worker Training** - Identification of Core Skills for basic levels of training; explore specializations for more advanced training; explore different types of certification available; and,
7. **Clerical** - Explore what is available and what is needed on the front line (taking minutes, preparation and packaging information) and utilize technology for delivery of these modules

While the challenges of geography; staff changes; completion of the AHHRI funding, which effectively removes Federal Government support; communication within and across jurisdictions and institutions; and the need for urgency are present, the willingness of partners to collaborate, share and blend resources to create innovative programs and approaches, continue to fuel this work. As NITHA explores new funding possibilities and new program opportunities in order to create an educated First Nations Work Force in the North that is responsive to individuals' and communities' needs, we remain committed to working collaboratively in ways that unleash the power and creativity in the North.

EMERGENCY RESPONSE COORDINATOR

Program Overview

The Emergency Response Coordinator (ERC) works with the Partnership to assist, support and advise on emergency response and preparedness. The position assists the Partners to increase emergency preparedness through community emergency response planning, pandemic planning (in liaison with the NITHA Public Health Unit), public access to defibrillation, First Aid/CPR training, and First Responder capacity development.

Achievements

NITHA's Emergency Response Working Group continues to meet regularly with four scheduled face-face meetings per year with the opportunity for remote meetings when necessary. Working Group communication has significantly increased and critical Partner feedback is becoming more efficient. Second level Emergency Response Coordinators are necessary for the safety of our population but are not funded by FNIHB. Consequently, NITHA provides $75,000 annually per partner to enable them to hire a full-time ERC at the second level. Progress within this portfolio is dependent upon this second level role.

NITHA continues to support First Responder Initiatives as follows:

- Stakeholder coordination;
- Advice and support regarding operational policies and procedures;
- Coordination with the long term goal to bring First Responder training "in house,"
- The NITHA ERC has already been trained to the Specialised Advanced Instructor Trainer level in anticipation of the long-term goal of bringing the "Train the Trainer' level of instruction "in house"

The process to bring First Responder training "in house" is a long journey in capacity building but will bring good returns on investment. The following outlines the current process and progress on "in house" Instructor training.

1. Approximately 350 First Aid and CPR/AED providers throughout the Partnership have been trained by these "in house" instructors since May 2013. The Partnership has seen a two-thirds reduction in cost of training by bringing this training "in house."
2. Once these instructors gain a minimum two years of experience as Instructors, they are eligible to upgrade to First Responder Level Instructors. One instructor has met the prerequisites and is currently eligible to increase his instructor capacity to First Responder.

Patrick Hassler
Emergency Response Coordinator

COMMUNITY SERVICES UNIT - "EMBRACING CHANGE"

The importance of First Responders and their impacts on a community cannot be understated and NITHA will continue to support and advise communities in the implementation and sustainability of First Responder groups because the goal at NITHA is to increase the number and utilization of First Responders.

Evacuations are an inevitable fact of living in flood and fire zones. NITHA continues to work with stakeholders and responsible parties within this area of response. Furthermore, involvement in these partnerships has resulted in the NITHA ERC and the NITHA MHO having access to critical time sensitive information involving provincial risks and mitigating actions in a prompt and efficient manner, which, in turn has led to more integrated, timely, and appropriate responses.

Community Risk Assessments are ongoing. The process NITHA has been using has generated positive feedback and is continuing to make steady progress. NITHA provided $20,000 in one time funding to initiate community risk assessments and to orientate the second level ERC`s to the process. Partnering with the Office of the Fire Commissioner and FNIHB has provided valuable perspective and underscored both the relevance and importance of this process. Currently, we have completed 11 NITHA Partner communities and will support second level ERC`s to continue community risk assessments.

The NITHA ERC works with the Nurse Program Advisor and third party contractors to enhance the **Orientation Skills Training** (OST) for nurses in the context of pre-hospital and acute emergencies areas. Discussions on advanced vascular access, advanced airway management, emergency resource management, and orientation to the emergency response in the North enhance the OST program. The NITHA ERC also advises Partners on training options and assists in the coordination of external programs such as Pediatric Advanced Life Support®, Advanced Cardiac Life Support®, International Trauma Life Support® and Geriatric Emergency Management®.

The NITHA ERC also works with the Nursing Program Advisor to ensure that prehospital treatment and transport changes or advancements are articulated to the Partners. Information surrounding changes and new information regarding prehospital spinal immobilisation, life threatening arrhythmias in children and ALTE (apparent life threatening event) we provided to the Partners through the Nurse Managers Working Group. NITHA Ebola Contingency Group began holding regular teleconferences in January. The NITHA ERC`s involvement in this group ensures that the NITHA Partners unique challenges of remoteness and internal capacity are considered when addressing the emergency response needs of Ebola preparedness. The NITHA ERC and FNIHB are currently drafting a health annex to the First Nations Emergency Planning manual (that was released by AANDC at the First Nations Emergency Management Forum) that will include a level 4 pathogen contingency to ensure that best practice and guidelines from Ebola preparedness are not lost when the momentum of the acute outbreak is diminished.

Challenges

NITHA communities` Emergency Response Plans and Emergency Preparedness have been supported with an Annual Review Policy and Procedure, as well as with ongoing Community Risk Assessments. An annual review of Emergency Response Plans is an industry standard that will be more achievable using the Annual Policy and Procedure for assistance. The Policy and Procedures also assist in safe storage of updated plans by providing for storage options through NITHA. However, this process has remained sluggish and requires cooperation and manpower at the community level. Critical to the success and implementation of this process is the dedicated manpower at the second and community levels; NITHA continues to advocate for funding for these positions.

Training challenges have been identified within the Partnership. Travel and lodging costs continue to grow making training more costly and requiring exploration of other options. Currently, with the changing agreements between AANDC and the Province of Saskatchewan training through Provincial Government Relations is becoming not only more accessible but opportunities to host training are also emerging. Critical training in remote areas is more focused on Health Care Professionals such as Pediatric Advanced Life Support, Advanced Cardiac Life Support and International Trauma Life Support; they are all being evaluated to discern more efficient and higher quality delivery options for the future.

Dedicated full-time positions in the area of Emergency Response and Preparedness, remains the most significant challenge. Second level and community positions are needed to conduct Risk Assessments, update emergency response plans, build contingency plans, as well as to prepare communities for unique contingencies such as evacuations. Without these positions progress will be hampered.

Priorities

NITHA ERC will continue to support the Partners, through their respective ERCs, in ensuring community response plans are taking an "All Hazard" approach. The "All Hazards" approach is a sound, evidence-based approach to emergency planning. This approach considers many plans are rarely accessed and are, therefore, not familiar to the community. Adopting an "All Hazards" approach will ensure that the document is accessed for all community contingencies not just for pandemics or major community disasters. As a result, the emergency response plan will not only become more familiar but also used with greater ease by community members. Currently, as part of conducting community risk assessments we are involving community members and stakeholders to identify the unique risks to their communities, prioritize these risks, and then build contingency plans to mitigate these risks. The Partner ERC`s will be able to continue conducting these assessments with NITHA advice and process support now that they have gone through the process a few times.

While many organizations are mobilized during a large emergency, such as an evacuation, the NITHA ERC will continue to engage these organizations and ensure that the Partner community voices and concerns are heard and addressed. Northern communities are very unique and require a tailored approach during emergency events that differs in many ways from First Nations communities in the South. The NITHA ERC will ensure that the "North" is not made to fit in the "Southern" box in regards to emergency response but rather holds a place uniquely its own.

COMMUNITY SERVICES UNIT - "EMBRACING CHANGE"

First Responder groups are an extremely important part of the community response and pre-hospital treatment on reserve. The NITHA Partnership in many cases finds themselves many hours from definitive care and pre-hospital emergency medical services. **Functioning First Responder groups can help shorten this window in getting basic life support care to their community much faster than outside agencies.** They also enhance the emergency medical system by being local "experts" in language, terrain, resources and access to the sick or injured. First Responders become important resources in times of community disasters and pandemics. Because they are able to continue their education, the can more effectively assist in injury prevention awareness and community emergencies. For these reasons the NITHA ERC will support and assist communities as they build sustainable First Responder initiatives through initiatives that bring the training "in house" as well as by engaging stake holders and Regional Health Authorities.

NITHA continues to support the Partners in Pandemic and Communicable Disease Contingency Planning by updating the NITHA Communicable Disease Plan and the *NITHA Communicable Disease Planning Manual* every two years. The most current versions are now available on the NITHA website (nitha.com). To further support the Partners the NITHA MHO and ERC are working to develop a standard of stocking Pandemic related supplies using a Per Capita schematic. This would address overstock and expiring equipment challenges faced throughout the Partnership.

The NITHA ERC will be partnering with Injury Prevention stakeholders within the Partnership and externally to support the Partners in their Injury Prevention initiatives. The ERC is currently familiarizing himself with stakeholders and reviewing past initiatives to build a solid understanding upon which future initiatives can emerge. In the future, second level personnel will receive more support in violence, abuse, and injury prevention.

PUBLIC HEALTH UNIT

Program Overview

The 2014-2015 Annual Report from the NITHA public health unit (PHU) provides an overview of program activities during the year. The report captures highlights of yet another successful year at NITHA. It also highlights some of the accomplishments of dedicated staff of the PHU who share their wealth of knowledge and skills with the NITHA partnership.

The PHU provides technical advice and expertise to the NITHA partnership in various program areas including community health assessment, communicable disease surveillance, health protection, disease and injury prevention, and health promotion.

During the 2014-2015 fiscal year, the PHU staff worked diligently on their individual work plans to accomplish the unit's mandate of improving the health and wellbeing of NITHA population through a NITHA-wide public health strategy. Activities of the PHU program leads are accomplished through a number of working groups within the partnership. These include Public Health Working Group, HIV working group, Infection Prevention and Control working group, Population Health Promotion working group, and Pharmacy and Therapeutics Committee. Throughout the year under review, PHU program leads successfully hosted quarterly meetings of these working groups to discuss pertinent public health issues.

As part of strategies to broker jurisdictional barriers, we have strengthened relationship with other northern partners under the auspices of Northern Healthy Community Partnership (NHCP). Through the NHCP, we have been able to work together across sectors to promote health and well-being of NITHA community members.

According to the data seen in this report, sexually transmitted infections (particularly gonorrhea and chlamydia), HIV, Hepatitis C, tuberculosis, MRSA, and animal bites, continue to pose major challenges for the NITHA partnership. Currently, it is difficult to ascertain testing rates for HIV in NITHA communities. As a result, it is challenging to determine the true picture of the epidemic within partner communities. During the

Nnamdi Ndubuka
Medical Health Officer

Linda Rogozinski
Executive Assistant

Deanna Brown
Program Administrative Assistant

year under review, the PHU continued to prioritize communicable disease program and provided evidence-based resources and current best practices to partners. In the coming year, the unit will continue to make concerted efforts to address these public health issues in collaboration with partner communities and as part of a provincial wide approach.

Achievements, challenges, and priorities of various program leads within the PHU are discussed in the next section.

Priorities

1. Improvement of immunization rates within partner communities and development of immunization standard as part of provincial wide public health strategy
2. Continuing implementation of the TB High Incidence Strategy
3. Enhancement of communicable and non-communicable disease surveillance
4. Continue to strengthen internal and external communication strategies

PUBLIC HEALTH NURSE ADVISOR

Program Overview

The NITHA Public Health Nurse (PHN) position was newly created during the 2014-15 fiscal year. The previous Nurse Epidemiologist position was restructured to include PHN and Epidemiologist positions. Both positions were filled in January 2015.

PHN provides overall immunization coordination for the Partnership and provides ongoing education to nurses and other members of the health team working in the area of immunization. PHN is responsible for developing; recommending; and providing expert leadership, consultation and clinical assistance to the NITHA Partnership in implementing public health nursing policies and programs that are evidence based, meet provincial/national standards and reflect the mission, vision, and values of NITHA.

In consultation with our 2nd level service providers, NITHA PHN focused on the following areas; immunization, health prevention, health education and health promotion. Other areas of responsibility include vaccine management and immunization consultation.

Successes

Innoculist Exams

During the year under review, NITHA PHN received, assessed and marked 107 Immunization Certification exams scripts from nurses within the Partnership. We aimed to provide a written review and feedback to nurses within 10 business days. NITHA and FNIHB have contributed to the ongoing updates and revisions to the initial and recertification exams.

Immunization

Overall, the Childhood Immunization rates improved this year compared to the previous year;

	2013	2014
1 year old population	86%	89%
2 year old population	82.20%	83.10%
7 year old population	92%	93%

Table 1: Average Immunization Coverage

**Please refer to Epidemiologist report for specific Immunization Statistics.

Carrie Gardipy
Public Health Nurse Advisor

PUBLIC HEALTH UNIT - "EMBRACING CHANGE"

Within the 2014 Childhood Immunization Coverage report, there is a wide variation in Immunization rates amongst the NITHA Communities. It was recognized that many NITHA Communities have obtained over 90% overall Immunization coverage. NITHA would like to acknowledge these accomplishments at the next Annual General Meeting.

Contrariwise, some NITHA communities have shown a consistently lower level of Immunization rates. In collaboration with 2nd level partners, NITHA will work with those communities to enhance Immunization uptake.

Saskatchewan Health launched the Panorama System in Feb 2015. There are presently 12 Communities within NITHA utilizing the Panorama system as of March 31/2015. Overall, the majority of the NITHA Communities on the Panorama system have reported good overall satisfaction in the initial usage of the Inventory and Immunization modules. NITHA's role in Panorama includes trusteeship, training coordination, communications and support. NITHA provided initial Panorama Training for all CHN's utilizing the Panorama system.

NITHA/FNIHB provided refresher training in January 2015 for all CHN's utilizing SIMS before the deployment of Panorama system in Saskatchewan. The Immunization Management System /Panorama was deployed on Feb 2, 2015.

The PHN participated in various provincial Panorama working groups.

Vaccine Regulation and distribution to all Partners

During the year under review, all existing biological refrigerators in NITHA communities were inspected and 5 new ones were purchased. A total of 3,495 doses were wasted (majority due to vaccine expiry) and an additional 479 doses were wasted due to cold chain breaks. This is in contrast to 817 doses wasted last year due to cold chain. The significant reduction of vaccine wastage due to cold chain could be attributed to that fact that majority of NITHA communities are now able to store vaccines with chest style refrigerators that maintain temperatures between 2 and 8 degree Celsius for up to four days. NITHA will continue to work towards minimizing cost related to cold chain breaks.

Student Practicum Placement

This year, NITHA successfully hosted practicum students from School of Public Health, University of Saskatchewan; College of Nursing, University of Saskatchewan; and Public Health Agency of Canada. MPH student placement project focussed on an Immunization Program Evaluation. This was initiated within a NITHA Community that had lower Immunization coverage rates. The goals were to monitor and improve the Immunization program. The evaluation plan follows the professional evaluation framework. Consultation with the Community will continue in the next fiscal year.

NITHA representation with stakeholders on the various Committees; NITHA PHU, Saskatchewan Immunization Coordinators, Saskatchewan Public Health Nurse Managers/ RHA's, FNIHB & NITHA Nurse Managers, Saskatchewan Panorama.

Each PHN Manager within the NITHA Partnership decided to implement the Saskatchewan Child Health Clinic Guidelines. Within the next fiscal year, NITHA will assist each partner in the roll out of these guidelines.

Upcoming Events:

- NITHA Nursing Conference – October 2015
- Child Health Clinic Guidelines Training- To be provided at each 2nd level and at the annual NITHA Nursing Conference in October 2015.
- Panorama Training for newly employed CHNs

EPIDEMIOLOGIST

Program Overview

The Epidemiologist position is new this year to NITHA. Epidemiology is the science that studies the patterns, causes, and effects of health and disease conditions in defined populations. The Epidemiologist provides data to inform policy decision makers and ensure evidence-based practices are implemented. Epidemiologists can help with study design, collection, statistical analysis and interpretation of data. An example might be the data tools used to help pinpoint the food that caused a food borne illness outbreak where several people and several food items were involved.

The NITHA Epidemiologist position provides overall health coordination including tracking of immunizations, communicable diseases and non-communicable disease rates.

Successes

The position was filled in January of 2015. In that brief time the Epidemiologist has created important relationships with The Ministry of Health (MOH) and the First Nations Inuit Health Branch (FNIHB). The Epidemiologist needed to start by finding and cleaning all of the data that NITHA currently had and obtaining any other data from partner agencies that held it.

Demographic

The epidemiologist started with receiving the population distribution in NITHA by age groups from 2004 to 2013 from the First Nations Inuit Health Branch. The data was used to create population distributions by gender and by age group. This data was then separated into individual community databases. It is now available all together as amalgamated data or by community.

Next was to obtain communicable disease and sexually transmitted infection data from the Provincial data collection system called iPHIS and add that to the databases. The data that had been collected at NITHA over time was then included.

The charts and data below are some examples of the level of reporting that is now available to NITHA and the partner agencies and communities. Regular, timely reporting to partners or communities are currently being determined and implemented.

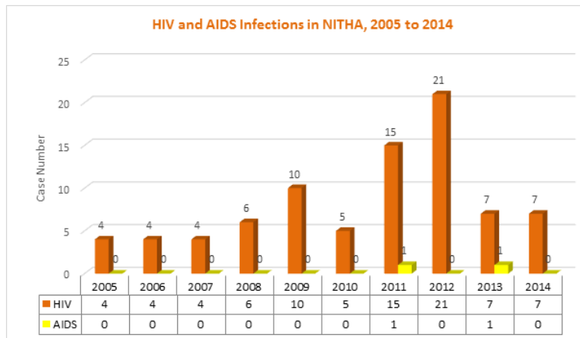
HIV and AIDS

The Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV severely weakens the immune system, leaving people vulnerable to many different types of infections and diseases. HIV is transmitted through: unprotected sexual intercourse; needle-sharing; and pregnancy, delivery and breastfeeding.

The risk factors for acquiring HIV are both Socio – economic behavioral factors such as poverty, substance use, including injection drug use, sexually transmitted diseases, and limited access to health services.

Between 2005 and 2014, 87 patients were diagnosed with HIV/AIDS. The following list is some analysis on the data.

- The numbers of newly identified HIV cases has decreased notably since 2012.
- There was a sharp drop in both male and female HIV numbers in 2013 and 2014.
- The incident rate of HIV in NITHA is more than that in Saskatchewan and Canada.
- Majority of HIV cases were in the 30-39 year age group.
- Injecting drug use is the highest self-reported risk factor for acquiring HIV.
- Most patients with HIV are also infected with hepatitis C.
- No babies were born infected with HIV since 2005.
- The majority of people diagnosed with HIV in the past decade are still alive.



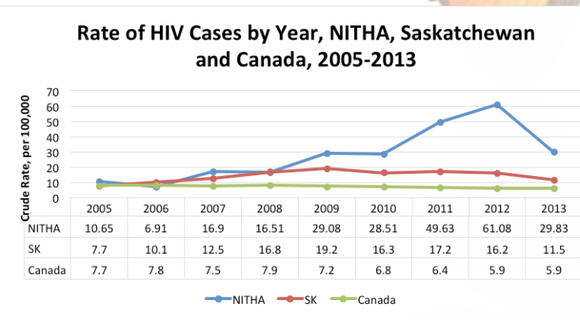
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
HIV	4	4	4	6	10	5	15	21	7	7
AIDS	0	0	0	0	0	0	1	0	1	0

Figure 1. Reported Cases of HIV/AIDS in NITHA, by Year, 2005-2014

Seven new HIV cases were reported in 2014, the same number as in 2013. From 2004 to present, NITHA has a total number of 84 cases. Two developed AIDS since 2004 and none in 2014. There are cases from NITHA communities, who were diagnosed and reported in another health region because they had lived there for six months or more.

It is unknown at this time why the HIV rates dropped in 2013. One suggestion is around reduced testing rates. Even when the rate dropped, it was still 4 times higher than the national rate and 3 times higher than the provincial rate.

Risk exposure behaviour is collected at the time of patient testing. Injection drug use is the most commonly self-reported risk exposure (46%).



	2005	2006	2007	2008	2009	2010	2011	2012	2013
NITHA	10.65	6.91	16.9	16.51	29.08	28.51	49.63	61.08	29.83
SK	7.7	10.1	12.5	16.8	19.2	16.3	17.2	16.2	11.5
Canada	7.7	7.8	7.5	7.9	7.2	6.8	6.4	5.9	5.9

Figure 2. Rates of HIV Cases by Year, NITHA, Saskatchewan and Canada, 2005 - 2013

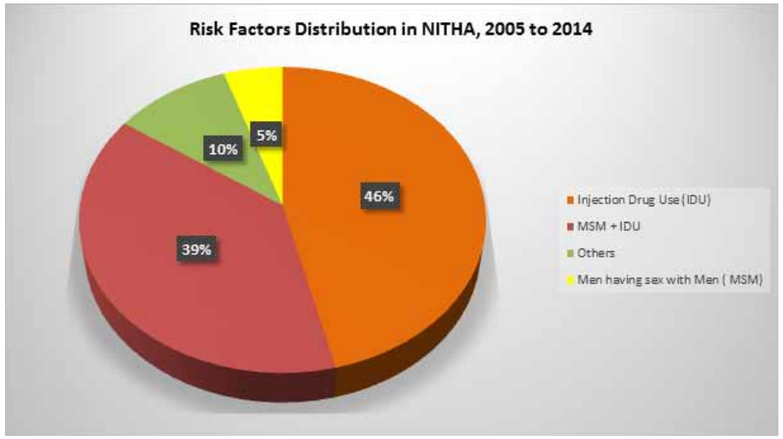


Figure 3. Percentage of distribution of HIV Patients by Risk Factors, NITHA, 2005-2014

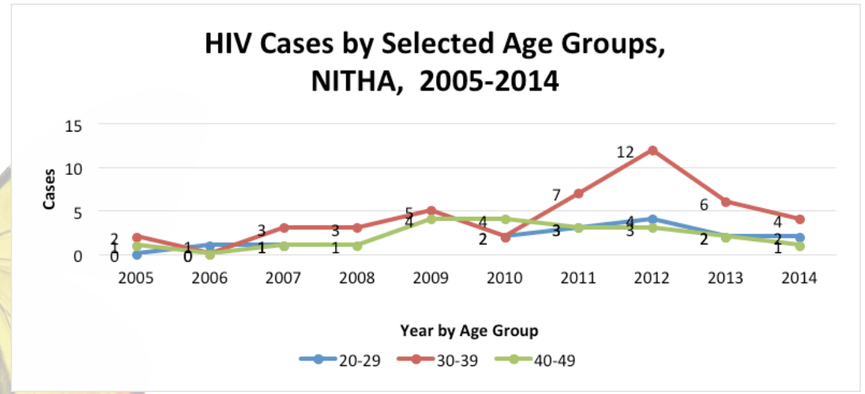


Figure 4. HIV Cases by Selected Age Group, NITHA, 2005-2014

Sexually Transmitted Infections (STI)

Sexual transmitted infections, specifically Chlamydia and Gonorrhea infections are considerably high in NITHA communities. Young female First Nations are at highest risk. Controlling and reducing the infections is a priority in NITHA partnership.

In 2014, there were 1, 152 cases of STI's , that is approximately 3 new cases per day. Reducing the incident rate of STI's in NITHA communities is a challenge and priority. For 2014, the number of chlamydia reported was 838, which is 8 percent (73 cases) lesser than the previous year. Cases of gonorrhea increased by 14 percent (41 cases) compared to the 2013. The 2014 registry for gonorrhea was the highest since 2009 (see figure 5).

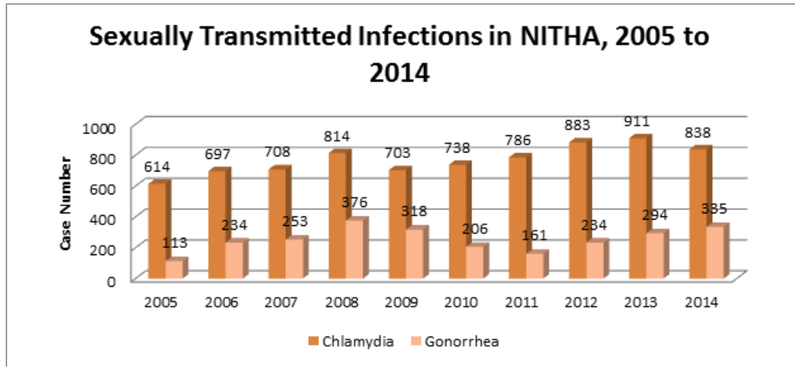


Figure 5. Reported Cases of Chlamydia and Gonorrhea in NITHA by Year, 2005 - 2014

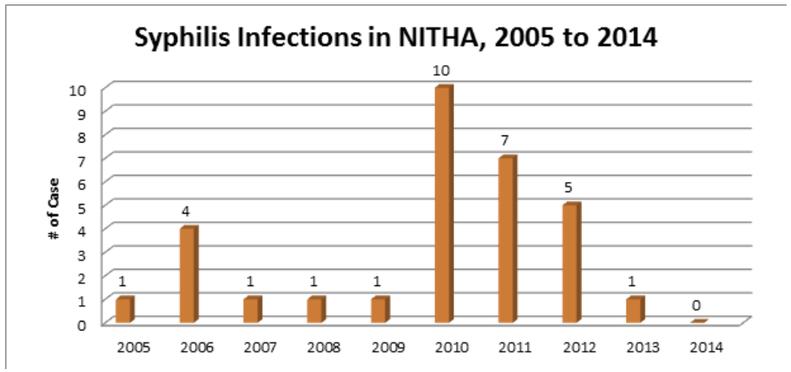


Figure 6. Reported Cases of Syphilis in NITHA by Year, 2005 - 2014

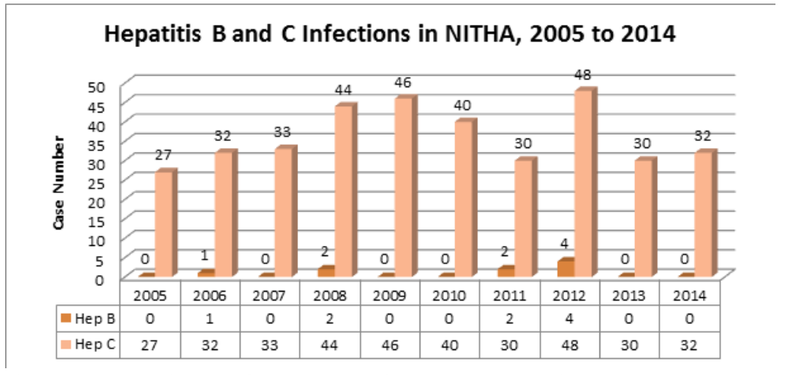


Figure 7. Reported Cases of Hepatitis B and Hepatitis C, NITHA by Year, 2005 - 2014

Community Acquired Methicillin Resistant Staphylococcus aureus (CMRSA)

Since 2009, MRSA cases reported every year were below the 400 mark. This year, a 12% increase from 2013 was observed, bringing to a new 5-year high of 422 cases. Only new cases are included in this report.

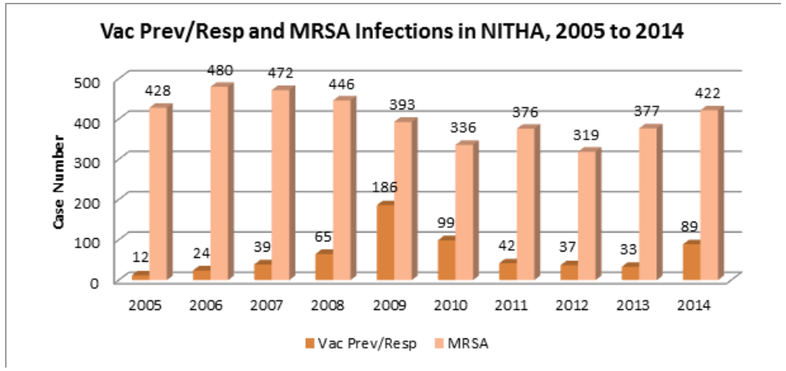


Figure 8. Reported Cases of Methicillin-resistant *Staphylococcus* aureus in NITHA by Year, 2005 - 2014

Childhood Immunization Rates

Immunization has proven to be one of the best prevention methods in Public Health. It is very important that children start their immunizations as soon as possible and to stay on schedules as this provides them with the earliest and best protection against serious communicable diseases.

During the year under review, the immunization rate for 1 year old children in NITHA ranged from 73.33% to 100% while rates for 2 year olds ranged from 42.06% to 100%. The immunization rates for 7 year olds ranged from 29.17% to 100% in 2014.

Immunization rates have been improving, however, work still needs to be done in those communities with low immunization rates to bring them up to protective levels so children are not at risk of preventable diseases. The national goal for immunization rates in order to achieve herd immunity is 95-97 percent.

The following graphs provide the average immunization rates for specific vaccines for one year old, two years old and seven years old children in the NITHA Partnership. Consistent with previous reports, the fewer doses in a series of vaccine has the highest coverage.

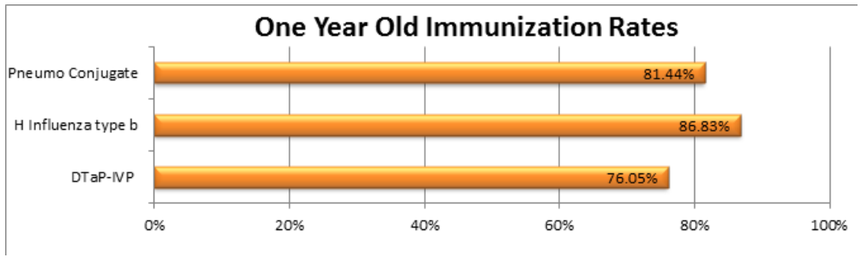


Figure 9. One-year old immunization rates, NITHA 2014

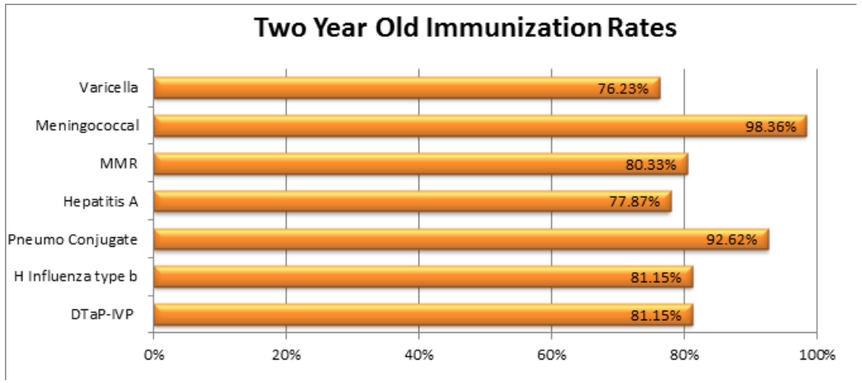


Figure 10. Two-year old immunization rates, NITHA 2014

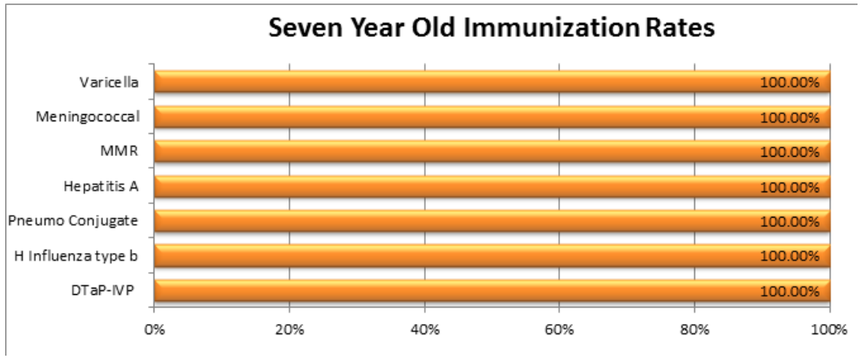


Figure 11. Seven-year old immunization rates, NITHA 2014

Adult Immunization

Influenza

In the 2014-15 influenza immunization season, NITHA communities were innovative in their advertising and reaching out to the public. Influenza clinics were held in a variety of sites not traditionally used such as stores, bingos, schools and community events. Social media such as Facebook was also used in some communities. Intranasal FluMist was used during the flu season. Most parents, children and nurses found this vaccine to be a positive addition to the program.

Statistics were collected on those from the age of 6 months and those over the age of 65. This year 1316 doses of influenza were provided to children under the age of 6 months to 8 years. There were 638 doses provided to those over the age of 65 years and 4853 provided to those aged 10-64 years. Overall, a total of 6807 doses of vaccine were provided for all ages during the year under review. This is less than what was provided during the 2013-14 fiscal year (8785 doses).

In the NITHA communities 69.06% of health care staff received influenza vaccine. This is an area that needs improvement not only to protect the workers but the communities they work with. In the NITHA office 86.96% of staff were immunized with influenza vaccine during the flu season.

Challenges

1. The most significant challenge for all Epidemiologist's is obtaining current accurate data to answer the questions that are being posed of them. There is presently a lack of standardized electronic data which limits the amount of data available for program evaluation, analysis, recommendations and to develop a meaningful health status report.
2. Communication can be a challenge. Immunization information is faxed to all communities and Nurse Managers as well as there are periodic teleconferences to provide updates. Not all nurses attend teleconferences and due to the various work arrangements some information may be missed. There may also be outdated information in the communities. Immunization programming and schedules change frequently and there needs to be a system to ensure that only current recommendations are available in the clinics.

Priorities

1. To continue exploring options for how to get more data to assist in program planning and evaluation throughout the partnership.
2. To work with communities to increase immunization rates including influenza immunization rate and children immunization rates to a level that will provide community protection.
3. To work with the FNIHB and Ministry of Health on how to reduce STI incident rates in NITHA.
4. Plan to work with Tobacco Project Coordinator to analyze baseline survey data on smoking.
5. Use ArcGIS software to plot the maps of population distribution, STD distribution and update every quarter.

COMMUNICABLE DISEASE CONTROL NURSE

Program Overview

Communicable diseases surveillance continue to be a priority for NITHA partnership. Prompt response and interventions are offered when concerns are identified.

The Communicable Disease Control (CDC) Nurse supports NITHA Partnership by the timely reporting of Communicable Diseases. Providing direct support to frontline health workers is an important component of the CDC nurse's roles in the prevention and control of infections in the community. This ensures that timely reporting and follow up of all communicable diseases is complete. In consultation with the Medical Health Officer, the CDC nurse responded to queries and offered education to frontline staff when necessary.

James Piad
Communicable Disease Control Nurse

Sexually Transmitted Infections

Sexually transmitted infections continue to be a significant public health concern in NITHA partnership. Chlamydia and gonorrhea constantly top the list of communicable diseases reported by NITHA. A total of 1,152 cases of chlamydia and gonorrhoea were reported by NITHA during the year 2014. Cases and their contacts were followed up and provided with appropriate care.

Syphilis is not as common as chlamydia and gonorrhea. It is highly communicable but preventable and treatable. In 2014, no new active case was reported by NITHA compared to one case reported the previous year. The laboratory reports received were from clients who had infection in the past and who had been successfully treated.

STIs in NITHA Communities remain above the provincial and national levels. The following factors may have contributed for the high number of cases: ineffective safer sex messages, inadequacy of consistent sex and health education, inadequate understanding of STI and its consequences, improper or non-use of protection like condoms, widespread use of illegal or illicit drugs and alcohol and newer HIV drugs that prolong the development of AIDS. Presence of STI increases the risk for HIV and Hep C / B. See Epidemiologist section of this report for statistical information on STIs.

Blood-borne Infections

Blood-borne infections refer to a group of communicable disease mainly transmitted by blood. HIV is also considered a blood-borne infection because it is efficiently transmitted by blood.

Hepatitis C (Hep C) and Hepatitis B are chronic liver diseases caused by Hepatitis C and B viruses, respectively. For 2014, 32 cases of Hep C were reported and none for Hep B. Hep C cases for the year was higher by two cases compared to previous year. This year's number is still below the 2012 figure which registered the highest since 2010. As in the previous years, current or past intravenous drug users comprise most of the Hep C cases. Simultaneous infection with HIV is a common occurrence because of similar modes of transmission. Hepatitis B / C and HIV are best transferred from one person to another by blood, commonly through sharing of contaminated drug paraphernalia, such as needles and syringes. Unlike Hep C and HIV, Hep B virus can be transferred to another through exposure to body fluids which include blood, saliva, semen and vaginal fluid.

A person can have Hepatitis B and C and HIV at the same time. Hepatitis B can be prevented by getting complete Hep B immunization. Prevention and control of communicable disease within NITHA partnership involves the same risk reduction strategies used elsewhere. These include:

- consistent and correct use of condoms
- reducing the number of sexual partners
- avoiding sharing of injection equipment
- routing screening
- treating infected individuals and ensuring that their partners are notified, tested, and treated.

See Epidemiologist section of this report for statistical information on blood-born infections.

Community Acquired Methicillin Resistant *Staphylococcus **aureus*** (CMRSA)

Methicillin Resistant *Staphylococcus aureus* (MRSA) infection continues to be a challenge in NITHA communities. The person infected will have no symptoms at all. The only way to detect MRSA by is laboratory testing, which is done by a swab in the nose, groin or sore, if there are. MRSA may stay with the person for a long time, or may be for life and it is difficult to determine when a person has cleared of bacteria and when the new infection has set in. CD nurse provided frontline nursing staff with relevant education and material resources in order for them to provide patients with current recommended treatment and prevention of MRSA.

Other Communicable Diseases

Other reportable communicable diseases, most of them vaccine preventable, have occurred sporadically in NITHA communities. Influenza (or Flu), caused by a virus and commonly with complications affecting the lungs, numbered 61. Those mostly affected were children under 5 years of age and adults above 50. Pertussis, also called "whooping cough" had 10 reported cases and those mostly affected were individuals below 19 years old and who either did not have pertussis or completed their pertussis immunization. One meningococcal infection, an infection affecting the brain, was reported from a child below 10 years old. These infections can be prevented by getting appropriate immunization.

Invasive types of infection, such as Invasive Group A Streptococcal Disease (IGAS) and Invasive Pneumococcal Disease have also been occurring in NITHA communities. Contacts of patients with pertussis, meningococcal infection and IGAS are tracked down and given treatment to prevent development of a full blown infection in them and to avoid their spread in the community.

Successes

1. Engagement of elders in planning and in disease prevention and control activities. Being the most respected persons in the communities, their words are honoured and their wisdom is always a benefit for communicable disease prevention and control program.
2. Awareness campaign. It creates higher level of awareness and empowers individuals in the community. With awareness, doubts were cleared and myths corrected.
3. Participation in conferences and workshops for knowledge / information updating. New knowledge gained from the attendance was applied and cascaded down to the partnerships.
4. Collaboration / coordination with other agencies for services / information / materials useful for the CD program. Materials like pamphlets and posters were handed out to the communities.

Challenges

1. Mobility of community members. Many people nowadays don't permanently live in their places of birth. They tend to move to communities where there are better opportunities for livelihood. In instances where they are diagnosed positive for a certain infection in a place they consider home, it takes longer time for them to be provided treatment because within a day or more, they cannot be reached anymore.
2. Use of other names / aliases and other personal information. There are some individuals who go from one clinic to another and get themselves tested for STIs. They use different names and other personal information that would confuse health care providers and making client identification difficult.
3. Difficulty of tracing cases and contacts. Some patients do not provide the names of their contacts. This makes contact tracing difficult. Proper testing and treatment should be done to both the case and the contact to really control further spread of infectious diseases.
4. Rapid turn-over of nurses / lack of nurses / and longer time for the vacant nurse position to be filled-up. Many nurses do not stay long in the community. Considering the important role of nurses in disease prevention and control, their absence could mean less to no follow-up of patients and contacts in the area. Health teachings / health education are not effectively done at the individual, family, and community level. This may mean more untreated infections and continuous disease transmission.
5. Confidentiality. Compared to other diseases, STIs and other related infections involve a higher level of confidentiality. Identifying a case or a contact entails a lot of caution so that confidentiality and privacy are not breached and that clients maintain a high level of trust in health care provider. At NITHA and partners, confidentiality and privacy are treated with utmost importance. NITHA always ensures that patients and contacts are tested and treated so that infections are controlled and further spread prevented.

Priorities

1. Sustain information campaign to improve awareness of the community on communicable diseases especially on the aspect of prevention and control and the importance of testing. Information campaign should be an on-going activity to continually remind the community of the risky behaviours and the prevention and control measures that need to be practiced at the individual level.
2. Reach out to other groups who might potentially be included in vulnerable population.
3. Engage more elders in the awareness campaigns. Elders are well respected persons in the community and their wisdom gives more impact to the campaign.
4. Involve youth in the information drive as many CD cases like the STIs come from the young population.
5. Strengthen existing relationships with schools and other organizations working in the communities.

ENVIRONMENTAL HEALTH ADVISOR

Program Overview

The Environmental Health Advisor (EHA) is a member of NITHA's Public Health Unit and works under the Supervision of the Medical Health Officer.

Treena Cottingham
Environmental Health Advisor

The goal of the EHA is to support the work of the Meadow Lake Tribal Council Environmental Health Officers (EHO's) and the Prince Albert Grand Council Environmental Health Officers, who also provide services to the Lac La Ronge Indian Band, the Peter Ballantyne Cree Nation and the Athabasca Health Authority. The EHA along with the EHO's and the partners and individual communities work together to identify and prevent Environmental Public Health Risks that could impact a partner community. The EHA may provide this support through training sessions and or providing or developing promotional or educational materials.

Some areas of Environmental Health where activities that may be undertaken through the EHA and EHO's, as identified by the communities, are:

- Drinking Water
- Food Safety
- Health and Housing
- Waste Water
- Solid Waste Disposal
- Facilities Inspections
- Communicable Disease Control
- Emergency Preparedness and Response
- Environmental Contaminants
- Research and Risk Assessment

The EHA is also responsible for the timely reporting and follow up of reportable illnesses. These illnesses fall into one of two categories, Zoonotic (animal borne) and Enteric (food or water borne) diseases. Provincially, the follow up and reporting are mandated by legislation. The EHA works closely with the Community Health Nurses (CHN) to provide the educational materials to assist in protecting the health of an individual and to prevent the potential spread of illnesses to the community. The EHA supports the CHN's by ensuring that the correct data collection tools are in place to meet the mandated reporting requirements.

Successes

The EHA maintained several important relationships with both internal and external partners. Attending Federal, Provincial, Municipal and non government agency meetings provides the EHA and NITHA the opportunity to ensure communication between agencies, allows NITHA to have input on proposed legislation or guidelines/policies, ensures EHO's are working with the most current information or what training or professional development may be required. The EHA is also available to complete best practice research on topics for EHO's or communities with specific concerns that needs support.

The EHA attended the Annual Joint Water Meeting. This meeting is for information sharing and discussing both water works and sewage works concerns and determining corrective actions for water systems in the north of the Province. It is attended by the Saskatchewan Water Security Agency, Mamawetan Churchill River Health Authority, and NITHA. Several shared systems were discussed and some concerns shared about long standing Drinking Water Advisories.

The EHA is a member of the Provincial Public Health Inspector Managers, and as such, is able to keep abreast of any new information systems, Legislation and other upcoming topics or environmental health concerns. These changes or new information are then communicated to the EHO's and communities.

Another venue for keeping up to date on technical advances is the Provincial, Canadian Institute of Public Health Inspectors Annual Education conference. This past year the EHA was able to attend information sessions on Flooding, Personal Service sanitation, and a major indoor air quality investigation/remediation.

One of the EHA's priority tasks was to develop and update animal bite/rabies policy, protocol, forms and procedures. This work was also completed and the updated forms shared with the CHN's and is available on the NITHA website as well.

In 2014, a total of 144 animal bites were reported and follow up. Of these, 140 (97%) were the result of dog bites. Children under the age of 10 made up 38% of the bites. Six clients required *Rabies Post Exposure Prophylaxis.*

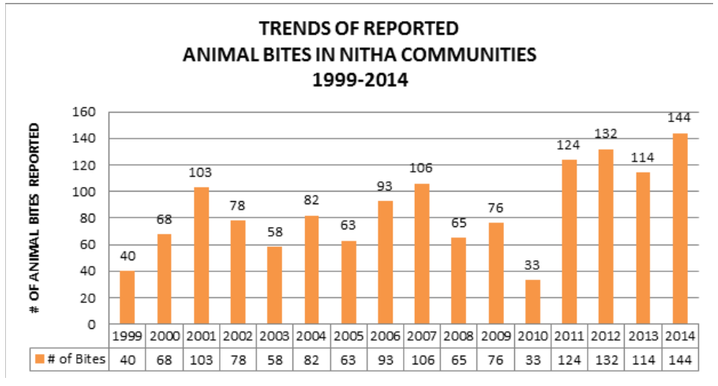


Figure 12. Trend of reported animal bites in NITHA communities by year.

Enteric disease cases continue to be low among NITHA partnership and has been trending down since 2001. In 2014, 23 cases were reported.

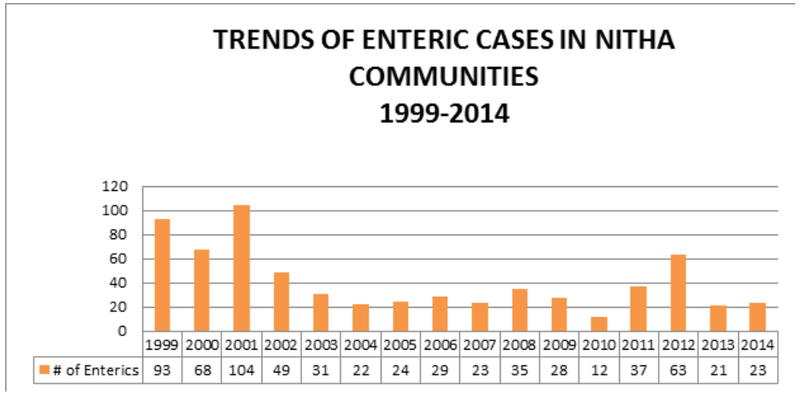


Figure 12. Trend of reported enteric diseases in NITHA communities by year.

Challenges

1. Prompt reporting and actions on animal bite and enteric cases by partner communities continues to be a challenge. This may be due to staffing, technology or routing of information concerns.

2. Inadequate completion of investigation forms by frontline nurses constitutes a challenge for the EHA in providing timely reporting.

Priorities

- Ensure timely notification, follow-up and reporting, of animal bite incidents and enteric cases. The EHA will work closely with Partner communities in order to meet provincial reporting requirements.
- Research and develop educational material for EHOs and health staff to use in the field based on best available practices in order to enhance service program delivery and assist communities with the management of risks associated with the various components of the Environmental Health Program.
- Research and develop training or educational materials and policies on WHIMIS, Transportation of Dangerous Goods and Biomedical Waste transportation.
- Complete the development of the EHA components of the On Line Infection Control Module.
- Complete the Development of the Communicable Disease Project with the NITHA Health Promotion Advisor and the NITHA Communicable Disease Control Nurse.

INFECTION CONTROL ADVISOR

Program Overview

The Infection Control Advisor (ICA) accomplished several activities in the past year in line with identified priority areas in the Infection Prevention and Control (IPC) Program. Last year was particularly interesting because a NITHA Infection Control policies and procedures manual was in place that guided much of the educational and training sessions. The main priority areas were; use of personal protective equipment (PPE), respiratory protection program, hand hygiene and maintaining a clean and safe healthcare environment. Much work was done on the introduction of monitoring tools for various infection control practices.

Ivan Serunkuma
Infection Control Advisor

Successes

The IPC working group meets on a quarterly basis and guides the activities of the IPC program. The program started with availing the IPC manual online via the NITHA website for easy reference and access. NITHA continues to provide hard copies of the manual as need arises. The ICA continues to update the policies and procedures in the manual as new information and best practice recommendations in IPC come up. It was necessary to develop or adopt activity reminders and monitoring tools to assist with performing various tasks. To accomplish this, several posters were sent out and health care environment assessment tools and hand hygiene audit guidelines were developed. As the year progressed, the ICA developed a policy on managing toys in health care facilities and guidelines for selection and use of cleaning agents and disinfectants.

Education of health care workers on infection control measures continued mainly focusing on important situations encountered daily at health centres and new issues that arose in the field of Infection Control. The educational topics provided include: routine practices of infection control and additional precautions, medical device reprocessing, adherence to hand hygiene, Personal Protective Equipment (PPE) and several others.

The ICA is in the process of developing an online Infection Prevention and Control module. This will be a ready to use resource for the orientation of new staff and ongoing education of all staff in breaking the chain of transmission of infections. The module will be highly interactive, user friendly and will allow provision of feedback to users.

The ICA provided training on Mask Fit testing to strengthen the Respiratory Protection Program of NITHA and the partnership. This training allows trainees to efficiently conduct Mask Fit testing for frontline staff to facilitate their protection from airborne infections like tuberculosis and measles. Together with the Environmental Health Advisor, the ICA provided an environmental cleaning training to janitors. Education to all healthcare workers was an ongoing process throughout the year bu sharing of information and distribution of materials (DVDs, posters, brochures) were increased during the infection control week.

Last year tested our preparedness to protect health care workers in the event of an outbreak of a severe, often fatal illness. Following the Ebola outbreak in West Africa, NITHA was involved in extensive preparations and training for enhanced PPE donning and doffing. The ICA played a vital role in planning and conducting "Train the Trainer" sessions for partner health care workers as part of the multiphasic approach initiated by the federal government. The ICA continues to participate in planning meetings pertaining to Ebola preparedness.

The ICA continued to provide advice on facility design and infection control during renovations of health care facilities within partner communities. Another role was the coordination of the dissemination of public Health information to members of the communities via radio. This proved to be a very useful means for the influenza campaign. At the time when Hantavirus was a threat to some of the communities, the MBC radio was again utilized to inform the public about preventive measures that can effectively provide protection.

Infection Control Advisor at one of the trainings for Ebola Enhanced PPE Use

Infection control, like many fields of health care, continuously changes to improve safety of staff, clients and visitors. The ICA ensures the partners are informed about relevant updates obtained from best practice standards and other authorities in the field of infection control. These updates involve a wide range of topics including; selection of products for cleaning and disinfection, evaluation of procedures for performing various infection control practices, and solutions to a variety of infection control issues.

Together with the CD Control nurse and the Medical Health Officer, ICA continued work with the HIV program. The NITHA HIV working group held several meetings throughout the year, mainly working on the NITHA HIV strategy. This strategy document is now complete and awaiting approval by NITHA Executive Council. The working group identified pertinent goals, objectives and activities as a response to the current HIV situation in NITHA communities. Education sessions on HIV were also provided to improve awareness about the different means of transmission and preventive strategies. Areas of focus for these sessions were: Risk of HIV acquisition with different sexual and behavioral practices and harm reduction in relation to intra venous drug use among other topics. The goals and objectives of the HIV strategy are to be used as a basis for formulating activities for the HIV program.

The ICA collaborates with the *Northern Healthy Communities Partnership* in providing awareness to address issues surrounding HIV through messaging relevant to northern communities. The ICA also participates in provincial and federal initiated HIV activities which enables NITHA to collaborate in developing a coordinated and progressive response to HIV.

Priorities

The development of the online Infection Prevention and Control course will be finalized and launching of the course will be done. Another priority is the review of the infection control manual with the aim of making relevant updates. More work will also be done on quality assurance /improvement in Infection control. Several trainings will be offered especially in the area of Mask Fit Testing (as part of a comprehensive respiratory protection program), environmental cleaning, Personal Protective Equipment use and safe disposal of medical waste. Other topics for education will be identified as the year progresses. As more health centres are renovated, the ICA will continue to offer advice on facility design and infection control during renovations/construction.

Upon approval of NITHA HIV Strategy by Executive Council, activities will be formulated and guided by the goals and objectives within the strategy. The goals, objectives and activities will be incorporated into the annual work plan of NITHA`s HIV program.

Challenges

Accessing health care services from different health care facilities located in various areas in the province or out of province can sometimes make it challenging to track the origin of healthcare associated infections. Education of health care workers and clients will be continued to assist with preventing these infections.

Antibiotic resistant organisms and their transmission present a treatment challenge. Education about antibiotic resistance and infection control routine practices help prevent transmission of antibiotic resistant microorganisms; education combined with antibiotic stewardship will help to prevent the occurrence of the resistance.

Stigma and discrimination remain a problem faced by people leaving with HIV/AIDS. This may lead to different degrees of involvement by individuals and various communities in the HIV/AIDS related initiatives. Educational and awareness campaigns will help to reduce stigma. Even with this, it is challenging to determine or evaluate shifts in attitudes (like stigma) and behaviours. The program still hopes to do so by carrying out surveys.

PUBLIC HEALTH UNIT - "EMBRACING CHANGE"

HEALTH PROMOTION ADVISOR

Population Health Promotion Program Overview

The goal of the NITHA Population Health Promotion program is to provide comprehensive support to the NITHA partners in the area of Population Health Promotion.

Good health is holistic and is more than the absence of disease. The Medicine Wheel teachings of balance – emotional, spiritual, physical and mental define good health. The World Health Organization defines good health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".

The overall health of communities is influenced by many factors beyond access to health care services and individual behavior. These factors are the **social determinants of health** and are the underlying root causes of many health and social issues in the NITHA communities. The impact of the social determinants of health, along with the effects of colonization and residential schools, has affected the health status of NITHA communities in a significant way.

Population Health Promotion strategies emphasize "upstream" approaches that work to address root causes of poor health by changing the conditions and environments in which people live, work and play. Effective population health promotion strategies are multi-faceted, long term and require multi-sectorial partnerships and strategies.

The Health Promotion Advisor's roles are to:

- Work with the NITHA partners and other partners to develop population health promotion strategies.
- Mentor and collaborate with NITHA partners to identify and plan capacity building opportunities to build the population health promotion skills.
- Provide support, guidance, and advice regarding population health promotion to the NITHA Partners.
- Develop partnerships at the local, provincial and federal levels to ensure evidence based population health promotion practice.

Linda Gilmour Kessler
Health Promotion Advisor

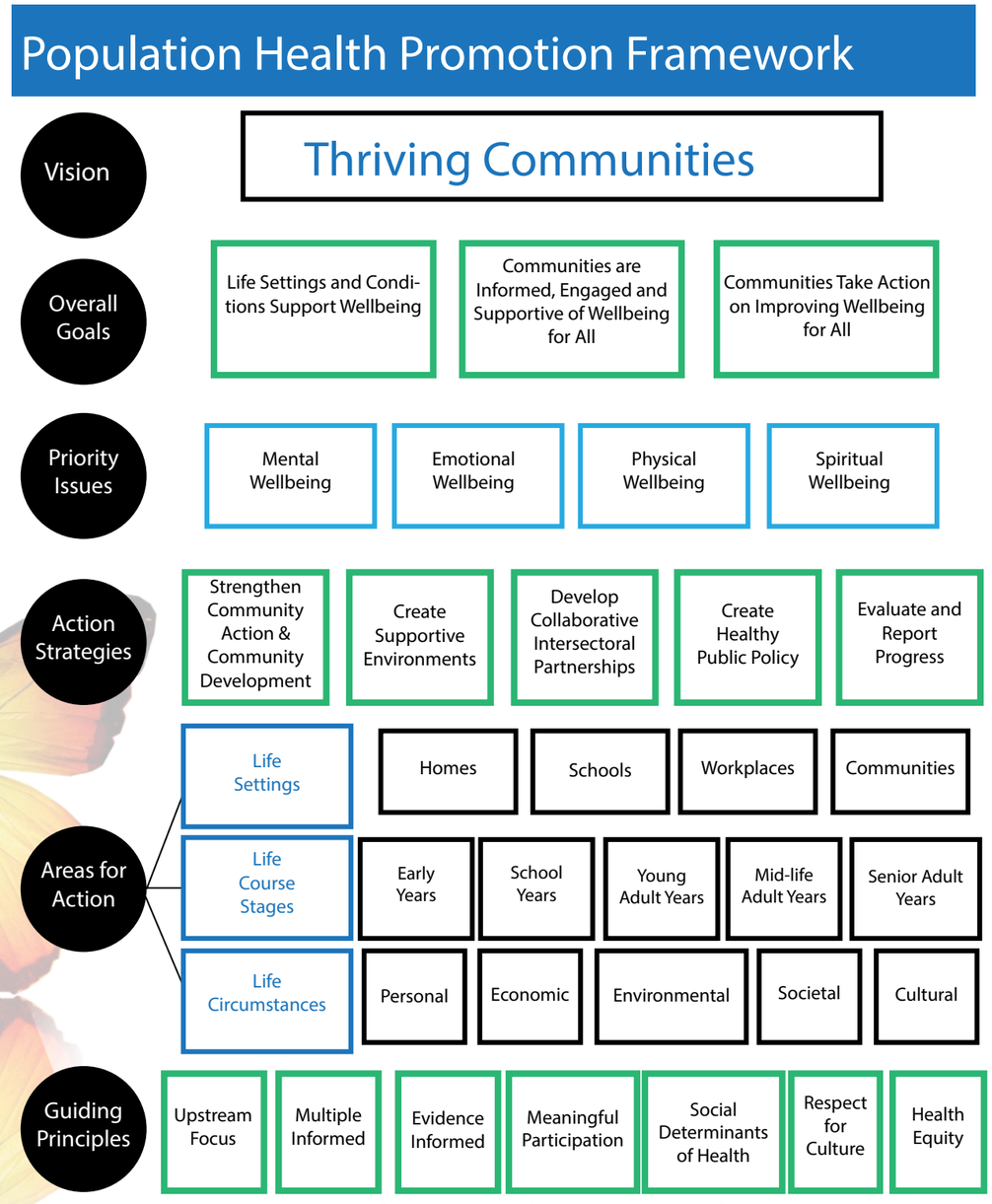


Figure 14: Saskatchewan Population Health Promotion

Adapted from: A Population Health Promotion Strategy for Saskatchewan - Healthier Places to Live, Work and Play

PUBLIC HEALTH UNIT - "EMBRACING CHANGE"

Population Health Promotion Highlights and Achievements

During the year under review, the NITHA Health Promotion Advisor provided leadership and worked collaboratively with the NITHA partners to plan, develop, and implement north-wide population health promotion strategies and initiatives.

1. Population Health Promotion Leadership

a) Northern Healthy Community Partnership

The Northern Healthy Communities Partnership (NHCP) uses a Population Health Promotion approach to enhance the health and well-being of communities and citizens living in northern Saskatchewan. The NITHA Health Promotion Advisor and NITHA Medical Health Officer (MHO) provide leadership roles for the NHCP, in partnership with the Northern Saskatchewan Population Health Unit. NITHA partners are active members of the NHCP core group and action teams.

The NITHA Health Promotion Advisor, along with the Northern Population Heath Unit's Health Promotion Coordinator, co-coordinated the NHCP and supported the NHCP to plan, implement and evaluate population health promotion initiatives and projects.

NHCP Co-coordinator Highlights:

- Collaborated with the NHCP chairs (MHO's), core group and action teams to identify population health promotion priorities, identify best practices, select, implement and evaluate population health promotion initiatives.
- Established a funding partnership with the Saskatchewan Cancer Agency (SCA) for northern tobacco reduction, healthy eating and community youth development. A one year funding agreement (August 2014-August 2015 of $70,000 is confirmed with the potential for ongoing funding of $75,000/year (pending SCA approval).
- Revised the NHCP Framework document to clearly delineate the various roles and functions of the NHCP Core Group, NHCP Action Teams, NHCP Co-chairs and the NHCP Co-coordinators and to reflect the strengthened partnership between First Nation and non-First Nation partners.
- Provided support to NITHA partners to participate and collaborate as NHCP partners on both the core group and action teams.
- Monitored NHCP representation and engaged additional NHCP action teams and core group members.
- Coordinated the development and distribution of monthly radio spots and health promotion theme packages.
- Planned and conducted a northern health promotion photo shoot to develop a library of stock photos (Pelican Narrows and Sandy Bay).

b) NITHA Population Health Promotion Working Group

The NITHA Health Promotion Advisor re-established the NITHA Population Health Promotion Working (NITHA PHPWG) group in January, 2015. The goals of the NITHA PHPWG are to use the population health promotion/community development models to support the health and well-being of NITHA residents and communities, acts in an advisory capacity to make recommendations regarding population health promotion and to collaborate to build population health promotion and community development capacity at the second level and community levels.

c) NITHA Communications

The HPA co-chaired the internal NITHA Communications/Social Media committee which identified needs, reviewed options and made recommendations to senior management regarding NITHA's communication and social media needs. As well, the HPA collaborated with the NITHA Communicable Disease Nurse and Environmental Health Advisor to draft a series of communicable disease presentations and handouts. (STI, Enteric, and MRSA)

2. Population Health Promotion Initiatives and Strategies.

a) Tobacco Reduction Initiatives

NHCP Northern Tobacco Strategy

The Northern Tobacco Strategy (NTS) was co-chaired by the NITHA HPA and has representation from the NITHA partners. The goals are to develop northern strategies for tobacco prevention, cessation and control while respecting the First Nation traditional use of tobacco for spiritual and ceremonial purposes. The NTS finalized the NTS Maternal Cessation module and the Youth Workshop. The HPA provided train the trainer workshops to NTS members and other key partner program leads. The HPA in turn, supported train the trainers to conduct a number of frontline workers who work with pregnant, postnatal and women with young children. Frontline workers included community/public health nurses, maternal child worker, community health representatives and others. Community youth workshops were also held by members of the NTS. The HPA took the lead to develop and pilot a tobacco cessation presentation and handout targeting the general population. The HPA also has opportunities provincially to highlight the successful Northern Tobacco Strategy work. The HPA developed a Northern Tobacco Strategy display and was a presenter for a provincial tobacco webinar. The NTS also partnered with the Smokers Helpline Service to launch and promote the services Cree and Dene.

Federal Tobacco Control Strategy

The HPA in collaboration with relevant unit staff wrote and developed a successful Federal Tobacco Control Strategy (FTCS) proposal on behalf of NITHA and the NITHA partners. See NITHA Tobacco Project Coordinator section of this report for further details.

b) Children and Youth Development

NHCP Building Vibrant Youth

The NITHA Health Promotion Advisor co-chairs the Building Vibrant Youth (BVY) action team to support NITHA partners who participate on the BVY. The main focus of the Building Vibrant Youth action team was the Northern Youth Role Model project, a very large undertaking for the team. Four northern youth role models were selected from northern Saskatchewan based on established criteria. The youth role models planned, implemented and evaluated a youth focused project in their community. Two youth leadership workshops were conducted in Fond du Lac and Pelican Narrows. This project received media coverage – press releases and follow up interviews with Eagle Feather News, the Northern and MBC Radio.

NHCP Babies, Books and Bonding

The NITHA Health Promotion Advisor provides support to NITHA partners who are members of the Babies, Books and Bonding action team (BBB). The HPA collaborates with NITHA partners to ensure eligible NITHA partner communities receive books. This past year, the BBB action team initiated the development of a northern themed book targeting the 18 month- 2 year age group.

c) Nutrition/Food Security

Healthy Eating Team

The NITHA Health Promotion Advisor provides support to the NITHA partners who are members of the Healthy Eating action team (HET). A beverage and snack presentation kit was developed to show the sugar and vitamin/mineral content of beverages and nutrient composition of snacks. The Northern Gardening manual was revised and the Northern Community Kitchen manual was completed. The HET also developed discussion cards and in-service presentations on breastfeeding and introducing solids, as well as baby recipe cards and infant portion plates.

The HET updated the northern Nutrition Policy template and developed a supporting presentation template. Organizations such as health, schools, and recreation are encouraged to adapt and use these materials as appropriate for their organizations.

The HET expanded the successful School Nutrition Mentorship Project (SNMP) this year. The Nutrition Mentor and a HET member visited and supported participating schools. Recipes, food preparation, menu planning and budgeting are demonstrated in each school with those responsible for the nutrition program.

d) Active Communities

NHCP Active Communities Team (ACT)

The NITHA Health Promotion Advisor provides support to NITHA partners who are members of the Active Communities action team (ACT). In May 2014, the ACT implemented Northern Physical Activity Month. This year the ACT worked to establish and clarifying the scope of the ACT team, as this team had previously been inactive for approximately a year. The ACT has updated their terms of reference with a new vision and mission and have developed a work-plan for the upcoming year.

During the year under review, HPA participated in several working group meetings including Provincial Population Health Promotion Practitioners Council and Saskatchewan Tobacco Reduction Coalition

Priorities

- In the upcoming year, the HPA will continue to work collaboratively with the NITHA partners to plan develop and implement north-wide health promotion strategies and initiatives. There are many opportunities for health promotion to have a positive impact on the health of children, youth, families and communities.
- Work with the NITHA partners to identify population health promotion priorities, identify best practices, select, implement and evaluate population health promotion initiatives.
- Collaborating with the Northern Population Health's Health Promotion Coordinator, to co-coordinate the Northern Healthy Communities Partnership and to support the NITHA partners who are involved in the NHCP population health promotion work.
- Continue to develop and maintain internal and external relationships and partnerships to support population health promotion initiatives.
- Build population health promotion capacity of the NITHA partners and other NITHA staff to plan, implement and evaluate population health promotion initiatives.
- Collaborate with and provide guidance and support to NITHA second level partners and NITHA staff for population health promotion initiatives.

TOBACCO COORDINATOR

Program Overview

Justina Ndubuka
Tobacco Project Coordinator

During the year under review, the Northern Inter-Tribal Health Authority and its partners received funding from First Nations and Inuit Health Branch (FNIHB) to implement tobacco reduction initiatives as part of the FTCS. This tobacco project seeks to address the high smoking rates among First Nations living on-reserve in northern Saskatchewan. This initiative will utilize the six essential components of the FTCS as outlined by FNIHB namely: protection, reduced access to tobacco products, prevention, education, cessation, and data collection and evaluation.

NITHA partners identified eight pilot communities who indicated their support, commitment and willingness to engage in the proposed activities for each of the six elements. The four primary indicators for this project are to: decrease the percentage of daily smokers; increase the number of smoke-free public spaces; number of promising smoking-prevention and cessation strategies; and number of smoking –related protection policies among the participating pilot communities, and eventually non-pilot partner communities.

The position of the NITHA tobacco project coordinator (TPC) was filled in February 2015 and is expected to work with the four community tobacco coordinators (CTC) from the partners to implement the six essential elements.

Community ownership, engagement and capacity building is critical to the success of the tobacco project. This will give the communities the skills, knowledge and abilities to continue to support and implement tobacco reduction activities after this project ends. Communities will be engaged and involved in the project as it is planned, developed and implemented.

Achievements

On commencing work, the TPC attended the community of practice workshop in Winnipeg in March 2015 for orientation with the federal tobacco control strategy. This workshop provided a high level overview of the project including goals, objectives, key performance indicators and evaluation plans.

The TPC began by determining the responsibilities and defining the set goals of the project. Annual work plan was also developed. TPC also created connections with the partners by visiting Peter Ballantyne Cree Nations and Prince Albert Grand Council offices. The tobacco coordinator also went to Little Red. Plans are underway to visit other partner communities in the next fiscal year.

It was identified that NITHA communities do not have baseline smoking data. The position having seen the need for a baseline data, developed survey tools for data collection including questionnaire, informed consent and participant information sheet. Survey tool was also developed to determine the number of smoke-free public places within participating communities.

The tobacco coordinator also developed annual work plan; conducted literature reviews and environmental scan on tobacco reduction best practices; started reviewing the maternal and youth module on tobacco cessation.

NITHA TPC is a member of the National Steering Committee on evaluation of FTCS. TPC attended all scheduled meetings during the fiscal year under review.

The TPC conducted environmental scan to determine current use of traditional tobacco in the pilot and non-pilot communities. There are misconceptions among first nations youth about traditional tobacco use in the communities, there is therefore the need to educate the youth on the differences between the traditional and commercial tobacco.

Effective communication is very vital in this project. TPC continued to ensure that the NITHA partners and the community tobacco coordinators are well informed about best practices and strategies on tobacco reduction.

Challenges

Identifying and addressing individual priorities of NITHA partners could be challenging.

Developing survey questionnaire for baseline data collection that meets the collective need of NITHA partners posed a significant challenge during the reporting year.

Priorities

- Finalizing smoking baseline data survey
- Developing additional resource materials for smoking cessation
- Planning and implementing community wide tobacco awareness campaign

TUBERCULOSIS PROGRAM

Program Overview

Contact tracing, outbreak management, support of the Strategy for the Management of Tuberculosis in High Incidence Communities and training and orientation of health care providers have been the main areas of focus for the TB program this year. A total of 26 community visits were made to 7 NITHA communities, 23 by the NITHA TB nurses and another 3 by contracted nurses. Due to issues with staffing, including difficulties finding nurses to contract to cover off permanent who were on extended medical leaves, the number of visits made to the communities was down considerably this year. As a consequence, we relied heavily on community health nurses on some occasions to manage contact tracing that was required in various communities. In the community where we were experiencing an outbreak we supported a portion of community nursing time to undertake the huge workload that managing the outbreak required.

Tuberculosis in NITHA Partner First Nations:

In 2014 there were 29 cases of suspect or confirmed active Tuberculosis in NITHA communities (see figure 15). This is 10 fewer cases than the previous year but more in line with the previous 5-year average of 30 cases. There were cases in 11 NITHA communities this year. 11 of the 29 cases were in one partner community that was officially declared as having an outbreak of Tuberculosis in July 2014. A detailed description of the outbreak and its management are provided in a latter section of this report.

Sheila Hourigan
TB Advisor

Eileen Oliveri
TB Nurse

Janine Brown
TB Nurse

Barb George
TB Nurse

Cindy Sewap
Program Administrative Assistant

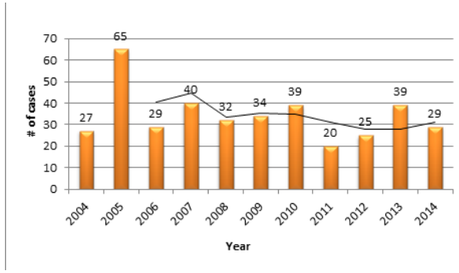


Figure 15. Number of NITHA TB cases per year (2004-2014)

The age distribution of 2014 Active and Suspect Tuberculosis cases is highlighted in Table 2 below.

Age (in years)	# of cases
0-4 yrs	4
5-14 yrs	0
15-24 yrs	10
25-34 yrs	2
35-64 yrs	13
65+ yrs	0
Total	**29**

Table 2. Age distribution of 2014 TB active cases

The age group contributing the greatest number of cases again this year was the middle age group, age 35-64. Figure 16 shows an increasing number of cases in the middle age group since 2010. The average rate of disease increased from 114/100 000 in 2008-2010 to 164/100 000 in 2012-2014. This is an interesting trend to keep our eyes on to see if it continues. The increasing rates of diabetes and other chronic diseases may be a factor as these diseases may increase ones susceptibility to disease. Substance use including smoking, and alcohol and drug use (particularly marijuana) are likely significant contributing factors as 49% of adults who developed active Tuberculosis from 2008-2014 had one or more of these lifestyle risk factors. Cigarette smoking is known to increase a person's risk of developing TB by 2 or 3 times. As well, 2 outbreaks in this time period including the current one included a number of adults in this age group which may have contributed to the increase.

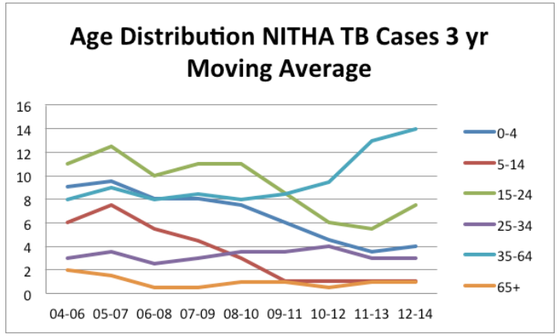


Figure 16. Age distibution of TB cases per year (2004-2014)

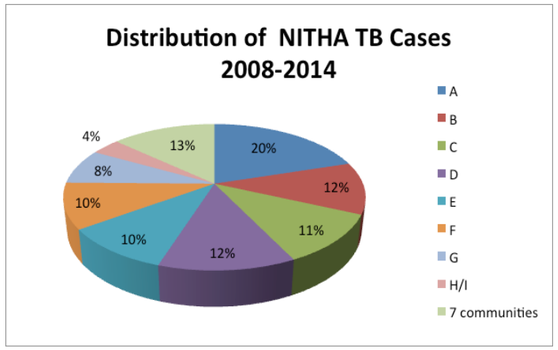


Figure 17. Distibution of TB cases by communities

Type of Disease	Smear Positive Pulmonary	Non-Smear+ Pulmonary	Extra Pulmonary	Disseminated
Adult 15& over	11	10	4	1
Child 0-14	0	4	0	0
Total	**11**	**14**	**4**	**1**

Table 3. Type of TB disease by age group

Figure 17 shows that between 2008 and 2014, 83% of all NITHA TB Cases were contained in 7 communities with 1 community contributing 20% of all TB cases. Four of the top five communities are piloting the high incidence TB strategy and the other is currently experiencing a tuberculosis outbreak.

The breakdown according to the type of disease is captured in Table 3.

Eleven out of 29 or 38% of cases were smear positive indicating more advanced disease and greater transmissibility at the time of diagnosis. Efforts to increase early detection of TB will be enhanced through the high incidence strategy.

Individual risk factors play an important role in whether a person develops active disease. The most common risk factors present in 2014 cases like previous years was recent exposure, with 18 of the total cases identified as having recent exposure. Other documented risk factors in the 2014 TB cases were smoking (11), alcohol overuse (19), marijuana use (3) and diabetes (1) and HIV (1).

Achievements

Professional and Community Education and Support

Community Health Nursing

The NITHA TB nurses provided orientation on various aspects of the TB program to 11 nurses at the community level in 2014-2015. Twenty-nine nurses attending the Orientation and Skills Training program participated in a presentation on early detection and treatment of TB.

Due to staffing issues within the NITHA TB program the community nurses were, on occasion, relied on heavily to manage contact investigations. When the NITHA nurses did visit communities for contract tracing (16 visits) outstanding follow-up needing completion by the team in the community was done diligently. The community nurses and their supporting staff are to be commended for their ongoing efforts in this area.

TB Program Workers:

Seven new TB program workers were trained and 9 received updates or additional orientation at the community level. 27 workers attended the annual TB Programs working workshop in Saskatoon.

In the outbreak community FNIHB supported 2 and then later 3 fulltime TB worker positions to manage the heavy DOT and contact tracing workload. This model of funding full time equivalency positions rather than basing funding on dose by dose calculations began in another community who had a significant outbreak and then moved into implementation of the High Incidence Strategy. This has proved to be successful approach as it allows for additional supportive activities including community awareness education which is so important during times of high activity. FNIHB also supported this approach in another community who had an increased number of cases and contact tracing activity above the usual for that community. One full time and one half time workers were hired in this community.

Case management is not the primary realm of the NITHA TB program as TB Prevention and Control Saskatchewan takes the lead in that area. However, we are called upon to troubleshoot on occasion. The NITHA TB program also supports case management through the provision of client incentives or enablers. These may assist the client, especially children in taking the medications, or may be used to motivate clients when there are compliance issues.

Contact Tracing:

Supporting contact tracing has become the primary emphasis of the NITHA TB program as it is the most valuable means of interrupting the cycle of transmission and of detecting cases early.

There were 12 contact traces required in NITHA partner communities in 2014 down from the 20 that were required in the previous year, 6 for smear positive and 6 for smear negative/culture positive. Four of these traces that were managed exclusively by the communities saved for regular telephone consultation by the NITHA TB program. Tuberculin skin testing, symptom inquiry (asking about the presence of symptoms) and collecting sputum for those people with very close contact or with symptoms, are some of the tools used by the TB nurses. This year 225 individuals were tuberculin skin tested in the course of contact investigation and 515 individuals whose prior skin tests were already positive were assessed for the presence of symptoms and risk factors. Of those that were skin tested 12 % were positive suggesting that transmission was occurring.

Childhood Screening Program:

This year as with the previous year, the enhanced childhood screening program for all communities with a 3-year average annual incidence of smear positive TB greater than 15/100 000 was delegated to be a community level responsibility. Eight of 12 communities have thus far reported on screening 127 children in this age group. One had a positive skin test but that child was also a contact to an infectious case so would not be counted as detected through screening. Low incidence communities were not required to screen any children at this age.

School entry screening was reported by 10 NITHA partner area schools Only children who have not had a BCG vaccination are eligible for this screening. Testing on 68 students has been reported to NITHA to date No eligible child had a significant skin test, for a rate of infection of 0%. This has been consistent over the last 3 years.

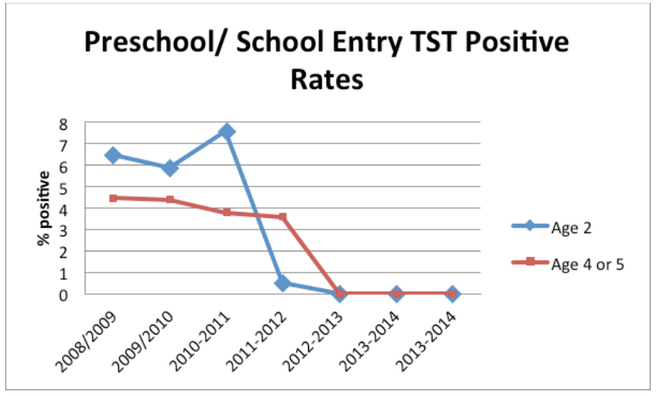


Figure 18. Childhood screening TST Positive Rates

Surveillance:

Monitoring incidence and transmission characteristics led to the determination that one NITHA partner community was experiencing an outbreak of tuberculosis. A management team comprised of all stakeholders was formed and strategies to manage the outbreak developed and implemented. Improvements in TB program databases are planned for the coming year which will serve to enhance our ability to collect and better analyze TB data.

High Incidence Strategy:

Four NITHA partner communities are pilot sites for implementing the *Strategy for the Management of Tuberculosis in High Incidence Communities*. One of the major focuses this year was the development of educational and promotional materials for each of the communities. With direct input from each community on priorities, language and artwork an educational pamphlet, fridge magnet, promotional newsletters and promotional bags were developed.

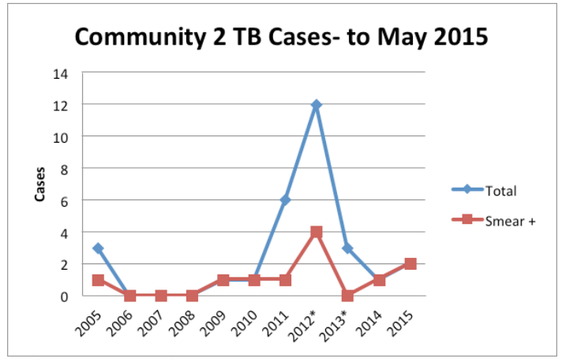
NITHA led 3 teleconferences with each management team for 3 of the pilot sites and participated in the teleconferences for the site led by Population Health.

Implementation of the majority of the strategies is ongoing with efforts being made to address areas that have not been tackled yet.

Outbreak Management

Community 2

This community, which experienced an outbreak beginning in 2011 had no further cases up until June of 2013 (see figure 19), then in March of 2014 there was a case from an urban centre that had epidemiologic links to the outbreak but there were no secondary cases. Two smear positive cases have been recently identified both of who were contacts to one or more of the outbreak cases in 2012 and who had new diagnosis of Latent TB infection at that time. Neither received preventative treatment for various reasons.



2012* includes 2 off reserve smear + cases, but not smear _ cases

2013* includes epidemiology linked ccases in other First Nation
Figure 6: Number of TB cases in Community 2 (2005-May 2015)

Figure 19. Community #2 TB Cases

Community 3

In July of 2013, a community that does not normally have a high incidence of tuberculosis, started to see an increased number of TB cases. By December there were seven cases in total and 2 of these were smear positive. All of these cases were epidemiologically linked. There were no further cases until May of 2014 and then by the end of June, 5 additional cases were diagnosed. See Figure 20 below.

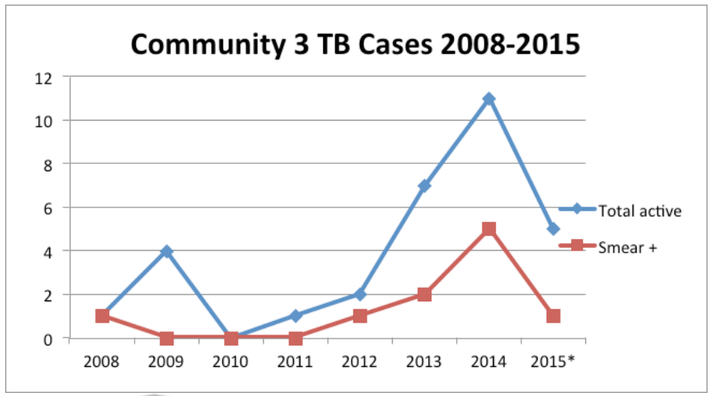


Figure 20. Community #3 TB Cases

It was decided at this time to declare an outbreak and to convene a group of stakeholders from the community and 2nd level health services, the NITHA TB Team, TB Prevention and Control Saskatchewan, FHIHB and from the Saskatchewan Disease Control Laboratory. With the formation of this outbreak management team, an analysis of concerns and contributing factors was undertaken which led to the development of specific strategies to address those concerns. This team initially met via teleconference every month and continues to meet bi monthly.

One specific area of concern that resulted in a change in approach was that there were a number of cases occurring in contacts that had been infected with TB many years ago. Normally such people are less likely to get sick from a second exposure because they have some degree of immunity. It was decided that such individuals would be prioritized according to risk and offered preventative treatment. Previously in Saskatchewan only those with newly positive skin tests and/or who met other criteria would be considered for such treatment. Table 4 below shows the number of people that have received preventive treatment or Treatment of Latent TB Infection as it is properly called, by age group since the start of the outbreak.

Age Group	2014		2015	
	TLTBI	GAP Therapy	TLTBI	GAP Therapy
0-14 years	2	10	11	4
15-34	15	-	16	-
35+	23	-	11	-

Table 4: Treatment of Latent TB infection and GAP preventative therapy

Another factor noted in the context of the outbreak was that the majority of cases and contacts were occurring in a specific geographical area of the community where there was a significant amount of socializing between households. It was suggested there may be people exposed that were not specifically named as contacts and so it was decided a door to door survey of the area would be conducted. 21 homes were visited, with 113 people screened, 60 of whom were screened with a TB skin test. Eight of those skin tested had a positive tests. No active cases were detected but of these new TST positive people, 3 are being treated for latent TB, 2 are being followed every 6months for 2 years and the remainder's investigations are ongoing. In addition, to the screening process, all households received TB education and were given a food hamper for their participation.

Some of the basic strategies essential to managing an outbreak are aggressive and timely contact tracing and a strong program of directly observed medication administration. To manage the heavy contact tracing workload the NITHA TB nurses made 11 community visits during the period from April 1st, 2014 until March 31st 2015. In addition, NITHA supported a portion of the community health nurse's time so she had adequate time managing the TB workload when the NITHA nurse was not in the community. The partner agency of this community was very supportive and ensured that the nurse had enough time dedicated to meet the program needs.

In order to support the DOT workload FNIHB was asked to fund the community for fulltime TB worker positions. Initially 2 positions and later 3 full time positions were funded. These 3 positions will continue to be supported into the next fiscal year.

Another interesting aspect of managing this outbreak has been the monitoring of the strains of the TB bacteria causing the cases. With the help of the Saskatchewan Disease Control Laboratory it was determined that the same strain of TB had caused all of the bacteriologically confirmed TB cases including the cases in other communities. The strain of bacteria was first seen in an isolated case in the outbreak community back in 2012. One of the outbreak cases, who was a heavy transmitter, was a contact to this case who was lost to follow-up. Strain information determined that 2 cases in a nearby community where there is lots of visiting back and forth were not the same as the outbreak. Had we not had this information we may have assumed they were related and therefore, managed accordingly.

At the time of writing this report there have been a total of 23 cases in the community and another 3 in other communities. Management is ongoing.

Challenges

1. Compromised resources to fully support the high incidence strategy and manage the heavy contact tracing workload due to being unable to recruit nurses to fully replace the full time nurses who were off.
2. Outbreak in community described above had some unique features which required the implementation of new strategies that were resource intensive.
3. Maintaining focus on the high incidence strategy when concurrently managing an outbreak.

Priorities

1. Contact tracing. This will remain a top priority for the program as it is the most important means available to us to find and prevent TB.
2. Ongoing support of high incidence strategies.
3. Ongoing outbreak management in the community above remains a priority for the NITHA TB program because of the need for coordination and heavy resource requirements.

ADMINISTRATIVE UNIT

Program Overview

The Administration Unit is responsible for the ongoing daily operations of NITHA. The staff members include the Executive Director, Executive Assistant, Finance Manager, Personnel/ Finance Assistant, eHealth Advisor, Senior Network Technologist, Human Resource Advisor and Receptionist Office Assistant.

Administration staff works collaboratively in promoting effective communication and coordination with the Partners and the many stakeholders whom are all integral to the success of NITHA and the services it offers. The staff supports the Partners in (1) Policy Development (2) Data Stat Collection (3) Developing Tools and Best Practices (4) Research and Analysis (5) Engaging the Partnership (6) Training (7) Informing Partnership on new/changing communication and current trends focussing on the First Nations culturally appropriate and sensitive service delivery.

Most specifically, the unit is responsible for the following:

- Accurate Financial Records
- Implementing Financial Decisions following guidelines set forth
- Financial Policies / Procedures Development and Maintenance
- Human Resource Policies/Procedures and Maintenance
- Recruitment and Retention for the North
- eHealth Planning / Development of electronic health information systems and maintenance for the North

Samantha Bear
Receptionist/Office Assistant
(Currently on Leave)

Donna Halkett
Term Receptionist/Office Assistant

HUMAN RESOURCE ADVISOR

Program Overview

The Human Resource Advisor works to support the NITHA Partnership to plan, implement, and operate human resource programs aimed at addressing Human Resource (HR) issues as a collaborative approach. This includes but is not limited to consultation, advice and the implementation of HR initiatives throughout the Partnership. Effective Human Resource Management (HRM) enables employees to contribute effectively and productively to the overall company direction and the accomplishment of the organization's goals and objectives.

Tara Campbell
Human Resource Advisor

The HR Advisor deals with issues related to people such as recruitment and retention, compensation, performance management, organizational development, occupational health and safety, employee wellness, employee benefits, employee relations, communications, HR administration, and employee training and development. The HRM process at NITHA is the responsibility of the HR Advisor who is supported by the Personnel Finance Assistant.

Achievements

Collaborative Support between NITHA and the Partners occurred in the following areas:

- HR Working group meet to provide support to one another and begin initial talks to on determine HR needs within their organizations.
- NITHA works with the Partnership to reach targeted applicants by placing job advertisements of vacant positions in the Partnerships on our website and various other methods including posting on nationtalk.ca.
- The Partnership has also continued to support NITHA in having their representatives actively participate in NITHA's resume screening activities and interviews. This support has ensured that NITHA is selecting the right candidates to fill vacant positions.
- Provided support in various areas such as researching salary grids and/or drafting/editing job descriptions.
- Continued work on reviewing and revising existing Personnel Management Regulations.
- HR Strategic Planning and Recruitment – During the last fiscal year NITHA had a few employees leave the organization, after each employee vacates a position; the position is reviewed to determine if filling in the same manner is required.

ADMINISTRATIVE UNIT - "EMBRACING CHANGE"

At the beginning of April 2014, NITHA's staff consisted of total of 24 employees, with the filling of vacant positions and the creation of 5 new positions NITHA seen it staff grow to 30 employees. As of March 31, 2015 NITHA had no vacant positions and are happy to report we ended the year fully staffed.

NITHA had a total of 124 applicants apply for the following 10 positions that were filled in the 2014- 2015 fiscal year:

POSITION TITLE	DATE FILLED
1. Tuberculosis (TB) Nurse	August 2014
2. Program Administrative Assistant, CSU	August 2014
3. Reception/ Office Assistant (maternity leave)	August 2014
4. Director of Community Services	November 2014
5. Public Health Nurse	December 2014
6. Epidemiologist	December 2014
7. Tobacco Project Coordinator	January 2015
8. Environmental Health Advisor	January 2015
9. IT Help Desk Technician	February 2015
10. Mental Health & Addictions Advisor	March 2015

At NITHA, our most valuable assets are our employees, we support the enhancement of people's skills and competency, because we believe learning is a life-long process. Our training activities during the year has included job specific training, new hire orientation and training activities recommended for all staff which included the following:

- First Aid and CPR training for all staff
- Corporate Employee Orientation for new hires
- Job specific training for new hires

Employee Group Benefits and Compensation - At NITHA, HR is responsible for the administration and management of the employee group benefits plan. NITHA offers its employees group benefits, a pension plan and work-life benefits. Annually, HR reviews the plan structure for all benefits available to staff to ensure that they are current and competitive. By providing our employees with improved benefit plans we have been able to take care of the welfare and wellness of our employees and their family/dependants.

Employee Relations - The HR Advisor provides advisory services required for preventing and resolving problems involving individuals which arise out of or affect work situations. In addition Human Resources is responsible for ensuring that there is adequate flow of information between employees and management to promote a better understanding of management's goals and policies.

Information is also provided to employees to assist them in correcting poor performance, on or off duty misconduct, and/or to address personal issues that affect them in the workplace. Employees are advised about applicable benefits, regulations, legislation, and policies and their legal rights and protections.

Employment Legislation Compliance - At NITHA, we have continued to ensure compliance to employment legislation. Broadly, NITHA is governed by the employment legislation as stipulated under the Canada Labour Code, Human Rights Legislation and the Common Law.

Performance Management - At NITHA our managers, supervisors and employees work together to plan, monitor and review employees' work objectives and overall contribution to the organization. Our performance management process is a continuous process of setting objectives, assessing progress and providing on-going coaching and feedback to ensure that employees are meeting their objectives and career goals. Over the past year, the HR Advisor was able to develop a new performance management tool that simplified and reduced the amount of time spent on the administration of the performance management process.

HR Policies and Procedures - Human resource policies provide information regarding how employees are expected to behave in the workplace. These policies are written statements on standards and objectives of the organization. They contain guidelines on how employees must perform their jobs and interact with each other. Managers, employees and the HR Advisor all have roles in ensuring that HR policies are effectively executed. The HR Advisor makes it an on-going activity to review, recommend, update and interpret HR policies and procedures. We have been able to share copies of our policy statements with HR professionals in the Partnership to support their policy development activities.

Occupational Health and Safety - This is the third (3) year the Occupational Health and Safety (OH&S) Committee has operated at NITHA. This committee consists of 5 staff members and 2 Management employees that meet at least 9 times a year. This year included the annual fire inspection and an unscheduled fire drill to test our fire escape plan, which we were able to make recommendations for improvement, overall it was a success. At this time we have no outstanding OH&S concerns. NITHA has taken the lead in establishing the Occupational Health and Safety Program that includes development of an OH&S binder containing all applicable material related to First Nations organizations. Work is still ongoing to complete this binder and to share it with the Partnership.

Employee Wellness - The Wellness Committee at NITHA provides information about wellness resources and services to assist in identifying and supporting the health and well-being of staff. It is NITHA's goal to ensure that all staff maintains a healthy work-life balance.

Social Committee - the HR Advisor actively participates in the coordination of social activities for staff including Christmas parties, staff appreciation activities, staff retreat and other special events.

Challenges

The health industry continues to be plagued with the shortages in skill set; NITHA and the Partnership Organizations are no exception to this. The demand for skills needed in the health industry is yet to be met by supply creating a competition between provinces, as well as, within provincial regional health authorities for these professionals.

NITHA, the Partnership, and other health organizations continue to experience insufficient Physician services in both the northwest and the northeast districts of Northern Saskatchewan. This is putting more pressure on community nursing services and will likely lead to demand for Nurse Practitioners in the North.

The capacity development strategies of NITHA in building skills required for various health professions in Northern Saskatchewan is a "long term goal" that will facilitate First Nation people to take up jobs at NITHA and within the Partnership Organizations. NITHA has established a working group with the Partnership to engage them in identifying the major issues within their organizations as a way to begin the process of address those outstanding issues.

Priorities

- To strive to achieve and maintain a full complement of staff for continuity of business operations at NITHA.
- To research and initiate automation of Human resources processes through the establishment of a Human resource Management Information system.
- Continue engaging the HR working group with Partnership members to identify shared strategic HR goals and objectives and outstanding major HR issues.
- Capture, document, and implement successful recruitment and retention strategies.
- Maintain HR Policies and Procedures that are in compliance with legislation.
- Continue revisions to the existing Personnel Management Polices and the General Procedures Manuals.
- Promote awareness of NITHA and its Partnerships services and job opportunities.

The Northern Inter-Tribal Health Authority Leadership, Management and staff wish to thank the following former employees of the organization for their contributions to the success of NITHA and we wish them all the best in their future endeavours:

Ramona Caisse
Program Administrative Assistant, August 2014

Shirley Woods
Nurse Epidemiologist, October 2014

Michael Woodward
Mental Health & Addictions Officer, October 2014

Mohamad ElRafihi
Environmental Health Advisor, October 2014

eHEALTH ADVISOR

Program Overview

NITHA guides and supports the Partners with eHealth development. Activities include aligning eHealth systems with the various program needs (ex. Panorama and Public Health Services) and coordinating meetings with the eHealth Working Group who comprise of representatives from the NITHA Partners.

- The key priorities this year were:
- Implementing SIMS and transitioning SIMS users to PANORAMA
- Developing community based Privacy and Information Security policies
- Readying for an Electronic Medical Record (EMR) project
- Readying for an IT Helpdesk service
- Upgrading the "CommunityNet" service

Charles Bighead
eHealth Advisor

Eric Xue
Senior Network Technologist

Ali Mirzaei
IT Help Desk Technician

Achievements

Early in the year, a few more northern communities wanted to get onto the Saskatchewan Immunization Management System (SIMS) and approached NITHA for support. NITHA coordinated with the second level and was able to procure new computer equipment and organize training. During the summer the province announced it would be replacing SIMS with the new electronic public health information system called PANORAMA in the fall. NITHA identified a network of Panorama "Super Users" among the Partnership and organized training sessions as well as refresher training sessions when the PANORAMA go-live date was delayed to February 2015. Currently there are fifteen Northern First Nations communities utilizing Panorama to manage Immunizations.

Panorama Refresher Training, January 21, 2015

To support the governance requirements for PANORAMA, the province proposed an amending agreement to the Public Health Data Sharing Agreement that was signed in 2009 by NITHA and the Health Regions. NITHA was successful with ensuring First Nations ownership and control of First Nations data was maintained in the amending agreement.

NITHA facilitated a comprehensive review of a set of privacy and information security policies with the MLTC/MLFNs Privacy Working Group. The policies were customized to be applicable and appropriate for Northern First Nations while being compliant with the Health Information Protection Act (HIPA). The policies are based on the Canadian Standards Association's "ten golden principles" for privacy and were presented at a few NITHA hosted conferences.

The final version of the EMR Information Governance report was released early in the year. The report identified First Nations issues around a shared EMR system and suggested solutions for moving forward. Later in the year, NITHA began developing a guide for implementing an EMR. Source information for the guide included findings from the EMR Information Governance report and lessons learned from MLTC's and eHealth Saskatchewan's EMR experience.

The NITHA Partners were successful in acquiring funds to hire Telehealth Coordinators. NITHA provided orientation and guided the registration process for First Nations sites to become official Saskatchewan Telehealth sites. Later in the year NITHA received funding to upgrade Telehealth equipment at a few sites that did not meet the technical requirements to become an official Saskatchewan Telehealth site.

NITHA began the process of implementing an IT helpdesk by recruiting a Helpdesk technician. The goal of the IT helpdesk is to provide reliable and timely response with frontline workers' IT issues and to free up the current IT personnel so that they may focus on implementing IT systems and services.

NITHA completed upgrading the CommunityNet service to 3mb at all First Nations health facilities. The 3mb service improves the internet experience and supports high definition video conferencing for Telehealth. NITHA also purchase new "Unified Threat Management" (UTM) devices to replace aging Firewalls. A UTM provides an extra layer of security and can also support better utilization of CommunityNet by monitoring internet use and controlling access as required.

Use of the electronic Community Based Reporting Template (eCBRT) tool developed by NITHA expanded to a few more communities. The sole purpose of the eCBRT tool is to make data collection for federal reporting as easy as possible.

NITHA received approval to begin the process of installing a new phone system at the NITHA office. The new phone system will reduce telecommunications cost by a considerable amount over the long term while introducing new "unified telecommunications" features such as sending and receiving faxes and text messages from a workstation computer.

NITHA continues to support the Partners with advanced IT services as required and liaising on behalf of First Nations with eHealth Saskatchewan.

Priorities

NITHA will promote use of PANORAMA to the other Northern Communities not using the voluntary system. NITHA will first perform an evaluation with current communities on Panorama to gage the value and benefits of Panorama as well as the challenges and obstacles to implementing and supporting the system.

NITHA will develop a configuration standard for the UTMs and organize training and implementation of the UTMs with the Partner IT personnel.

NITHA will initiate a "Shared EMR" project that will involve champion First Nations sites, Northern RHAs and the Northern Doctors (NMS). The goal is to ready First Nations for a shared EMR by establishing First Nations trustees, developing data sharing agreements among trustees, build up First Nations privacy capacities, and develop an implementation and sustainability plan to be executed in the second year.

NITHA will promote adoption and standardization of the Privacy and Information security policies developed by MLTC/MLFN with the other NITHA Partners and communities. These policies will modernize First Nations privacy practices and ready First Nations for electronic health information systems like an EMR.

The IT Helpdesk service is scheduled to go live in mid-May 2015. The service will have a 1-800 number which frontline workers can call into. The Helpdesk service integrates with an IT inventory system to support problem resolution.

FNIH has announced minor changes to the CBRT that are to be applied in the 2015-2016 reporting year and are also making major changes for the 2016-2017 reporting year. NITHA will analyze the changes once they are known and develop a strategy to update the eCBRT tool as required.

NITHA will implement a new "Unified Communications" phone system for the NITHA Office. Besides modernizing the phone system and reducing operating costs, one the purposes of the new system is to be a demonstration site of this technology for the NITHA Partners and communities.

ADMINISTRATIVE UNIT - "EMBRACING CHANGE"

FINANCE MANAGER

Program Overview

Health Funding Consolidated Contribution Agreement

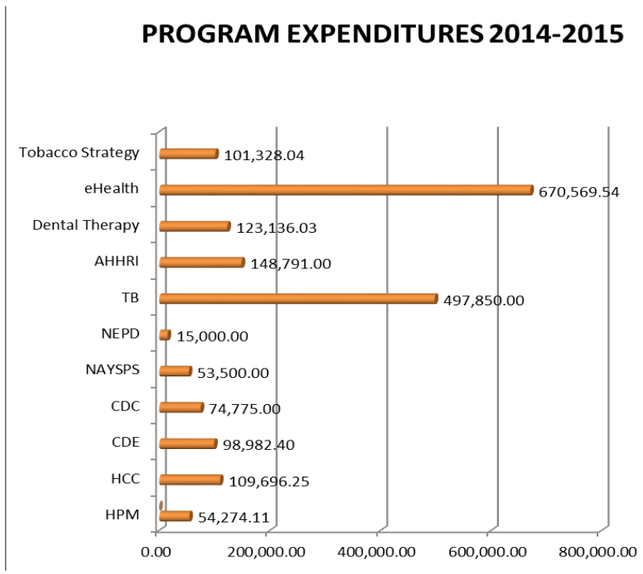
Northern Inter-Tribal Health Authority Inc. (NITHA) is reporting the first year of the new 5 year agreement with Health Canada which will expire March 31, 2019. The new agreement is a consolidated agreement containing Block, Flexible and SET funding.

Block Funding	$3,690,776
Flexible Funding	381,000
SET funding	1,383,261
TOTAL FUNDING	$5,455,037

The current year's consolidated agreement totaled $5,455,037 which supported the Public Health Unit (PHU), the Community Services Unit (CSU) and NITHA Administration as well as the programs illustrated in the chart below:

Lisa Lepine
Finance Manager

Glenna Thomas
Personnel & Finance Assistant



Current Years Events

On a quarterly basis the budgeted vs actual financial statements by program area are presented and reviewed by the NITHA Executive Council and the Board of Chiefs.

In March of 2015 a new budget for 2015-2016 fiscal year was approved by the Board of Chiefs.

NITHA received interest revenue of $40,168 which is allocated to the Scholarship Fund. NITHA distributed $20,330 in scholarships' to applicants pursuing a health career. NITHA's Board of Chiefs has approved to increase support to the students with a scholarship increase from $1,500 to $3,000 per students' academic year.

NITHA's Annual General Meeting was held on July 8th, 2014. The presentation of the audited statements and an opinion was stated by Deloitte LLP to the NITHA Executive Council and the Board of Chiefs. The opinion stated the financial statements were presented fairly, in all material respects.

NITHA tenders out the audit services every three years. Deloitte was chosen by the Board of Chiefs for another three year duration, starting in 2015 to the year 2017.

2014-2015 Financial Statements

The 2014-2015 audited financial statements unveil the financial portrait of this past year's programs and services provided to NITHA Partners and their communities. Included in the audited financial statements are:

- The auditor's opinion on the fairness of the financial statements
- Statement of Revenue, Expenditures and Fund Balances reflecting the combined revenue, expenditures and accumulated surplus
- Statement of Financial Position (Balance Sheet)
- Statement of Cash Flows
- Notes to the Financial Statements
- Detailed Schedules of Revenues and Expenditures by program

ADMINISTRATIVE UNIT - "EMBRACING CHANGE"

AUDITED FINANCIAL STATEMENTS

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

FINANCIAL STATEMENTS

March 31, 2015

Deloitte.

Deloitte LLP
5 – 77 15th Street East
Prince Albert, SK S6V 1E9
Canada

Tel: (306) 763-7411
Fax: (306) 763-0191
www.deloitte.ca

INDEPENDENT AUDITOR'S REPORT

TO THE BOARD OF DIRECTORS OF
NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

We have audited the accompanying financial statements of Northern Inter-Tribal Health Authority Inc., which comprise the statement of financial position as at March 31, 2015 and the statements of revenue, expenditures and changes in fund balances and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards for government not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of Northern Inter-Tribal Health Authority Inc. as at March 31, 2015 and the results of its operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards for government not-for-profit organizations.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Professional Accountants

August 25, 2015
Prince Albert, Saskatchewan

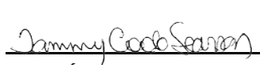
NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF REVENUE, EXPENDITURES AND CHANGE IN FUND BALANCES
year ended March 31, 2015

	Budget 2015 (unaudited)	Operating Fund (Schedule 1)	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2015**	Total 2014
REVENUE							
Health Canada	$ 5,211,558	$ 5,455,037	$ -	$ -	$ -	**$ 5,455,037**	$ 3,874,621
Northern Lights Community Development Corporation	-	-	-	-	-	**-**	104,429
Administration fees (Note 8)	105,201	177,748	-	-	-	**177,748**	131,509
Expense recoveries	3,090	8,160	-	-	-	**8,160**	17,452
Gain (loss) on sale of capital assets	-	-	-	-	24,108	**24,108**	(1,333)
Interest	43,465	-	-	40,168	-	**40,168**	50,122
Transfer (to) from deferred revenue	93,666	(224,144)	-	-	-	**(224,144)**	253,263
	5,456,980	5,416,801	-	40,168	24,108	**5,481,077**	4,430,063
EXPENDITURES							
Transfer programs and target programs	5,606,515	4,335,993	-	-	-	**4,335,993**	4,257,986
Expenses funded by appropriated surplus	-	-	670,419	20,330	-	**690,749**	660,860
Amortization of capital assets	-	-	-	-	128,006	**128,006**	158,596
	5,606,515	4,335,993	670,419	20,330	128,006	**5,154,748**	5,077,442
NET SURPLUS (DEFICIT)	$ (149,535)	1,080,808	(670,419)	19,838	(103,898)	**326,329**	(647,379)
FUND BALANCES, BEGINNING OF YEAR		(273,828)	3,450,566	469,198	299,779	**3,945,715**	4,593,094
TRANSFER TO CAPITAL FUND		(165,503)	-	-		**(165,503)**	(26,076)
TRANSFER TO APPROPRIATED SURPLUS		(570,682)	-	-	-	**(570,682)**	-
TRANSFER FROM OPERATING FUND		-	570,682	-	165,503	**736,185**	26,076
FUND BALANCES, END OF YEAR		$ 70,795	$ 3,350,829	$ 489,036	$ 361,384	**$ 4,272,044**	$ 3,945,715

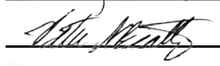
NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF FINANCIAL POSITION
as at March 31, 2015

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2015**	Total 2014
CURRENT ASSETS						
Cash and cash equivalents (bank indebtedness)	$ (472,245)	$ 3,350,829	$ 489,036	$ -	**$ 3,367,620**	$ 4,210,621
Accounts receivable	1,471,962	-	-	-	**1,471,962**	173,987
Prepaid expenses	8,591	-	-	-	**8,591**	8,637
	1,008,308	3,350,829	489,036	-	**4,848,173**	4,393,245
CAPITAL ASSETS (Note 4)	-	-	-	361,384	**361,384**	299,779
	$ 1,008,308	$ 3,350,829	$ 489,036	$ 361,384	**$ 5,209,557**	$ 4,693,024
CURRENT LIABILITIES						
Accounts payable and accrued charges	$ 619,703	$ -	$ -	$ -	**$ 619,703**	$ 653,643
Deferred revenue (Note 5)	317,810	-	-	-	**317,810**	93,666
	937,513	-	-	-	**937,513**	747,309
FUND BALANCES						
Unappropriated surplus	70,795	-	-	-	**70,795**	(273,828)
Appropriated surplus (Note 6)	-	3,350,829	-	-	**3,350,829**	3,450,566
Surplus appropriated for scholarships (Note 7)	-	-	489,036	-	**489,036**	469,198
Invested in capital assets	-	-	-	361,384	**361,384**	299,779
	70,795	3,350,829	489,036	361,384	**4,272,044**	3,945,715
	$ 1,008,308	$ 3,350,829	$ 489,036	$ 361,384	**$ 5,209,557**	$ 4,693,024

SIGNED ON BEHALF OF THE BOARD:



Chair



Board Member

ADMINISTRATIVE UNIT - "EMBRACING CHANGE"

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF CASH FLOWS
year ended March 31, 2015

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	2015	2014
CASH FLOWS FROM (USED IN) OPERATING ACTIVITIES						
Net surplus (deficit)	$ 1,080,808	$ (670,419)	$ 19,838	$ (103,898)	$ 326,329	$ (647,379)
Adjust items not affecting cash						
(Gain) Loss on sale of capital assets	-	-	-	(24,108)	(24,108)	1,333
Amortization of capital assets	-	-	-	128,006	128,006	158,596
	1,080,808	(670,419)	19,838	-	430,227	(487,450)
Changes in non-cash working capital						
Accounts receivable	(1,297,975)	-	-	-	(1,297,975)	(88,676)
Prepaid expenses	46	-	-	-	46	3,458
Accounts payable and accrued charges	(33,940)	-	-	-	(33,940)	83,405
Deferred revenue	224,144	-	-	-	224,144	(253,263)
	(26,917)	(670,419)	19,838	-	(677,498)	(742,526)
CASH FLOWS FROM (USED IN) INVESTING ACTIVITIES						
Purchase of capital assets	-	-	-	(201,391)	(201,391)	(26,076)
Proceeds from disposal of capital assets	-	-	-	35,888	35,888	-
	-	-	-	(165,503)	(165,503)	(26,076)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(26,917)	(670,419)	19,838	(165,503)	(843,001)	(768,602)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	290,857	3,450,566	469,198	-	4,210,621	4,979,223
TRANSFER TO CAPITAL FUND	(165,503)	-	-	-	(165,503)	(26,076)
TRANSFER FROM OPERATING FUND	(570,682)	-	-	165,503	(405,179)	26,076
TRANSFER FROM OPERATING FUND	-	570,682	-	-	570,682	-
CASH AND CASH EQUIVALENTS (BANK INDEBTEDNESS), END OF YEAR	$ (472,245)	$ 3,350,829	$ 489,036	$ -	$ 3,367,620	$ 4,210,621
CASH AND CASH EQUIVALENTS CONSISTS OF:						
Cash					$ 1,658,353	$ 535,155
Short-term investments					1,709,267	3,675,466
					$ 3,367,620	$ 4,210,621

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2015

1. DESCRIPTION OF BUSINESS

Northern Inter-Tribal Health Authority Inc. (the "Authority") was incorporated under the Non-Profit Corporations Act of Saskatchewan on May 8, 1998. The Authority is responsible for administering health services and programs to its members.

2. SIGNIFICANT ACCOUNTING POLICIES

These financial statements have been prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations and reflect the following significant accounting policies:

Fund Accounting

The Authority uses fund accounting procedures which result in a self-balancing set of accounts for each fund established by legal, contractual or voluntary actions. The Authority maintains the following funds:

i) The Operating Fund accounts for the Authority's administrative and program delivery activities,

ii) The Appropriated Surplus Fund accounts for funds allocated by the Board of Directors to be used for a specific purpose in the future,

iii) The Surplus Appropriated for Scholarships Fund accounts for funds allocated by the Board of Directors to be used for payment of scholarships in the future, and

iv) The Capital Fund accounts for the capital assets of the Authority, together with related financing and amortization.

Cash and Cash Equivalents (Bank Indebtedness)

Cash and cash equivalents consist of bank balances held with financial institutions and money market instruments.

Capital Assets

Capital assets purchased are recorded at cost. Amortization is recorded using the straight-line method over the estimated useful lives of the asset as follows:

Computers	3 years
Software	3 years
Equipment and furniture	5 years
Leasehold improvements	5 years
Vehicles	5 years

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Impairment of Capital Assets

When an item in capital assets no longer has any long-term service potential to the Authority, the excess of its net carrying amount over any residual value is recognized as an expense in the statement of revenue, expenses and changes in fund balances. Write-downs are not reversed.

Accumulated Sick Leave Benefit Liability

The Authority provides sick leave benefits for employees that accumulate but do not vest. The Authority recognizes sick leave benefit liability and an expense in the period in which employees render services in return for the benefits. The value of the accumulated sick leave reflects the present value of the liability of future employees' earnings.

Revenue Recognition

The Authority follows the deferral method of accounting for contributions. Restricted grants are recognized as revenue in the year in which the related expenses are incurred. Unrestricted grants are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Financial Instruments

Cash and cash equivalents, accounts receivable and accounts payable and accrued charges are classified as amortized cost. The carrying value of these financial instruments approximates their fair value due to their short term nature.

Use of Estimates

The preparation of the financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Key components of the financial statements requiring management to make estimates includes allowance for doubtful accounts, the useful lives of capital assets and accrual for accumulated sick leave. Actual results could differ from these estimates.

3. ECONOMIC DEPENDENCE

The Authority receives the major portion of its revenues pursuant to various funding agreements with the First Nations and Inuit Health Branch of Health Canada. The most significant agreement includes a 5-year health transfer agreement, which expires in March 31, 2019.

4. CAPITAL ASSETS

	Cost	Accumulated Amortization	Net Book Value 2015	Net Book Value 2014
Computers	$ 947,666	$ 887,165	**$ 60,501**	$ 72,263
Software	75,817	59,313	**16,504**	34,040
Equipment and furniture	442,342	333,405	**108,937**	84,929
Leasehold improvements	112,449	22,490	**89,959**	46,137
Vehicles	198,206	112,723	**85,483**	62,410
	$ 1,776,480	$ 1,415,096	**$ 361,384**	$ 299,779

5. DEFERRED REVENUE

	2015	2014
Dental Therapy	**$ 38,138**	$ 93,666
Tobacco Control Strategy	**279,672**	-
	$ 317,810	$ 93,666

6. APPROPRIATED SURPLUS

The Authority maintains an Appropriated Surplus Fund to fund program initiatives. Funds have been allocated within the Appropriated Surplus Fund for future expenditures as follows:

	2014 Opening Balance	Transfers	Expenses	2015 Ending Balance
Capacity development iniatives	$ 300,808	$ -	$ 54,692	**$ 246,116**
Human resources initiatives	-	50,000	7,920	**42,080**
Capital projects	832,980	(300,000)	6,817	**526,163**
E-Health solutions	300,990	300,000	300,990	**300,000**
Nursing initiatives	46,170	-	-	**46,170**
Emergency preparedness	300,000	300,000	300,000	**300,000**
Home care	-	36,086	-	**36,086**
Communicable disease emergencies	-	78,870	-	**78,870**
Special projects	10,000	-	-	**10,000**
Strategic planning and long-term planning	1,659,618	105,726	-	**1,765,344**
	$ 3,450,566	$ 570,682	$ 670,419	**$ 3,350,829**

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2015

7. SURPLUS APPROPRIATED FOR SCHOLARSHIPS

The Board of Chiefs of the Authority established a policy that any interest earned by the Authority be appropriated to fund scholarships for students entering post-secondary education in a medical field.

Beginning Balance	Interest	Expenses	**Ending Balance**
$ 469,198	$ 40,168	$ 20,330	**$ 489,036**

8. ADMINISTRATION FEES

The Authority charged the following administration fees to program activities based on funding agreements:

	Schedule	**2015**	2014
Home Care	6	**$ 9,972**	$ 6,698
Communicable Disease Emergencies	7	**9,005**	653
Communicable Disease Control	8	**6,967**	2,473
National Aboriginal Youth Suicide Prevention Strategy	9	**3,352**	5,311
Nursing Education	10	**1,046**	1,008
TB Initiative	11	**49,755**	39,655
Aboriginal Human Resource	12	**13,887**	18,735
Dental Therapy Program	13	**7,661**	-
E-Health Solutions / Panorama	14	**66,891**	50,958
Northern Engagement Session	15	**-**	6,018
Tobacco Control Strategy	16	**9,212**	-
		$ 177,748	$ 131,509

9. COMMITMENTS

The Authority occupies its office facilities on a lease agreement with Peter Ballantyne Cree Nation with annual commitment of $148,967 which expires March 31, 2020.

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2015

10. RELATED PARTY TRANSACTIONS

The Authority works as a Third Level Structure in a partnership arrangement between the Prince Albert Grand Council, the Meadow Lake Tribal Council, the Peter Ballantyne Cree Nation, and the Lac La Ronge Indian Band to support and enhance existing northern health service delivery in First Nations. The Authority made the following payments as it relates to administrative and program expenses:

	2015	2014
Prince Albert Grand Council	**$ 224,863**	$ 188,081
Meadow Lake Tribal Council	**$ 247,723**	$ 224,386
Peter Ballantyne Cree Nation	**$ 253,942**	$ 251,081
Lac La Ronge Indian Band	**$ 196,352**	$ 185,981

At March 31, 2015, there was $43,353 (2014- $113,186) of receivables and $57,166 (2014- $57,166) of payables with the Authority's partners listed above. These transactions were made in the normal course of business and have been recorded at the exchanged amounts.

11. FINANCIAL INSTRUMENTS

Credit Risk

The Authority is exposed to credit risk from the potential non-payment of accounts receivable. 99% of the accounts receivable is due from Health Canada, Meadow Lake Tribal Council and Prince Albert Grand Council.

The credit risk on cash and cash equivalent is mitigated because the counterparties are chartered banks and other institutions with high-credit-ratings assigned by national credit-rating agencies.

Interest Rate Risk

Investments of excess cash funds are short-term and bear interest at fixed rates; therefore, cash flow exposure is not significant.

Liquidity Risk

Liquidity risk is the risk of being unable to meet cash requirements or fund obligations as they become due. The Authority manages its liquidity risk by constantly monitoring forecasted and actual cash flows and financial liability maturities, and by holding cash and assets that can be readily converted into cash. As at March 31, 2015, the most significant financial liabilities are accounts payable and accrued charges.

Schedule 1

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
SUMMARY OF OPERATING FUND REVENUE, EXPENDITURES AND SURPLUS FROM PROGRAMS PRIOR TO INTERFUND TRANSFERS
year ended March 31, 2015

	Schedule	Health Canada Funding	Other Revenue	Administration Fees (Note 8)	Transfer (To) From Deferred Revenue	Total Revenue	Expenditures	**Surplus (Deficit) 2015**	Surplus (Deficit) 2014
BLOCK FUNDING									
Public Health Unit	2	$ 879,477	$ 1,102	$ -	$ -	$ 880,579	$ 796,191	**$ 84,388**	$ (62,611)
Administration	3	1,126,815	3,148	177,748	-	1,307,711	1,183,706	**124,005**	201,432
Community Services Unit	4	709,926	-	-	-	709,926	470,041	**239,885**	105,330
Health Planning & Management	5	510,000	-	-	-	510,000	54,274	**455,726**	-
Home Care	6	145,782	-	-	-	145,782	109,696	**36,086**	-
Communicable Disease Emergencies	7	175,500	2,353	-	-	177,853	98,982	**78,871**	-
Communicable Disease Control	8	74,775	-	-	-	74,775	63,778	**10,997**	18,195
NAYSPS	9	53,500	-	-	-	53,500	53,500	**-**	-
Nursing Education	10	15,000	-	-	-	15,000	15,000	**-**	-
		3,690,775	6,603	177,748	-	3,875,126	2,845,168	**1,029,958**	262,346
SET FUNDING									
TB Initiative	11	497,550	300	-	-	497,850	519,837	**(21,987)**	(123,908)
Aboriginal Human Resource	12	148,791	-	-	-	148,791	148,791	**-**	-
Dental Therapy Program	13	67,608	-		55,528	123,136	123,136	**-**	-
E-Health Solutions	14	669,313	1,257	-	-	670,570	597,733	**72,837**	-
Northern Engagement Session	15	-	-	-	-	-	-	**-**	-
		1,383,262	1,557	-	55,528	1,440,347	1,389,497	**50,850**	(123,908)
FLEXIBLE FUNDING									
Tobacco Control Strategy	16	381,000	-	-	(279,672)	101,328	101,328	-	-
TOTAL		$ 5,455,037	$ 8,160	$ 177,748	$ (224,144)	$ 5,416,801	$ 4,335,993	**$ 1,080,808**	$ 138,438

Schedule 2

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PUBLIC HEALTH UNIT
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 885,683**	**$ 879,477**	$ 730,551
Expense Recoveries	**1,030**	**1,102**	(139)
	886,713	**880,579**	730,412
EXPENDITURES			
Meetings and workshops	**6,500**	**5,876**	2,491
Personnel	**851,094**	**756,059**	741,593
Professional fees	**2,000**	**2,028**	3,507
CDC Conference	**15,500**	**-**	-
Environmental Cleaning Workshop	**1,000**	**842**	-
40 Developmental Assets	**6,308**	**30**	6,287
Program materials	**20,700**	**19,347**	22,252
Travel and vehicle	**21,500**	**12,009**	16,893
	924,602	**796,191**	793,023
SURPLUS (DEFICIT)	**$ (37,889)**	**$ 84,388**	$ (62,611)

Schedule 3

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ADMINISTRATION
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 1,151,460**	**$ 1,126,815**	$ 1,193,493
General Project Cost Recoveries (Admin Fees)	**105,201**	**177,748**	131,509
Expense recoveries	**1,030**	**3,148**	3,297
	1,257,691	**1,307,711**	1,328,299
EXPENDITURES			
Bank Charges	**3,000**	**1,949**	3,515
Equipment lease and maintenance	**39,929**	**36,041**	41,149
Facility Costs	**231,864**	**232,789**	136,552
Meetings and workshops	**159,360**	**106,754**	149,679
Personnel	**736,198**	**642,219**	603,815
Professional fees	**81,030**	**54,626**	78,104
Telephone and supplies	**103,200**	**88,810**	90,674
Travel and vehicle	**31,927**	**20,518**	23,379
	1,386,508	**1,183,706**	1,126,867
SURPLUS (DEFICIT)	**(128,817)**	**124,005**	201,432
TRANSFER TO CAPITAL FUND	**-**	**-**	(7,881)
	$ (128,817)	**$ 124,005**	$ 193,551

Schedule 4

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNITY SERVICES UNIT
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 709,926**	**$ 709,926**	$ 686,953
Expense Recoveries	**1,030**	**-**	-
	710,956	**709,926**	686,953
EXPENDITURES			
Meetings and workshops	**5,000**	**2,784**	1,335
Personnel	**520,596**	**349,770**	457,109
Professional fees	**12,360**	**12,000**	12,000
Program Costs	**163,000**	**99,082**	100,003
Program materials	**1,500**	**1,066**	1,275
Travel and vehicle	**8,500**	**5,339**	9,901
	710,956	**470,041**	581,623
SURPLUS	**$ -**	**$ 239,885**	$ 105,330

Schedule 5

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HEALTH PLANNING AND MANAGEMENT
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 510,000**	**$ 510,000**	$ -
	510,000	**510,000**	-
EXPENDITURES			
Meetings and workshops	**72,000**	**36,605**	-
Professional fees	**50,000**	**13,000**	-
Program costs	**378,000**	**-**	-
Travel and vehicle	**10,000**	**4,669**	-
	510,000	**54,274**	-
SURPLUS	**-**	**455,726**	-
TRANSFER TO APPROPRIATED SURPLUS	**-**	**(455,726)**	-
	$ -	**$ -**	**$ -**

Schedule 6

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HOME CARE
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 144,707**	**$ 145,782**	$ 73,544
	144,707	**145,782**	73,544
EXPENDITURES			
Administration fee	**14,471**	**9,972**	6,698
Meetings and workshops	**8,700**	**5,167**	1,758
Personnel	**31,500**	**27,820**	37,614
Professional fees	**10,000**	**10,000**	-
Program costs	**79,036**	**56,121**	22,334
Travel and vehicle	**1,000**	**616**	5,140
	144,707	**109,696**	73,544
SURPLUS	**-**	**36,086**	-
TRANSFER TO APPROPRIATED SURPLUS	**-**	**(36,086)**	-
	$ -	**$ -**	**$ -**

Schedule 7

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNICABLE DISEASE EMERGENCIES
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 175,500**	**$ 175,500**	$ 6,850
Other Revenue	**-**	**2,353**	-
	175,500	**177,853**	6,850
EXPENDITURES			
Administration fee	**13,550**	**9,005**	653
Personnel	**25,501**	**9,779**	914
Mask Fit Testing	**7,000**	**8,152**	5,283
IPC eLearning	**40,000**	**17,000**	-
EBOLA	**89,449**	**55,046**	-
	175,500	**98,982**	6,850
SURPLUS	**-**	**78,871**	-
TRANSFER TO APPROPRIATED SURPLUS	**-**	**(78,871)**	-
	$ -	**$ -**	**$ -**

Schedule 8

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
CDC - IMMUNIZATION
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 74,775**	**$ 74,775**	$ 60,000
	74,775	**74,775**	60,000
EXPENDITURES			
Administration fee	**7,477**	**6,967**	2,473
Equipment lease and maintenance	**14,230**	**14,032**	28,755
Personnel	**20,000**	**20,053**	-
Program costs	**13,298**	**14,120**	-
Programs materials	**8,773**	**8,606**	10,577
	63,778	**63,778**	41,805
SURPLUS	**10,997**	**10,997**	18,195
TRANSFER TO CAPITAL FUND	**(10,997)**	**(10,997)**	(18,195)
	$ -	**$ -**	**$ -**

Schedule 9

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NAYSPS
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 53,500**	**$ 53,500**	$ 53,500
	53,500	**53,500**	53,500
EXPENDITURES			
Administration fee	**5,350**	**3,352**	5,311
Program costs	**48,150**	**50,148**	48,189
	53,500	**53,500**	53,500
SURPLUS (DEFICIT)	**$ -**	**$ -**	**$ -**

Schedule 10

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING EDUCATION
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 15,000**	**$ 15,000**	$ 15,000
	15,000	**15,000**	15,000
EXPENDITURES			
Administration fee	**1,500**	**1,046**	1,008
Personnel	**12,600**	**13,753**	13,022
Program materials and supplies	**900**	**201**	970
	15,000	**15,000**	15,000
SURPLUS (DEFICIT)	**$ -**	**$ -**	**$ -**

Schedule 11

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TB INITIATIVE
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	$ **497,550**	$ **497,550**	$ 419,250
Expense Recoveries	**-**	**300**	**-**
	497,550	**497,850**	419,250
EXPENDITURES			
Administration fee	**54,888**	**49,755**	39,655
Equipment lease and maintenance	**351**	**413**	375
Facility Costs	**2,016**	**4,000**	1,650
Personnel	**420,429**	**366,682**	360,529
Professional fees	**20,000**	**8,832**	-
Program costs	**41,000**	**51,097**	73,542
Incentives	**8,000**	**6,640**	2,438
Outbreak Services	**-**	**-**	18,091
Telephone and supplies	**9,337**	**8,818**	9,317
Travel and vehicle	**47,750**	**23,600**	37,561
	603,771	**519,837**	543,158
DEFICIT	$ **(106,221)**	$ **(21,987)**	$ (123,908)

Schedule 12

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ABORIGINAL HUMAN RESOURCE
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	$ **139,791**	$ **148,791**	$ -
Other Revenue	**-**	**-**	13,754
Transfer from deferred revenue	**-**	**-**	336,929
	139,791	**148,791**	350,683
EXPENDITURES			
Administration fee	**12,703**	**13,887**	18,735
Meetings and workshops	**1,500**	**554**	3,340
Program costs	**123,088**	**133,936**	328,005
Program materials and supplies	**2,500**	**414**	603
	139,791	**148,791**	350,683
SURPLUS (DEFICIT)	$ **-**	$ **-**	$ -

Schedule 13

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
DENTAL THERAPY
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 76,608**	**$ 67,608**	$ -
Northern Lights Community Development Corp	**-**	**-**	104,429
Transfer from deferred revenue - NLCDC	**93,666**	**93,666**	-
Transfer to deferred revenue - NLCDC	**-**	**(38,138)**	(93,666)
	170,274	**123,136**	10,763
EXPENDITURES			
Administration fee	**7,661**	**7,661**	-
Equipment lease and maintenance	**30,130**	**-**	-
Facility Costs	**59,184**	**58,852**	10,763
Meetings and workshops	**9,000**	**6,143**	-
Personnel	**46,299**	**36,047**	-
Professional fees	**16,000**	**14,433**	-
Travel and vehicle	**2,000**	**-**	-
	170,274	**123,136**	10,763
SURPLUS (DEFICIT)	**$ -**	**$ -**	$ -

Schedule 14

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
E-HEALTH SOLUTIONS
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	**$ 669,313**	**$ 669,313**	$ 565,480
Other Revenue	**-**	**1,257**	540
	669,313	**670,570**	566,020
EXPENDITURES			
Administration fee	**62,836**	**66,891**	50,958
Equipment lease and maintenance	**8,560**	**8,359**	-
Personnel	**84,200**	**92,107**	97,847
Professional fees	**8,505**	**1,749**	41,100
Program costs	**430,354**	**420,585**	368,528
Materials and supplies	**-**	**4,301**	4,110
Travel and vehicle	**5,928**	**3,741**	3,477
	600,383	**597,733**	566,020
SURPLUS (DEFICIT)	**68,930**	**72,837**	-
TRANSFER TO CAPITAL FUND	**(68,930)**	**(72,837)**	-
	$ -	**$ -**	**$ -**

Schedule 15

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NORTHERN ENGAGEMENT SESSION
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	$ -	$ -	$ 70,000
	-	-	70,000
EXPENDITURES			
Administration fee	-	-	6,018
Meetings and workshops	-	-	8,782
Personnel	-	-	11,153
Travel and vehicle	-	-	44,047
	-	-	70,000
SURPLUS (DEFICIT)	$ -	$ -	$ -

Schedule 16

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TOBACCO CONTROL STRATEGY
SCHEDULE OF REVENUE AND EXPENDITIURES
year ended March 31, 2015

	Budget 2015	2015	2014
REVENUE			
Health Canada	$ 107,745	$ 381,000	$ -
Transfer from deferred revenue	-	(279,672)	-
	107,745	101,328	-
EXPENDITURES			
Administration fee	2,845	9,212	-
Meetings and workshops	1,000	748	-
Personnel	20,946	12,096	-
Program costs	76,454	76,454	-
Telephone and supplies	3,000	305	-
Travel and vehicle	3,500	2,513	-
	107,745	101,328	-
SURPLUS (DEFICIT)	$ -	$ -	$ -

Physical Address:
Chief Joseph Custer I.R. #201
Peter Ballantyne Cree Nation Office Complex
Main Floor, 2300 10th Avenue West
Prince Albert, SK. S6V 6Z1

Phone (306) 953-0670
Fax: (306) 922-0593
www.nitha.com

Mailing Address:
P.O. Box 787
Prince Albert, SK. S6V 5S4

NORTHERN INTER-TRIBAL HEALTH AUTHORITY