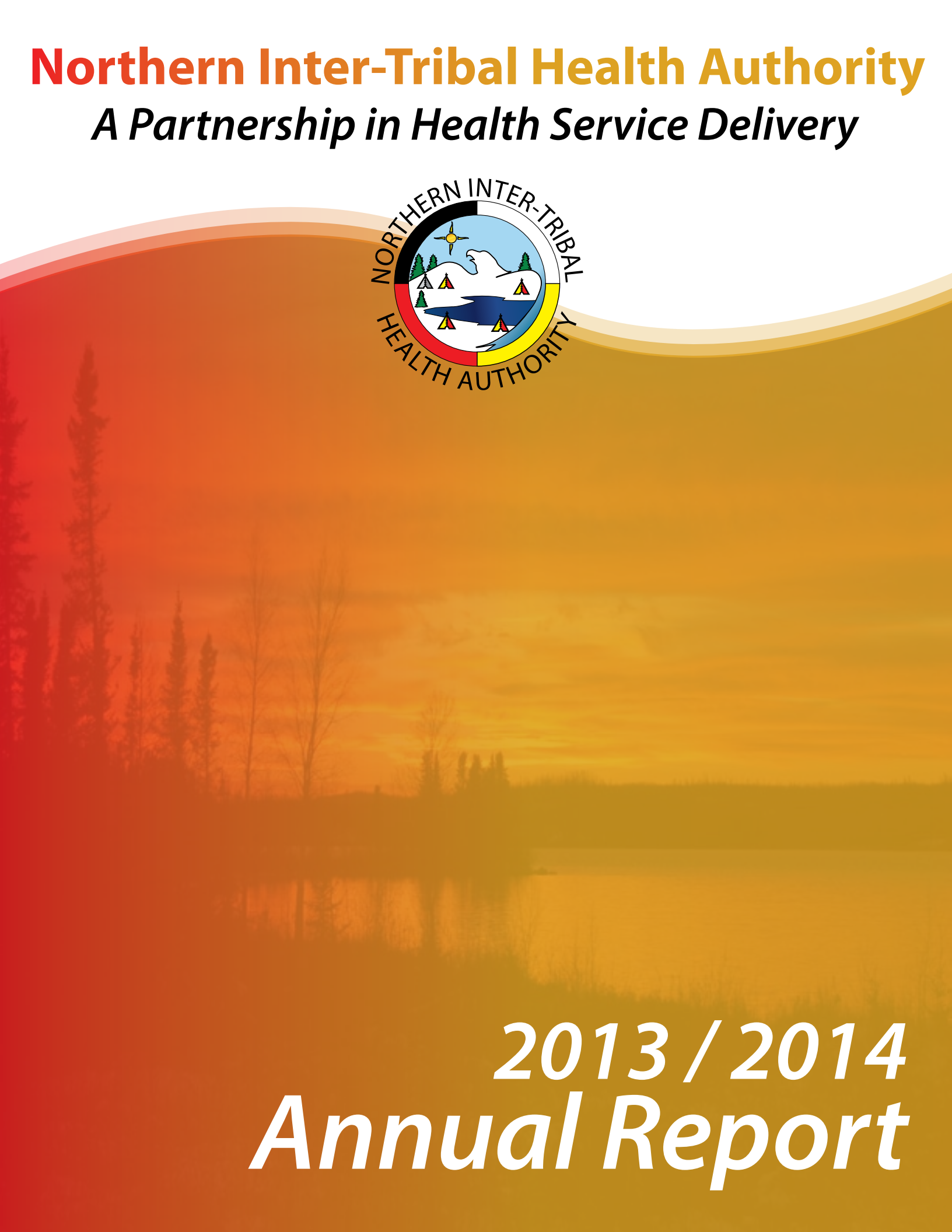
Northern Inter-Tribal Health Authority

A Partnership in Health Service Delivery



2013 / 2014 Annual Report

CONTENTS

About NITHA

Dedication to Senator John Morin p.01
Our Vision, Mission, and Principles p.02
About NITHA p.03
Services We Provide p.03
The Partnership p.04
Partnership Communities p.05
Governance p.06
Guided by our Elders p.07
Organizational Chart p.08
Message from the Chair p.09
Executive Director Address p.10
Dress for the Cause Event "NITHA Breast Buddies" p.12
Scholarship Recognition p.14

Community Services Unit

Introduction p.16
Nurse Program Advisor p.17
Capacity Development Advisor p.20
Mental Health & Addictions Advisor p.29
Emergency Response Coordinator p.32

Public Health Unit

Introduction p.35
Nurse Epidemiologist p.36
Communicable Disease Control Nurse p.42
Environmental Health Advisor p.46
Health Promotion Advisor p.50
Infection Control Advisor p.55
TB Advisor p.57

Administrative Unit

Introduction p.64
Human Resource Advisor p.64
eHealth Advisor p.68
Finance Manager p.74
Audited Financial Statements p.76

This year's report is dedicated to the memory of our dear friend

"Senator John Morin"

Elder John went home to be with the creator and join his late wife and their deceased children on January 29, 2014. Elder John Morin was a long standing participant in the Board of Chiefs and Executive Council Meetings representing Peter Ballantyne Cree Nation. John will forever be remembered for his dedication to the organization and for his belief in the NITHA Partnership and its work toward helping to improve the health and wellbeing of the residents in Northern Saskatchewan.

The following is an excerpt of a prayer provided by Elder John Morin at a Board of Chiefs Meeting.

"Thank you and good morning to each one of you, I will recite a prayer…

Pray for unity that the spirit of love which we celebrate today

Empower us to overcome our differences and to celebrate our similarities

We pray for the elders, the Chiefs and Councils and all other members of our Nations

We ask you Lord to unite us together in the spirit of cooperation and

With justice and peace, we ask this through Christ our Lord. Amen."

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 organizations 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.

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?

Third Level services are provided by NITHA to the Northern Multi-Community Bands and Tribal Councils. These services are delivered directly to Second Level Partners and include disease surveillance, communicable disease control, health status monitoring, epidemiology, specialized program support, advisory services, research, planning, education, training and technical support.

Second Level services are provided by the Northern Multi-Community Bands, Tribal Councils and in some cases a single Band to the First Level Communities. These services include program design, implementation and administration, supervision of staff at first and second level, clinical support, consultation, advice and training.

First Level services are provided in the community directly to the community members.

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

The Partnership

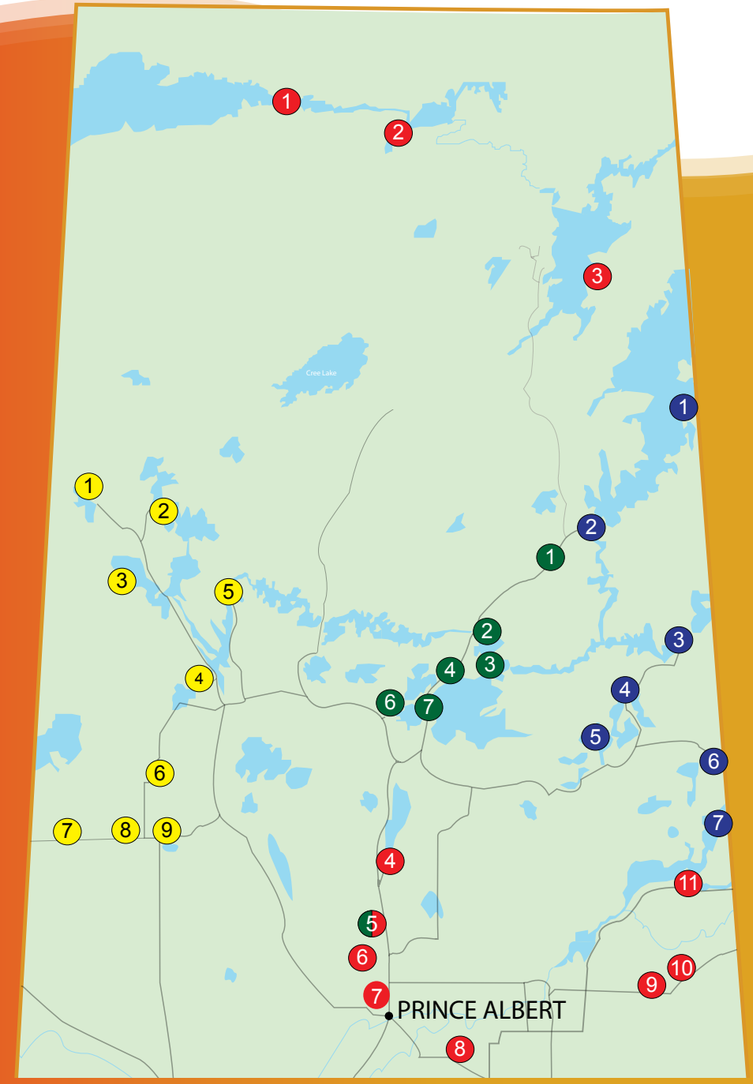
Prince Albert Grand Council
PO Box 1775
851-23rd Street West
Prince Albert, SK S6V 5T3
Phone: (306) 953-7248
Fax: (306) 764-6272
www.pagc.sk.ca

Meadow Lake Tribal Council
8002 Flying Dust Reserve
Meadow Lake, SK S9X 1T8
Phone: (306) 236-5817
Fax: (306) 236-6485
www.mltc.net

Peter Ballantyne Cree Nation
PO Box 339
2300-10th Avenue West
Prince Albert, SK S6V 5R7
Phone: (306) 953-4425
Fax: (306) 922-4979
www.peterballantyne.ca

Lac La Ronge Indian Band
PO Box 1770
La Ronge, SK S0J 1L0
Phone: (306) 425-3600
Fax: (306) 425-5520
www.llrib.ca

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

CHAIRPERSON
GRAND CHIEF
RON MICHEL
Prince Albert
Grand Council

VICE CHAIRPERSON
TRIBAL CHIEF
ERIC SYLVESTRE
Meadow Lake
Tribal Council

CHIEF
PETER A. BEATTY
Peter Ballantyne
Cree Nation

CHIEF TAMMY
COOK-SEARSON
Lac La Ronge
Indian Band

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.

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

ARNETTE WEBER-BEEDS
Peter Ballantyne
Cree Nation

SARAH WALKER-CAVANAGH
Lac La Ronge
Indian Band

Guided by Our Elders

ELDER
VITALINE READ

ELDER
GERTIE MONTGRAND

ELDER
MARYLYN MORIN

ELDER
MIKE DANIELS

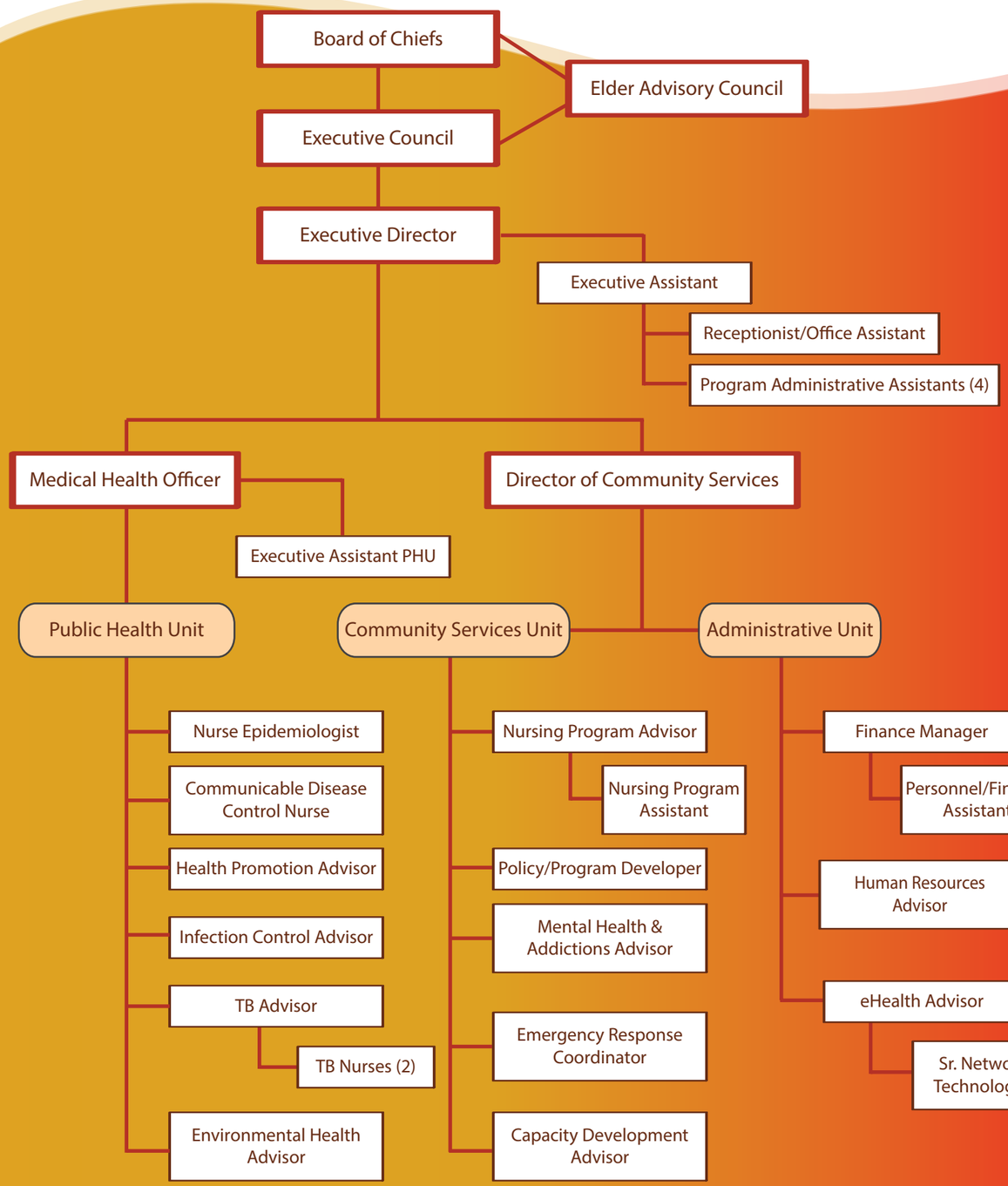
ELDER
ROSE DANIELS

ELDER
KATE HAMILTON

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



Message from the Chair

NITHA Chairperson
Grand Chief Ron Michel

As the Chairperson of the Northern Inter-Tribal Health Authority, I am honored to report on behalf of the Board of Chiefs. The past year has been a year of transition for our organization. Changes took place in the members of the leadership and the management staff. Chief Peter A. Beatty representing the Peter Ballantyne Cree Nation joined the Board of Chiefs and Health Director Sarah Walker-Cavanagh representing the Lac La Ronge Indian Band joined the Executive Council. NITHA also welcomed the following management staff, Mary Carlson as Executive Director and Dr. Nnamdi Ndubuka as Medical Health Officer and leader of the Public Health Unit. These changes were embraced and with that, NITHA experienced a successful and rewarding year. The management team completed the 5 year Community Health Plan which played a key role in securing the 5 year Transfer Agreement 2014-19.

The NITHA Partnership worked towards improving programs and services for our Northern members and we will continue to work towards that in the coming year. The people in the communities and improving their health are what is at the forefront of our minds. Despite how important it was to secure funding for 5 years, it is still apparent that NITHA and the Partner Organizations are not receiving adequate resources to deliver the programs and services needed in our communities. This past year we addressed the funding concerns with the Federal Government and will continue to do so. It is important to note that over the past year, some positive movement has been seen in supporting First Nations Self Governance, however; with that must come adequate funds in order for us to be successful.

This past year also marked a time of sadness for us as we lay to rest our dear and my personal friend and long- time Elder of the Northern Inter-Tribal Health Authority Inc., and Peter Ballantyne Cree Nation, Senator John Morin. This years' report is dedicated to Elder John's memory and to the support he provided the organizations over the years. Elder John believed in the NITHA Partnership and the important work we do to help our community members to improve their health and the health of generations to come. With that, I am pleased to present to you the 2013-14 Annual Report.

Respectfully Submitted,

Grand Chief Ron Michel
NITHA Chairperson

Executive Director Address

This annual report represents the Northern Inter-tribal Health Authorities activities and results for the fiscal year ending March 31, 2014. 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 2013-2014 fiscal year was my 1st year as the Executive Director and proved to be exciting and rewarding. We were successful in completing and submitting the 5 year Community Health Plan to First Nations and Inuit Health Branch; the plan was approved and has provided us with a 5 year funding agreement from 2014-19. The plan lays the foundation for the development of annual work plans of the staff within the organization. The work plans for the 2014-15 fiscal year have been developed and will be implemented in the coming year.

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 2013-14 fiscal year are as follows:

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

The assigned proxy for each meeting for the 2013-14 fiscal year were as follows:

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

The council of Elders for each meeting for the 2013-14 fiscal year were as follows:

- Elder Mike Daniels, PAGC
- Elder Vitaline Read, MLTC
- Late Senator John Morin, PBCN
- Elder Kate Hamilton, LLRIB

It was with great sadness that we laid to rest Senator John Morin, PBCN. Senator Morin was a true strength of and leader to our organization. His presence and contributions are dearly missed.

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. The Executive Council meets on a quarterly basis; the Executive Council for the 2013-14 fiscal year were as follows:

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

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.

PRIORITIES

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

- Developing a political advocacy strategy for transfer sustainability.
- Defining our 3rd level role with our Partners and our funders
- Developing a comprehensive analysis of the shortfalls in NIHB program
- Developing a comprehensive communication plan for the organization, and
- Rejuvenating the School of Dental Therapy.

Respectfully Submitted,

Mary Carlson
Executive Director

Executive Director
Mary Carlson

Executive Assistant
Heather Gunville

Heather provides administrative support to the Board of Chiefs, Executive Council, Elders and the Executive Director. She also provides supervision and leadership to some members in the office support team.

Dress for the Cause Event "NITHA BREAST BUDDIES"

The Northern Inter-Tribal Health Authority staff joined together to form a team entitled "NITHA Breast Buddies" to raise money for Breast Cancer Research. Because everyone has or knows someone who has been impacted by Breast cancer, we felt it was important to support this initiative. We also believe that by taking part we not only raised funds, we raised awareness. Through promotion and education we made significant contributions to those who may not have considered early detection otherwise. NITHA held a total of 3 events, a 50/50 Raffle, a Pancake Breakfast and a Prize Draw which generated a total of $2027.81.

NITHA Breast Buddies thanks the following organizations/businesses for their generous donations and support and to those who attended the events:

- Action Printing Company Ltd.
- Advantage Credit Union
- Amy's On Second
- Best Western (Marquis Inn)
- Burkett's Flowers Ltd.
- Canadian Tire
- Carlton Honda
- Carlton's Bakery & Coffee Shop
- CIBC
- Crescent Heights Pharmacy
- D & L Gourmet Meats Inc.
- Days Inn
- Deloitte
- Diamond North Credit Union
- Dr. Java's Coffee House
- Family Foods (IGA)
- Four Seasons Cleaning Ltd
- Frank Dunn Toyota
- Fresh Air Experience
- Giant Tiger Stores Limited
- Good Life Fitness
- Home Building Centre
- Iceberg Pure Water
- KFC
- Lac La Ronge Indian Band
- Lakeland Ford
- Lone Wolf Catering
- Mann-Northway Auto Source
- Meadow Lake Tribal Council
- Missinnippi Broadcasting Corporation
- North Star Trophies
- Northern Inter-Tribal Health Authority Inc.
- PA Software
- Prince Albert Grand Council
- PAGC Tribune
- Peter Ballantyne Cree Nation
- PBCN Fuel & Convenience Store
- Prince Albert Alarm Systems Lt
- Prince Albert Inn
- Riverside Dodge Chrysler Jeep
- Safeway
- Scentiment's Floral Ltd
- Shananigan's Coffee & Dessert Bar
- Shelly's Hair Repair
- Sobeys
- Superstore
- Take 10 Fitness
- Tim Horton's
- Travelodge Prince Albert
- Unitech Office Solutions Ltd
- Val's Floral Boutique

Congratulations to our 2013 Scholarship Recipients

Back Left to Right: Arnold Naytowhow, Montreal Lake; Grand Chief Ron Michel, PAGC; Councillor Leon Charles, LLRIB; Vice Chief Dwayne Lasas, MLTC; Chief Peter A. Beatty, PBCN;

Front Left to Right: Vice Chief Simon Jobb, PBCN; Karmen Naytowhow, (Scholarship Recipient) Chief Tammy Cook-Searson, LLRIB; Colleen D. Burns (Scholarship Recipient); Jolene Hanson (Scholarship Recipient).

A total of 21 applications for the NITHA Scholarship were received in 2013, 16 of those applicants were successful in meeting the requirements and were awarded a Scholarship. Congratulations to the recipients and all the best to each of them as they continue to move forward in reaching their goals.

1. Colleen D. Burns-PAGC- James Smith-2nd year at SIAST Licensed Practical Nursing - Academic
2. Carlene Custer-PBCN-Pelican Narrows-4th year Nursing Education Program of Saskatchewan (NEPS) - Academic
3. Colleen Daniels-PAGC-Hatchet Lake/Wollaston-2nd year Bachelor of Science/Kinesiology at University of Saskatchewan - Effort
4. Shay-Anne Daniels-PAGC-Hatchet Lake/Wollaston-2nd year College of Medicine at the University of Saskatchewan - Academic
5. Jolene Hanson-MLTC-Buffalo Narrows-4th year Bachelor of Science in Nursing at the University of Saskatchewan - Academic
6. Jessica Hueser-LLRIB-Lac La Ronge-2nd year Doctor of Naturpathic Medicine at Boucher Institute of Naturopathic Medicine - Academic
7. Kendra Lee McKay-PAGC-James Smith-1st year Master of Nursing - Academic
8. Aaron McKenzie-LLRIB-Grandmother's Bay-2nd year Bachelor of Nursing - Academic
9. Sally McLeod-LLRIB-Grandmother's Bay-2nd year Bachelor of Nursing - Effort
10. Patricia McNamara-PAGC-Sturgeon Lake-2nd year Diagnostic Medical Sonography - Academic
11. Cora Mirasty-Lac La Ronge Indian Band-2nd year in Doctor of Medicine - Effort
12. Jerline Morin-PBCN-Pelican Narrows-2nd year Bachelor of Nursing - Effort
13. Karmen Naytowhow-Bird-PAGC-Montreal Lake-2nd year Bachelor of Science in Nursing - Effort
14. Alan Kirsten Ross-PAGC-Red Earth-2nd year Bachelor of Nursing - Effort
15. Brayden Sauve-PAGC-James Smith-5th year of Medicine at Medical University of America. - Academic
16. Shaona McKenzie-LLRIB- Stanley Mission- 2nd year Bachelor of Nursing - Effort

Community Services Unit

Program Administrative Assistant
Ramona Caisse

Ramona provides administrative support to the staff in the Community Services Unit and is a member of the office support team.

Program Overview

The Community Services Unit provides support and knowledge sharing in areas of homecare, primary care and community health nursing, as well as capacity, development, mental health & addictions and emergency preparedness.

The unit staff provides support through:

1. program/policy development,
2. data stat collection and analysis,
3. developing tools and best practice,
4. research and analysis,
5. engaging the Partnership,
6. training; and
7. informing the Partnership on new/changing communication and trends.

The preceding list is the 7 Pillars which is the basis for the 5 year strategic plan and all NITHA Workplans and provides a guide for focusing on First Nations culturally appropriate and sensitive service delivery.

The unit staff engages the Partnership through coordinated working group meetings held quarterly. These meetings provide an opportunity for engaging the partner staff on issues affecting their organizations and provide direction to the NITHA staff on how to assist them in resolving those issues.

NURSE PROGRAM ADVISOR

Nurse Program Advisor
Fay Michayluk

Program Overview

The Nursing Program Advisor during the past year has played a major role in the activities associated with formalizing ***a process to deal with the Transfer of Medical Function, 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 the NITHA Nurse Managers and Saskatchewan Registered Nurses Association (SRNA) NITHA has been and will continue to be very involved as the SRNA implements the Bylaw changes. Ongoing development of the Educational Program and the Prior Learning Assessment Reviews as it relates to the development of the RN with Additional Authorized Practice 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 must aim for a seamless transition from the Transfer of Medical Function to the RN with Additional Authorized Practice and thus continue to provide safe accessible and quality nursing care for those living in the north.

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 model. 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. Working closely with the Partner Organizations the Nursing Program Advisor will focus on the completion of an environmental scan, a needs assessment and feasibility study and these activities will be of high priority in the 2014 – 15 work plan.

Achievements

The Orientation Skills Training occurs three to four times a year and is determined by the numbers of new nursing hires. In 2013 the following sessions were held:

- June 2013 – 8 participants
- July 2013 – 7 participants
- December 2013 – 7 participants
- March 2014 – 7 participants

The program consists of two segments, the one week skills training which is 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 recommends signature by the physician. 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 has been reviewed by chart audit and skills review.

Several nurses employed by NITHA Partner organizations and communities have completed chart audits and skill reviews to update their plans for the Prior Learning Assessment Review.

The preceptor and mentorship of new nurses and nurses requiring updates is arranged by the individual NITHA Partner Organizations. NITHA reimburses the Partner Organizations for the preceptor and mentorship. Thus NITHA funds the entire OST program on behalf of the Partner Organizations.

NITHA contracts a physician, Dr. Leo Lanoie, who has worked with the organization for many years; Dr. Lanoie continues to provide medical reviews and clinical support for nurses in the field.

Currently all teaching materials have been reviewed, revised and updated to meet best practice guidelines.

Accomplishments

NITHA Working Groups:

NITHA Nurse Managers – monthly teleconferences, four face to face meetings
NITHA Home Care Managers – held four teleconferences, three face to face meetings.

Home Care Working Group Involvement: work involves planning, policy development, policy review and procedure review at the Regional level and in collaboration with NITHA Partner Organizations. Review and input into the FNIHB work plan

- FSIN Home Care Working Group (HCWG) meetings held quarterly
- HCWG subcommittees on Palliative Care End of Life Care, HIV and Blood Borne Infections, chronic disease, development of a new Home Health Aid Manual, planning committee for the FSIN HCWG Home Health Aid Conference and HCWG Discharge Planning kit review

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.

Other Committee involvement:

SASK MOU of UNDERSTANDING ON FIRST NATIONS HEALTH AND WELL BEING – the Common Table on Continuing Care – 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. This committee is chaired by FNIHB. There have been three meetings held, the last being October 2013.

FNIHB FALL NURSING CONFERENCE PLANNING COMMITTEE – committee member involved in selection of educational sessions and selection of presenters.

NITHA External Committees:

- Provincial Committee on Lower Extremity Wound Management Pathway Development
- Provincial Screening Committee on Colorectal Cancer

Quality Improvement and Risk Management provides an opportunity for continuous learning using formal steps to make improvements. Focusing on improved client care in the delivery of all aspects of nursing care, Quality Improvement seeks to meet clients' needs by using a structured process to identify and improve all aspects of care and service.

Attended the introduction and training in Quality Improvement and Risk Management, November 2013. NITHA plans to provide an introductory session for Health Directors, Nursing Managers and Community Leaders in June 2014.

NITHA Home Health Aid Training held on December 3 – 5, 2013 for 33 Participants. Presentations included important issues determined by the NITHA Home Care Nurse Managers.

NITHA Nursing Leadership Training – "Legal Issues in Nursing" March 2014 – 35 Participants included Nurse Managers representing all areas of nursing service delivery.

Priorities

1. Collaborative Team meetings initiated with the first occurring June 11, 2014. Dates have been established for future meetings in 2014 -15. The meetings provide a forum for sharing ideas, program reviews and developments, plans for education opportunities and training needs for all groups.
2. Continue to support the Orientation Skills Training 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.
3. 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.
4. Initiate discussions, identify needs and develop a plan to address the long term and special care needs within NITHA Partner organizations.
5. Community Health Nursing Program Review /Orientation- develop and ensure the delivery of this program twice in 2014 – 15, to provide a training opportunity for Community Health Nurses.
6. Home Care Nursing Program Review / Orientation- develop and ensure delivery of this program twice in 2014 – 15, to provide an opportunity for Home Care Nurses a refresher.
7. Home Health Aid Training, the training will be planned with the input from Home Care Nurse Managers and information gathered from the evaluations from the 2013 sessions.
8. Completion of an environmental scan, a needs assessment and feasibility study to address the continuing care needs of the NITHA Partners and provide a summary of options for long term care, special care needs, palliative care and respite care.

CAPACITY DEVELOPMENT ADVISOR

Program Overview

Capacity Development Advisor
Linda Nosbush

The goal in the capacity development portfolio is to provide opportunities for First Nations People to engage in certified training in health careers without having to leave their Communities for extensive periods of time. This involves building the internal capacity in First Nations communities rather than importing expertise from outside.

In order to make this happen, barriers to access were addressed, and innovative program delivery models were explored through the use of the latest technology.

Priorities

The strategic priorities for 2013-14 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 managing the implementation of AHHRI (The Aboriginal Health Human Resource Initiative) through working collaboratively with the NITHA Partners, Post-Secondary Institutions, and the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS). The focus was on certified programs that will lead to national credentials in these priority areas:

- Mental Health and Addictions
- Health Directors/Coordinators/Managers
- Practical Nurses and Nurses

Cultural Competence training materials that could be integrated into all these training programs as well as be utilized with existing staff to create culturally safe environments for all our community members was also a focus this year.

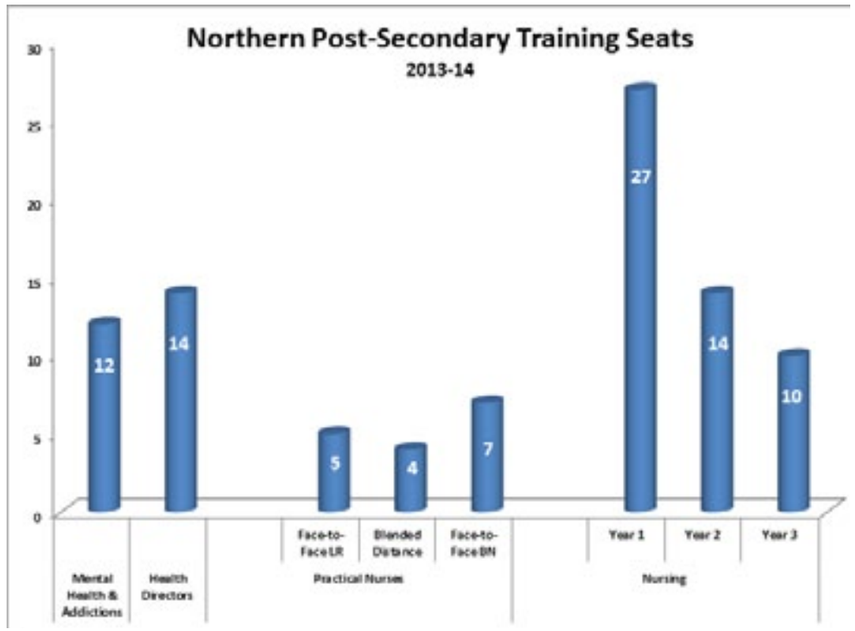
Achievements

There have been a number of exciting achievements in professional training this year. While it is true that Blended Distance Programs can be more costly, we were able to discern this year from our program and financial records that for every dollar invested there is at least a fifteen dollar return on that investment. Not only are we building internal capacity in our communities we are also achieving returns on investment individually, collectively, and financially.

Professional Programs Leading to Certification

The past year has been very productive for the joint ventures of the NITHA AHHRI Partners and the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS); 93 students were involved in post-secondary programs, an increase of 13 students from last year. This work is facilitated by the Capacity Development Advisor on behalf of NITHA and is enhanced by her credentials including certification as a Professional Trainer with the Canadian Professional Trainers Association.

We continue to use the Thompson (2012) Health Human Resource Report to guide our efforts as well as the ongoing input of the NITHA Executive Council and the Northern Labour Market Health Sector Training Subcommittee which includes employers (provincial and First Nations), government (provincial and federal), post-secondary training institutions, professional associations, and other funders.



Health Directors/Managers/Coordinators - 14 Health Directors/Coordinators are in the Certified Health Director/Manager Program through the Canadian First Nations Health Managers Association (FNHMA). The courses are based on the National DACUM which reflects the NITHA DACUM with the exception of an additional core set of competencies in Community Development within NITHA's Framework. Present students will:

- Complete their requirements by the end of June, taking just 20 months to complete these five courses
- While maintaining full time employment, and;
- Write their comprehensive exam in the early summer.

This program is delivered in the Intensive Format which means that students receive a binder of readings to complete before the intensive week-long meeting, complete several assignments during this week and finish one major assignment within a month of the meeting.

In the March Face-to-Face, FNHMA brought a film team from Ottawa and interviewed all the students, our Executive Director, Elder Mike Daniels, and myself to develop a promotional video for this National Training and Certification Program. FNHMA's Executive Director, Marion Crowe, has this to say about our students:

> *I am so proud to have this group complete their studies and attain their designation in a collective. Their perseverance and dedication to obtaining this achievement has been a journey that FNHMA has been honoured to share with them. As the first in Canada to obtain their certification by completing the program outside the Prior Learning Assessment and Recognition Program, FNHMA has been able to use their feedback to ensure that our program is reflective of the grassroots health managers' needs and in fulfilling FNHMA's mission which is to provide leadership in health management activities by developing and promoting quality standards, practices, research, certification and professional development to expand capacity for members and First Nations.*
>
> *NITHA continues to set the bar in the delivery of quality health services high, and this investment in their Health Managers is a fine example of their commitment.*

Mental Health and Addictions - Twelve students completed five courses in their 26-course program this academic year (ending June 30, 2014). They will have completed half this new integrated *Mental Health and Addictions Worker Certificate Program* through SIAST by the end of June 2014 and will also have attained Level II of the *Community Development Certification*.

This program employs a blended distance delivery model and, is called 'upskilling' since all students work full time and attend class part time. They meet in Prince Albert for an Intensive Week of Instruction at the beginning of each term (May and September, 2013; January, March, and June, 2014) and then meet online with their instructor once per week for three hours.

The 12 students in the *Mental and Addictions Certificate Worker* Program

Program Head and Instructor for the students described the students this way:

> *NITHA students have not only completed the readings and assignments, they have shown keen interest in applying what they are learning to their work environments. Furthermore, they have been willing to do the personal work on their own healing journeys so that they can be of assistance to others in a professional role.*

This training will provide National Certification through CACCF (Canadian Addiction Counsellors Certification Federation) and could also lead to international certification should students so desire. Anticipated completion date is December 2016.

Practical Nursing (LPN)

The Practical Nursing Program was the first Blended Distance offering through the NLMHSTS and NITHA Partnership and was piloted in three PBCN communities from 2007-2009.

NITHA Capacity Development Advisor's role is to work with SIAST to ensure that:

- Students have the supports that they require, such as mentors and tutors;
- To fund the technology, along with SIAST, that ensures LPNs operate at the cutting edge of accessing evidence-based information from electronic mobile devices upon graduation; and
- Materials and teaching processes are sensitive to First Nations ways of learning and interacting with the environment. For example, Sociology courses pose some difficulty for students because they are largely presented as theories; as a result of our interaction with SIAST, Instructors are becoming more open to introducing these theories through story which not only makes them easier for students to engage with the content but also enhances their memory of it.

Today, Practical Nursing is offered in the North in both face-to-face and blended distance delivery systems. This past year the following cohort groups have been involved in the LPN Program:

- **Face-to-Face**
  - La Ronge - 5 students finished June 30, 2013 and wrote their National Licensing Exam in May and had their Pinning Ceremony upon completion of the Program;
  - Buffalo Narrows - 7 students began a new program in October 2013; 4 of the students are NITHA Partnership members;
- **Blended Distance** - 4 students finished in December 2013 and wrote their National Licensing Exam on January 8, 2014 and had their Pinning Ceremony on January 9, 2014.

There are now 24 graduates from Northern Practical Nursing Programs and all of them are living and working in the North. This year the SIAST Program Head, Karen Ullyott, reported that she'd received the best clinical evaluation ever for one of our Blended Distance students and had this to say:

> *I value the partnership with Northlands College and the Northern Inter-tribal Health Authority. The educational partners provide knowledge of the resources available in the students' home communities and allow the program to capitalize on existing strengths. They are constantly searching for ways to support student learning.*
>
> *I admire the students for their resilience in completing a demanding educational program. While much of the learning takes place in their home community, they travelled to other communities to participate in clinical and simulated lab experiences. This meant leaving their families and other supports to participate in these learning experiences.*

Pinning Ceremony for Blended Distance Students in January 2014. Top Centre and clockwise: Justina Lemaigre, Verdeen Cook, Anita Ballantyne and Shirley Morin.

Buffalo Narrows Cohort with the Dean of Nursing, Woodland Campus Program Head, Instructor and myself in October 2013

Nursing (RN)

The new Distributed Learning BSN was initiated in 2011-12 and utilizes Remote Presence Technology. Instructors operate from the College of Nursing at the University of Saskatchewan in Saskatoon and students have a lab instructor in each of the two sites where the program is offered (La Ronge and Ile a la Crosse). This year the following students are enrolled:

- 27 students in Year 1 in La Ronge - Northlands and NORTEP; Creighton; Buffalo Narrows; and Ile a la Crosse
- 14 students in Year 2; 4 in Ile a la Crosse and 10 in La Ronge
- 10 students in Year 3; 4 in Ile a la Crosse and 6 in La Ronge

The Program is offered through the University of Saskatchewan and is utilizing Remote Presence Technology as part of the instructional methodology in order to provide more 'hands-on' meaningful learning under the supervision of university instructors. The students in La Ronge named their robot "Robo Gale" and those in Ile a la Crosse named theirs "IleXPERT."

PBCN has recently purchased their own robot (picture on the left), the Intouch RP-7 Robot (in the middle), to support their clinical work with physicians through remote presence technology. Students from La Ronge pose with their robot on the far right lower picture and above them Pat Blais, the Lab Instructor in Ile a la Crosse poses with the robot and patient model "SimMan" that is a piece of technology for patient simulation and clinical practice also used in the Nursing Program.

The NITHA Capacity Development Advisor's role in the Nursing Program is to work with the College of Nursing to:

- Ensure that First Nations students ways of learning and knowing are honoured;
- Provide assistance in the development of an Evaluation Framework for each year of the program and for the full program;
- Provide feedback and work with them to optimize the Remote Presence Technology; and
- To learn from them about Remote Presence Technology. In fact, this willingness to learn from them has resulted in their offering use of the technology for our other training programs when they are not using it; and
- Help them apply what we've learned through our other Northern training programs to the new nursing degree program.

Comprehensive Evaluation of Certified Training Programs

As required by the AHHRI Federal Program which partially funds our post-secondary certified training programs, NITHA is required to do a comprehensive evaluation. To that end, NITHA through an RFP process chose Laurence Thompson Strategic Consulting to do this work. Laurie began work in January with in-person and phone interviews of students, former students, employers, post-secondary institutions and NITHA Leadership. The report will be ready by the end of June. The evaluation and recommendations included will help us to plan for the future.

Dental Therapy

The National School of Dental Therapy closed in 2011. Since then the Partnership has become increasingly aware of the need for oral health services in the North and the impact on oral and general health if preventive and restorative services are not provided in an ongoing way from six months of age onward. Under leadership of our Executive Director, a Working Committee has been established to:

1. To describe the oral health team and its team of professionals and propose how they might work 'in concert' in new and creative ways to respond to the needs of Northern and remote populations in Saskatchewan using a population health model;
2. To propose a training model that is responsive to the needs of Northern and remote peoples, particularly First Nations. This program needs to be:
   - Northern-based
   - Acquire national accreditation
   - Enable laddering to and from other oral health programs in the province
   - Have a Cultural Competence Component
   - Utilize Remote Access Technology
   - Have the College of Dentistry, University of Saskatchewan hold the Affiliation Agreement
   - Be linked with other Oral Health Programs in the Province
   - Develop an Action Plan that sacrifices neither integrity nor credibility in an expedited time frame
3. To propose a solution that creates ongoing opportunity for 'upskilling' and 'knowledge exchange' in ways that capitalize on the latest remote presence technologies in our Northern Distributed Learning Registered Nursing Program;
4. To develop a training program that enables laddering and possible credit for continuing education hours;
5. To discern a model for interprofessional collaboration. There has been dialogue and a willingness to work more collaboratively with the Northern Medical Services Program and with the College of Nursing at the University of Saskatchewan.

The Capacity Development Advisor is a member of this committee and as her contribution to the work has developed an extensive literature review has been undertaken that summarizes international, national, and Northern work. It also includes a detailed description of the Oral Health Workforce in Saskatchewan as well as integrates the recommendations of the Canadian Academy of Health Science Report on *Improving Access to Oral Health Care for Vulnerable People Living in Canada* (2014), and the *Reducing Renal Disease* Federal, Provincial and Territorial Framework for Action to Improve Oral Health (2012). She has also examined the demographics of the oral health workforce, particularly Dental Therapists and Dentists in relation to the population of the North. Furthermore, this report included a presentation of a variety of training models with some recommendations for the Working Committee to consider.

Career Ladders

The development of Career Ladders enables students to continue to build their professional competence across their careers. The following has been accomplished with Career Ladders this year:

- **The Mental Health and Addictions Studies Career Path** has developed across five post-secondary institutions, is an example of how one might build a career path from the Prep level to the Post Graduate Diploma level. This year the new courses in the Certificate Program were developed and the Diploma course development is now underway. FNUC/University of Regina are developing the Holistic Health and Healing Degree and discussions are beginning with the School of Public Health for a Post Graduate Diploma at the University of Saskatchewan
- This year a Career Ladder was developed with the Associate Dean of Research & Graduate Programs, and Director of the Kenneth Levene Graduate School of Business, Faculty of Business Administration at the University of Regina, that will enable those with at least 30 undergraduate credits to begin a three-course **Master's Certificate in Organizational Leadership**. The first course in this program, newly developed for our needs, will be offered in the fall of 2014 and is entitled *Leadership and Management in an Indigenous Context*. It was developed by Eber Hampton and the late Larry Sanders from the University of Regina and is an outgrowth of the joint research project *Seeking Models of Aboriginal Health Human Resources* with NITHA and The Indigenous Peoples' Health Research Centre at the University of Regina as lead partners and SAHO and FNIH as supporting partners which was completed in 2010. This three-course Master's Certificate will ladder into a Master's Degree and will count for 3 of the 10 courses required.

This marks the first time that the FNHMA has been awarded academic credit for its new program in Canada. In addition, this Master's Certificate in Organizational Leadership is open to other employees who have at least 30 undergraduate credits which will enable a larger NITHA Cohort to attain graduate level background.

For those students who either do not want to pursue graduate studies or who require more undergraduate credits, plans are almost complete for a 12-15 credit **Specialist Certificate** through SIAST's Business, and Health and Science Deans and their departments.

Major Documents Developed

- Find Hope, Live Promise and Echo the Future - A critical reflection of the AHHRI work from April 1 2012 - December 31, 2013, 214 pages.
- Considering Responses to Oral Health Needs in Northern Saskatchewan, developed to support our work to re-establish a Dental Therapy Program, 54 pages.

Major Presentations and Events

While many presentations occur during a year, some have the potential for greater impact; they are described below.

Invited presentations to the **Memorandum of Understanding Working Group** (FSIN, Federal and Provincial Government) in Saskatoon, the **FSIN Home Care Working Group** in Prince Albert, helped me make those groups working in Saskatchewan aware of the NITHA initiatives. Ongoing work with the College of Nursing is helping to fashion the new Distributed Learning Nursing Degree in the North and ensure that its evaluation schemes reflect the needs of NITHA Partnership students.

Travel to Communities in early October to meet with students in their home communities and to talk about their training programs was a very meaningful process for students. They could express their needs more readily in their home contexts and workplaces and have come to understand how much NITHA values the work students are doing.

An invited presentation at the **AHHRI National Knowledge Exchange** in Calgary at the end of October provided an opportunity to share outcomes, knowledge gained, and future plans at this National gathering of FNIH and AHHRI sites across Canada.

The inaugural **Northern Health Career Forum** on January 14, 2014 was streamed live to over 50 high school and post-secondary Guidance Counsellors across Northern Saskatchewan and included 24 presenters and several participants in the NITHA Boardroom. The Northern Labour Market, Careers Subcommittee invited NITHA to develop and deliver this forum. We worked with KCDC (Keewatin Career Development Corporation in La Ronge). This inaugural Forum was organized to provide an opportunity for counsellors to learn about the Health Career Opportunities available in Northern Saskatchewan. The day opened with Prayer by Elder Mike Daniels, a message from our Medical Health Officer Dr. Nnamdi Ndubuka, greetings from Northlands College, an overview of the training programs and outcomes to date by myself, and was followed by presentations by faculty in Mental Health and Addictions (SIAST), Practical Nursing (SIAST), Health Director Training (First Nations Health Managers Association in Ottawa), and Nursing (University of Saskatchewan). A brief presentation on Career Laddering by the Capacity Development Advisor was followed by a Panel Discussion that included Elders, Employers, Employees (former students) and present students. Questions were emailed in and answered throughout the day. Elders Mike and Rose Daniels ended the day with a Thanksgiving Prayer.

Ongoing work with the **Northern Labour Market Health Sector Training Subcommittee** is very productive. This committee comprises many partners, including employers (both First Nations and Regional Health Authorities), government (Federal and Provincial), post-secondary training institutions and funders. At each meeting, the Capacity Development Advisor provides an update on the training in the region and other major developments in these programs. The mandate of this committee is:

- Determine and to assess employment and training needs of the health sector in Northern Saskatchewan; and
- Development and to oversee the implementation of a long-term training strategy to train Northerners for a range of occupations in the Northern Health Sector.

An invited presentation at the **International Remote Presence Technology Forum** in March at University of Saskatchewan with Charles Bighead entitled *Adopting Technology in Remote & First Nations Health Services* enabled us to interact with participants from Russia, the Philippines, Great Britain, the United States (Alaska, Ohio, and California) and Canada. This invitational conference was small and therefore provided an invaluable opportunity for knowledge exchange and dialogue.

Cultural Competence

In order to help students and staff develop cultural competence, that is, the ability to provide culturally safe care for their clients.

- **Cultural Competence** is a process that involves the health care provider actively developing their knowledge and skills specific to client/client population's culture and world view (IPAC-RCPSC Family Medicine Curriculum Development Working Group, 2009);
- **Cultural Safety** exists in environments which are safe for people; where there is no assault, challenge or denial of their identity, of who they are, and what they need. It is about shared respect, shared meaning, shared knowledge and experience; it is about learning together with dignity and true listening (Williams 2003).

As a result of a broad exploration of the topic, we are developing a series of Prezis, based on the National Native Addictions Partnership Foundation's (NNAPF) Stepping Stone Model (see below) that includes stories, PowerPoints and a range of audio-visual material. While this is a valuable resource, we felt the need to contextualize it for Northern and Remote First Nations communities in Saskatchewan. Therefore, we are developing six video vignettes based on extended interviews with our own Northern Elders to be incorporated into the Prezis; KCDC is doing the technical work. This will be ready in the early fall for use.

National Native Addictions Partnership Foundation (NNAPF). 2012. Renewal Stepping Stones to Cultural Safety.

Priorities

The priorities for next year will be:

- Mental Health and Addictions
- Health Director/Manager Certification Training and Career Ladders
- LPN and RN Programs
- Completion of the Cultural Competence materials
- Dental Therapy
- Collaborative development of a bridging program with our post-secondary partners

Conclusions

While many barriers are being removed, challenges still remain in the planning, managing, and organizing of program services within the Partnership. They include: travel costs that consume major portions of budgets, capacity to respond to the broad range of community-based worker needs in our communities, lack of academic preparedness for science-based health careers, and the computer literacy skills required for blended distance learning. We have a Public Health Graduate Student do a practicum with us over the spring and summer to help us build the foundations for a bridging program which will meet the academic and computer challenges students face.

While we have challenges, we also have strengths to work with. Elders, Employers, Management, Post-Secondary Institutions, Governments, Funders, and Communities are working together to support students and make dreams a reality.

MENTAL HEALTH AND ADDICTIONS ADVISOR

Mental Health & Addictions Advisor
Michael Woodward

Program Overview

In consultation with the Partners the goal of the program is to develop a comprehensive framework including a model of service delivery encompassing prevention, assessment, education, intervention, treatment, and aftercare within the mental health and addiction services. This framework will reflect the incorporation of models drawn from research literature that are culturally appropriate and create an environment of cultural responsiveness within which healing can occur. The Partner communities will develop their own distinctive, home-grown programs and service delivery systems.

The Mental Health and Addictions Advisor position was filled in December 2013, after being vacant for 6 months. One of the first tasks of the new advisor was to get acquainted with staff and begin to build relationships with Partners. It was important to define the role, review resources and begin finalizing the work plan. The advisor visited a few communities and met as many people as possible and associated with various programs, stakeholders and personnel.

The Mental Health and Addictions Advisor support's the Partnership in Mental Wellness, by working collaboratively and supporting the 2nd level and acknowledging community approaches. The key areas of the third level support role of mental health and addictions are: building capacity to influence policy and practices in mental health and addictions; innovation in programs and services including identification and implementation of wise and best practices; improving service delivery from a micro and macro perspective; enhance services for children and youth and strengthening processes and improving accountability and outcomes.

It is the role of the Mental Health and Addictions Advisor to:

- Strengthen the capacity of First Nations to deliver culturally appropriate and responsive services.
- Identify best practice and best fit for the Partners and their communities;
- Offer clinical expertise and educational opportunities which build capacity to be 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 developing their own infrastructure and capacity which includes standards, policy and procedure development.

Achievements

The electronic library continues to expand and research on best practises is on-going to be included in the library. The research papers, articles, and other material have been catalogued and saved by topic for easy access and dissemination.

Policy Development/Standards/Protocols/ Procedures:

- Compiling information to begin standardization of policy and procedure in accordance to the Mental Health Services Act as well as creating familiarity with the Youth Drug Detoxification Stabilization Act.
- Developing a Prevention Strategy based on Canadian Center on Substance Abuse standards.
- After meeting with Partners begin to standardize Mental Health and Addiction services in collaboration with MHA Working Group.

Data Stat Collection & Analysis:

- Met with MLTC Health Directors in North Battleford to evaluate and discuss individual community Mental Health, Wellness and Addictions programs, we developed a survey for each of the communities within MLTC which will help provide feedback and direction for MLTC membership in regard to Mental Health and Addiction programming.

Developing Tools and Best Practices:

- Providing information and resources to increase the awareness of the developmental impact on early tobacco use and subsequent psychiatric illness.
- Provide resource material in regard to Canadian Center on Addiction and Mental Health current best practices.
- In consultation with the Canadian Center on Substance Abuse (CCSA) implement the Standards for Youth, Community, and Schools Substance Abuse Prevention Programs.
- Research on Diabetes in association with Alcoholism and use of best practices.

Training Second Level/Train the Trainer

- NAYSPS - Planning for Safe Talk in most communities. Safe talk is a training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aide resources. (FNIHB- recognizes this training)
- Communicated with FNIHB in regard to NAYSPS funding and Safe talk meeting requirements.
- Proposal to move forward with Buffalo Riders Early Intervention Training Program developed by the National Native Addictions Partnership Foundation.

Informing Partnership on New/ changing communication and current trends:

- Presentations in regard to the Mental Health Services Act as well as the Youth Drug Detoxification Stabilization Act. Develop and implement an educational power point presentation for health care staff in regard to the Mental Health Services Act.
- Creating a power point presentation to communicate with Partners in regard to CCSA standards of prevention for substance abuse.
- Forming of MHA Working Group to meet in June 2014.

Challenges

Certainly one of the major challenges is the complexity of the organizations, the Partners and stakeholders. Despite mental health and addictions being adequately staffed, the level of need in the regions can be overwhelming. This in turn makes shifting from crisis intervention to prevention difficult. Another significant challenge is to find a model of intervention that supports the Crisis Response Teams at the second level.

An additional challenge continues to be geographic location and the costs associated with providing training to remote and isolated communities.

Priorities

- Continue a "Centre of Excellence "for dissemination of research in programs and services in Mental Health & Addictions for First Nations.
- Facilitate and support the Partners as they continue to improve their service delivery systems.
- Establish a process to support continuous quality improvement (CQI).
- Improve the continuum of mental health and addictions services by drawing linkages between approved stakeholders.
- Maintain representation on approved committees to advise on issues and program contents that relate to Mental Health & Addictions.
- To coordinate the prevention and intervention efforts across lifespan within human services.
- To enhance the experience of First Nations consumers of provincial Mental Health & Addictions services.
- Streamline Case Management (CM)processes; Examine the opportunities to improve on the effectiveness of CM processes; (e.g. standardized assessment forms).

EMERGENCY RESPONSE COORDINATOR

Program Overview

The Emergency Response Coordinator (ERC) works with the Partnership to support and advise on emergency response and preparedness issues. The position is evolving and beginning to encompass past initiatives such as 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. The NITHA ERC is positioned to assist the Partnership in areas relating to the emergency response.

Emergency Response Coordinator
Patrick Hassler

Achievements

NITHA's Emergency Response Working Group is meeting 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 now more efficient. Second Level Emergency Response Coordinators are necessary for the safety of our population but are not funded by FNIHB. Therefore, NITHA supports each Partner by providing $75,000 annually per partner to enable the coordinator role at 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. Training for First Aid and CPR Instructors occurred throughout the Partnership resulting in 5 Certified Instructors as of May 2013. Further instructor level courses will be planned for 2014.
2. Approximately 200 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."
3. Once these instructors gain a minimum two years of experience as Instructors, they are eligible to upgrade to First Responder Level Instructors as early as May 2015.

The importance of First Responders and their impacts on a community cannot be understated and NITHA will endeavour 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. Due to the increased communication and orientation of these parties' needs, we have been able to stream line some of the necessary paper work in an attempt to reduce "bottle necks" in the evacuation process. Adding the Clients With Special Needs form to the 2013 Smoke and Fire Guidelines will help reduce line ups at reception centers to see a Health Care Professional. Gaining a seat at the Emergency Planning Officers meetings has also helped increase communication between the Partnership and higher level planning meetings. Outcomes such as the Province's exploring Points North as a Staging Area for Northern evacuations is a direct result of this involvement. 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 more prompt and efficient manner, which, in turn has led to more integrated, timely, and appropriate responses to needs.

Community Risk Assessments are ongoing. The process NITHA has been using has generated positive feedback and is continuing to make steady progress. 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 are exploring options to develop a more cost effective process; potentially, we could use the video conferencing infrastructure capabilities within the NITHA Partnership to assist us.

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® and International Trauma Life Support®.

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.

Manpower in the area of Emergency Response and Preparedness remains the most significant challenge. Second level and community manpower is 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 dedicated full time positions in these areas progress will be hampered and move forward on a jagged front.

Priorities

Since the industry standard has changed for emergency response plans, the NITHA ERC continues to work with Partner communities to ensure that they are aware of, and compliant with, the changes. The most significant change has been in taking an "All Hazards" approach to community Emergency Response Plans. The "All Hazards" approach is a sound, evidence-based approach to emergency planning. This has occurred because 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 ERP 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.

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.

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 NITHA Emergency Response Coordinator, along with the NITHA Medical Health Officer, Infectious Control Advisor, and Nurse Epidemiologist, will update these documents in 2014. 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.

The NITHA ERC has been working with FNIHB to produce an *Emergency Response Planning Manual*. The goal is to produce a tool that is easy to use and will assist the Partners in updating and producing both Emergency Response Plans and Contingency Plans; the current documents are too technical and not user-friendly. As progress is made, the document will be vetted through the NITHA Emergency Response Working Group. This will ensure ease of use and input and insight of Partners.

Public Health Unit (PHU)

Program Overview

The NITHA Public Health Unit (PHU) provides technical advice and expertise to the NITHA Partnership in preparing for, and responding to, public health threats and risks. These roles are carried out in a variety of settings, primarily through the programs and services of the five core functions of public health: community health assessment, communicable disease surveillance, health protection, disease and injury prevention, and health promotion. The PHU has a broad goal of improving the health and well-being of the NITHA population through a NITHA-wide public health strategy. In executing this mandate, the PHU, through its Medical Health Officer (MHO) and program leads, work collaboratively with several stakeholders. These include but not limited to First Nations and Inuit Health Branch of Health Canada, Saskatchewan Ministry of Health, Northern Population Health Unit, Regional Health Authorities, Saskatchewan Population Health Council, Saskatchewan TB Prevention and Control, and NITHA Partners. On-going collaboration and engagement with aforementioned stakeholders within a multi-jurisdictional environment remain a critical role of the PHU as it provides opportunities for continuing advocacy towards addressing social determinants and public health policies that impact the NITHA Partnership communities.

The unit presently consists of an MHO, Nurse Epidemiologist, TB Advisor and TB nurses, Health Promotion Advisor, Communicable Disease Control Nurse, Infection Control Advisor, Environmental Health Advisor and support staff. The MHO position has been vacant since April 2010. This position was filled in August 2013. During the period under review, the MHO provided strategic direction, leadership, coordination, and supervision of the PHU in the areas of program implementation.

The PHU continued to provide day-to-day monitoring and intervention of communicable disease and non-communicable diseases. Tuberculosis, blood borne pathogens (HIV, Hepatitis B & C), sexually transmitted infections, and Methicillin-resistant Staphylococcus aureus infection continue to impact on the health of the NITHA Partnership communities to a significant proportion. The unit continued to respond to these public health threats by providing programming and information to our Partners.

The NITHA Public Health Working Group (PHWG) has representations from all NITHA Partners. This group met quarterly during the year under review to provide direction and guidance to the NITHA PHU on pertinent public health issues. The PHWG also

Medical Health Officer
Nnamdi Ndubuka

Executive Assistant
Linda Rogozinski

Linda is the Executive Assistant to the Medical Health Officer and is a member of the office support team.

Program Administrative Assistant
Deanna Brown

Deanna provides administrative support to staff in the Public Health Unit and is a member of the office support team.

provided leadership and guidance in the development of health policies, protocols, procedures and guidelines for entire Partnership.

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
2. Continuing implementation of the TB High Incidence Strategy
3. Enhancement of communicable and non-communicable disease surveillance
4. Strengthening internal and external communication strategies
5. Adaptation of a population health promotion model for NITHA PHU

NURSE EPIDEMIOLOGIST

Program Overview

Nurse Epidemiologist
Shirley Woods

Epidemiology is the study of health and illness patterns, and all factors associated with health and
illness. It helps us to identify risk factors for disease, best treatments and preventative measures. This
information assists communities to plan programs in the areas needed most and to develop strong public health programs.

The NITHA Nurse Epidemiologist (NE) position provides overall immunization coordination for the Partnership. NE also provides ongoing education for nurses and other members of the health team working in the area of immunization. Vaccine management is also provided as vaccines are ordered, shipped and monitored through the NITHA Public Health Unit (PHU). PHU distributes vaccine to all NITHA communities and ensures cold chain protocols are followed. In addition PHU measures vaccine wastage and provides feedback and education to communities to reduce vaccine wastage. The vaccines used in our communities are purchased by the
Saskatchewan Ministry of Health and we receive close to $500,000 worth of vaccine to distribute to the NITHA Partnership communities.

Achievements

During the year under review, the NE worked with FNIHB and the Ministry of Health to implement the inventory module of Panorama for inventory management of the vaccine. Panorama is a public health electronic health system that is being implemented across the province.

The NE participated in a number of working groups related to Panorama. These groups consist of the First Nations Change Management Group, the Provincial SPRINT (Saskatchewan Panorama Redesign, Implementation & Networking Team) and SPRINTER (Configuration work groups for Immunization and Family Health) Working Groups. Much of the work in these groups is to ensure the system will meet the needs of First Nation individuals, families and communities. Work is ongoing in the area of Panorama and will be completed in the coming year.

Immunization

Immunization continues to be the best protective intervention for the prevention of vaccine-preventable diseases. Statistics on all programs are collected at different times of the year depending on logistics. Preschool statistics are collected on a calendar year and this report reflects 2013. Influenza statistics are collected on a fiscal year or flu season and will reflect the most recent influenza season (2013-14).

The other statistics are collected on a school year and will reflect the 2012-13 school year. Presently data is collected manually from most Partner communities.

During the year under review, the communities of Red Earth and the LLRIB with the exception of Little Red started using the Saskatchewan Immunization Management System (SIMS) for their immunization record. The AHA First Nation communities (Fond du Lac and Black Lake) and James Smith First Nation have been using SIMS for 1-2 years and an evaluation was completed for these communities. The evaluation was very positive with high healthcare provider satisfaction with the system and the audit indicated the results were similar to Regional Health Authorities (RHAs) which have been using SIMS for a number of years. In all three communities, staff indicated that clients expressed no concern over the privacy and security of SIMS. Additional communities have expressed interest and will begin using in the new fiscal year. The NE will continue to work with NITHA Partners in this regard.

Preschool

Infants begin immunization at two months of age with Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae B (DTaP-IPV-Hib) and Pneumococcal conjugate 13-Valent (Prevnar) vaccine. It is important that children start their immunizations as soon as possible and to stay on schedule as this provides them with the earliest and best protection against serious disease. The DTaP-IPV-Hib are provided in one needle at 2, 4, 6, and 18 months while the Prevnar is given at 2, 4, and 12 months of age.

During the year under review, the rates of immunization for the preschool age group ranged from 5.6% to 100% in some communities. Upon reaching the age of one year, a child receives four injections. These are for the Prevnar; Measles, Mumps, German Measles (Rubella), and Varicella (Chicken Pox) (MMRV); Meningococcal; and Hepatitis A. At 18 months of age children become eligible to receive a boost of DTaP-IPV-Hib as well as an additional MMRV and Hepatitis A.

Immunization rates for 2 year olds in individual communities ranged from 6% to 100% during the year under review. The range for immunization rates in the 7 year olds was 49-100%. Again, work needs to be done in those communities with low immunization rates to bring them up to protective levels. The national goal for immunization rates is 95-97 percent so in some communities we are well below the goal and at a level where children are at risk for vaccine-preventable disease. Discussions have occurred with those communities with low rates and recommendations for improvement shared.

The following graphs provide the average immunization rates for specific vaccines in the NITHA Partnership. As is expected, the fewer doses in a series of vaccine has the highest coverage.

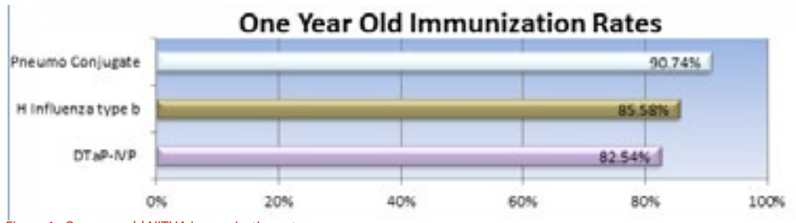


Figure 1: One-year old NITHA immunization rates

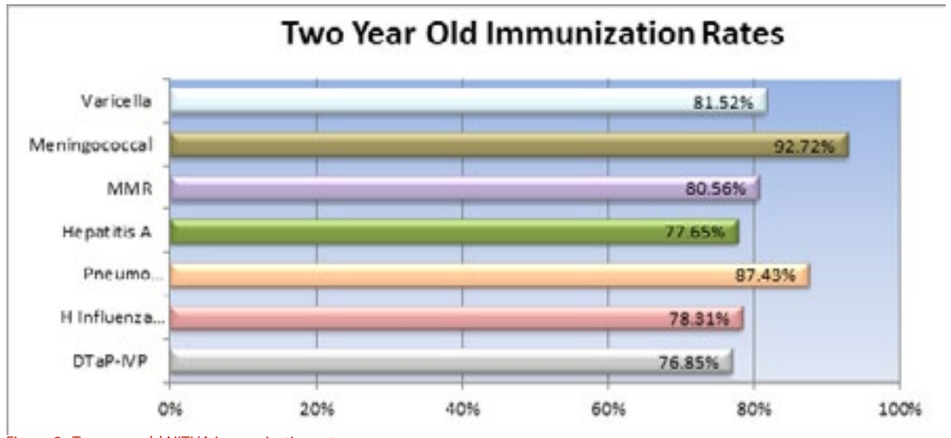


Figure 2: Two-year old NITHA immunization rates

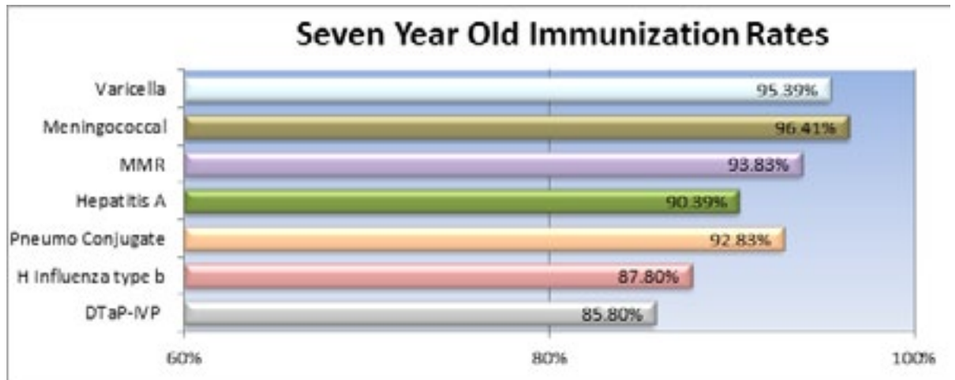


Figure 3: Seven-year old NITHA immunization rates

Figure 4 show an average vaccine coverage within the Partnership in the last 7 years. Chart indicate that in 2010, NITHA had the highest coverage with 90%. In 2013, we were 8% lower than that year.

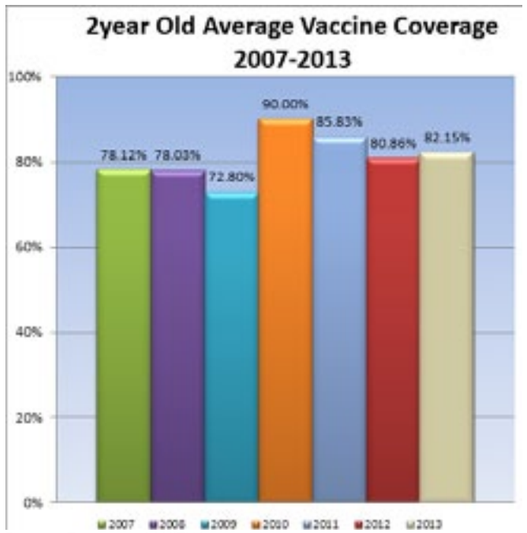


Figure 4: Two-year old NITHA average vaccine coverage

School Immunization

Immunization against Human Papillomavirus (HPV) was launched in September 2008. There are several short-term indicators that can be measured to evaluate the program effectiveness. One of them is analysis of coverage rates with the HPV vaccine. This is a 3 dose vaccine series. During the year under review, 268 students in the grade 6 population were eligible with 87.7% (n=233) receiving their first dose. This is down 10.3% from last year. Of the eligible students, only 63.8% (n=171) received a third dose. This is also down 8.2% from last year. Grade 6 students also receive meningococcal, varicella (chicken pox if they have not previously had the disease), and Hepatitis B vaccine. This year 92.5% of eligible students received their meningococcal immunization which provides protection against four different types of meningococcal disease. This is up slightly from 90% last year.

There were 273 students eligible for varicella vaccine with 76.9% (n=210) receiving it. Hepatitis B vaccine is a two dose series and 71% (n=213) received two doses. Grade 8 students receive Tdap (Tetanus, Diptheria and acellular pertussis) and for those students not previously having 2 doses of MMR this was recommended as well. During this year, 408 students were eligible for Tdap immunization. Of those eligible, 82.6% (n=310) received the immunization.

There is an MMR catch-up program for grade 8 and grade 12 and this group saw 82.4% and 46% respectively immunized. The grade 8 saw a slight decrease of 4.6% while the grade 12 saw a 25.4% decline in those receiving an MMR vaccine.

Adult Immunization

Immunization is required throughout the lifespan. For most adult immunizations statistics are not collected.

Influenza

The 2013-14 influenza immunization season started slower than usual but with the first cases of H1N1 influenza occurring in December and a strong recommendation from the Ministry of Health to increase coverage rates to protect the general population, uptake rates increased dramatically within the Partnership. 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. FluMist an intranasal vaccine was introduced in January with positive results. Parents, children and nurses all found this vaccine to be a positive addition to the program.

Statistics were collected on those under the age of 9 years and those over and under the age of 65. This year 2 435 doses of influenza were provided to children under the age of 9 years. There were 601 doses provided to those over the age of 65 years and 5 239 provided to those aged 10-64 years. Health care staff within the entire Partnership received a total of 510 doses. Overall, a total of 8 785 doses of vaccine were provided for all ages during the year under review. This is more than double what was provided during the 2012-13 fiscal year (3 760 doses).

In the NITHA communities 53.6% 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 82.6% of staff were immunized with influenza vaccine.

Sale Vaccines

NITHA continues to work with the Saskatchewan Association of Health Organizations to purchase those vaccines not publicly funded. The amount of sale vaccines remains low due to increasing eligibility for publicly funded vaccine. At this time international travelers and vaccine for some employers are the majority of the clients for this service.

Inoculist Exams

This year 108 inoculist exams were received and processed. Immunization is considered a special nursing procedure as the procedures involved in immunization may not be taught in the basic nursing education program. After the initial nursing program, registered nurses must write an annual inoculist exam to maintain competency. NE provided support to the nurses in the field when they are uncertain about vaccine scheduling or other immunization questions. NE also provided ongoing education regarding new or changing immunization programs. New nurses participate in education program to prepare for working in nursing stations and all of these nurses receive an in-service on immunization.

Cold Chain

NITHA continues to work towards minimizing costs related to cold chain breaks (periods of time in which the vaccine is not stored between 2 and 8 degrees Celsius). Each year NITHA coordinates the servicing of all biological refrigerators, purchases new refrigerators as well as repairs of existing equipment. NITHA continues to purchase chest style refrigerators that maintain temperatures for 5 days without power. Power outages contribute to the number of cold chain breaks in our communities and in some cases generators were not working or hooked up or battery backups have not worked. Additional coolers, warm mark, cold mark monitors and thermometers have been purchased. There were a total of 2 768 wasted doses which more than doubled the 1 380 from last year reported to NITHA and an additional 817 doses lost due to cold chain. This is in contrast with the 2 844 doses last year. This positive decrease may be due to less extensive power outages and an increased use of the chest fridges that maintain cold chain for longer periods of time. The losses are largely due to improper inventory management and vaccine outdating. The increase in wastage may also be related to better reporting this year. The proposed Panorama system has an inventory system and this may facilitate better management within the communities in the coming year.

Student Practicum Placement Program

During the year under review, NITHA provided practicum placement for 2 Master in Public Health (MPH) students who were funded through the Public Health Agency of Canada. These students assisted in a number of projects such as literature reviews on immunization and vulnerable populations, TB and smoking, and incarceration as a determinant of health. An electronic system for TB contact trace investigations was developed as well as population denominators updated and analysed. They also assisted in other activities as needed.

Challenges

1. The most significant challenge for the NE is obtaining current accurate data specific for NITHA communities (excluding communicable disease and immunization data as this data is collected and housed within the NITHA PHU). 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. The use of two systems in Saskatchewan, paper based in First Nations jurisdictions and SIMS in RHA's, proves challenging for health care providers to ensure a clients' immunizations are up to date. Although paper based systems have historically had success, it becomes more difficult to keep these records accurate and up-to-date as people and communities become more mobile. This becomes challenging for continuum of care as clients are seen across different communities and jurisdictions.
3. The lack of a consistent electronic charting system for immunization remains a challenge. There is considerable time spent in many communities trying to track paper records. The statistical collection of data from a paper based system is time consuming and has the potential for errors. For example, during the influenza season statistics were required on a daily basis which meant support staff needed to call communities to have nurses do a manual count of both vaccine and doses of vaccine given to various age groups.
4. In some communities, immunization is not considered a priority and the nurses' time is spent on other program areas. Some communities have consistently low immunization rates which puts the community at risk for vaccine preventable diseases.
5. Some nurses have cited the frequent school closures related to weather, funerals or other situations as impacting the time available for nurses to complete the school immunization program.
6. 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.
7. On-time immunization is also an area that should be improved. Children should receive their immunizations during the time recommended. For example, infants are due for their first needles at 2 months of age and should receive at 2 months. A number of children will receive their first needles at an older age leaving them vulnerable.

Priorities

1. To work with those communities with low immunization rates to increase rates to a level that will provide community protection.
2. To improve access to client records to accommodate parents who move between communities by having health care providers access and utilize electronic immunization records.
3. To standardize child health clinics by using best practice guidelines.
4. To continue exploring options for accessing data to assist in program planning and evaluation throughout the Partnership.

COMMUNICABLE DISEASE CONTROL NURSE

Program Overview

Communicable Disease Control Nurse
James Piad

Communicable disease surveillance continues to be a priority for the NITHA Partnership. NITHA responds to requests and inquiries from the Partnership and offers interventions when concerns are identified. The Communicable Disease Control (CDC) Nurse supports 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.

Sexually Transmitted Infections

This year the number of reported sexually transmitted infections (STIs) increased by 3% for chlamydia and by 25% for gonorrhea in comparison with last year. The chlamydia cases had been increasing each year from 2009 onwards as shown in figure 1. Gonorrhea cases reported in 2013 is the third highest recorded in the past ten years. It has been observed to increase since 2011. It is a common observation that an increase in one STI accompanies increases in other STI's because behavioral risk factors are the same for all.

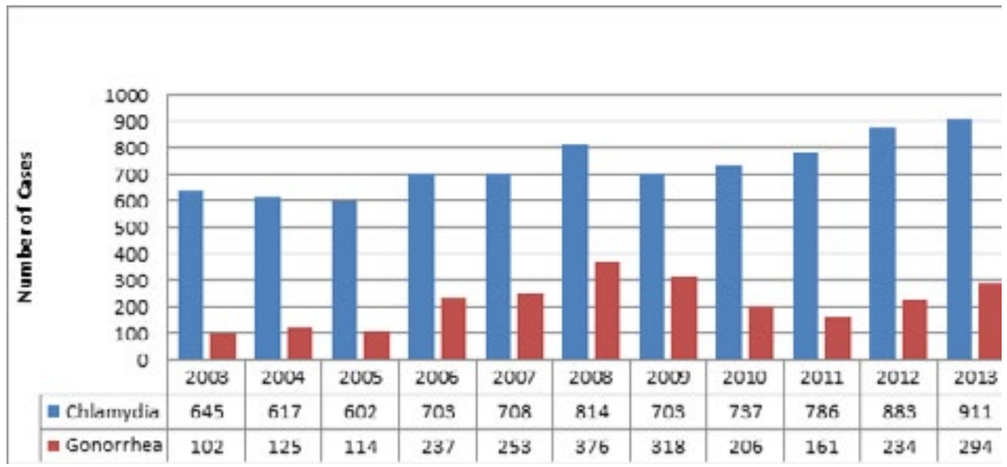


Figure 1. Reported Cases of Chlamydia and Gonorrhea in NITHA Communities by Year, 2003-2013

Aggregate rates for NITHA communities are still above the provincial and national levels. Reasons for these are poorly understood but the following factors have contributed for the high rates: 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. Syphilis is an STI with more fatal complications than chlamydia and gonorrhea. It is highly preventable and treatable.

There has been a decline in the reported number of cases of syphilis since 2010 in NITHA communities. In 2013, only one case was reported in NITHA compared to five in 2012, seven in 2011 and ten in 2010 (see figure 2). This represents a 90% decrease in the past four years.

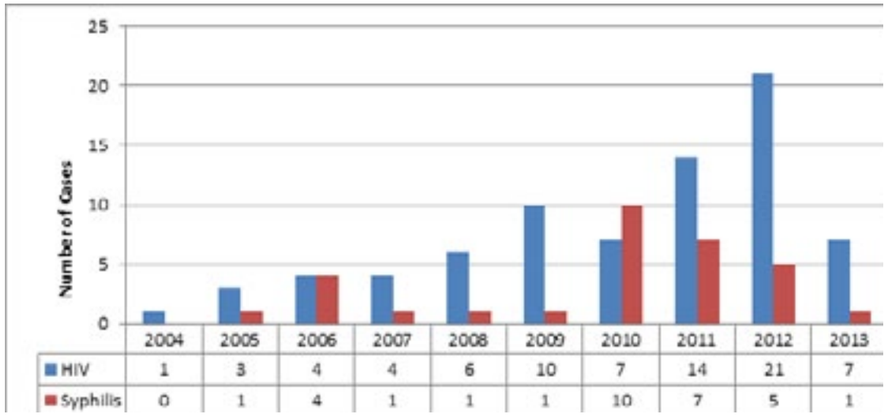


Figure 2. Reported Cases of HIV and Syphilis in NITHA Communities by Year, 2004-2013

There has also been a reduction in reported HIV cases in NITHA compared to the last two years. Seven were reported in 2013 compared to 21 in 2012 and 14 in 2011 (see figure 2). From 2004 to present, NITHA has a total number of 77 reported cases of HIV, not including those residing in other health regions. Of the total cases, two developed AIDS; one was reported this year.

Blood-borne Infections

Hepatitis C (Hep C) is a chronic liver disease caused by Hepatitis C virus. Thirty cases were reported during the year under review suggesting a decrease by nearly 38% in comparison to the number reported in 2012 and a 28% reduction from the previous five year average, from 2008 to 2012 (see figure 3). Current or past intravenous drug users comprise most of the Hep C cases. Sharing contaminated drug use paraphernalia, such as syringes, is the main mode of Hep C transmission in NITHA communities. Co-infection with HIV is a common occurrence because of the similar modes of transmission. Presence of STI increases the risk of Hep C transmission.

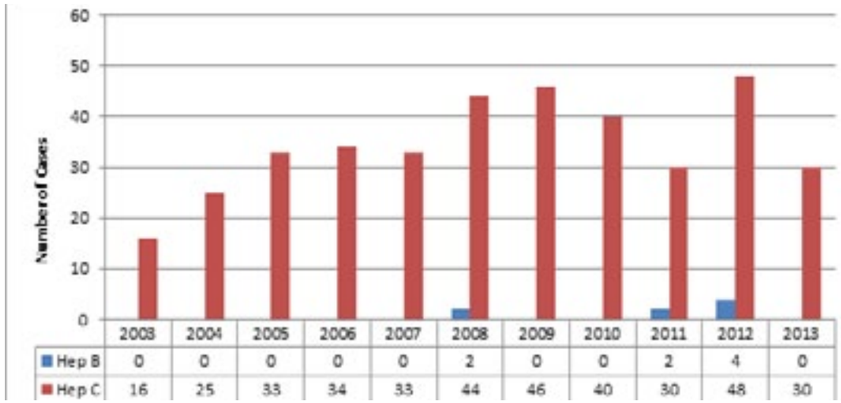


Figure 3. Reported Cases of Hepatitis B and Hepatitis C in NITHA Communities by Year, 2003 - 2013

Hepatitis B (Hep B) is another viral infection affecting the liver. It can be transmitted several ways as the virus is found in many body fluids like blood, saliva, semen and vaginal fluid. No case was reported during the period under review.

Community Acquired Methicillin Resistant Staphylococcus aureus (CMRSA)

Methicillin-resistant Staphylococcus aureus (MRSA) infection continues to be a challenge in NITHA communities. It is difficult to determine when a person has cleared the bacteria and when a new infection has set in. Only newly diagnosed cases are included in this report.

Generally, the number of reported cases started to decline in 2007. The number though in 2013 increased by 18% from 2012 and by 1% from the previous five year average, from 2008 to 2012 (see figure 4).

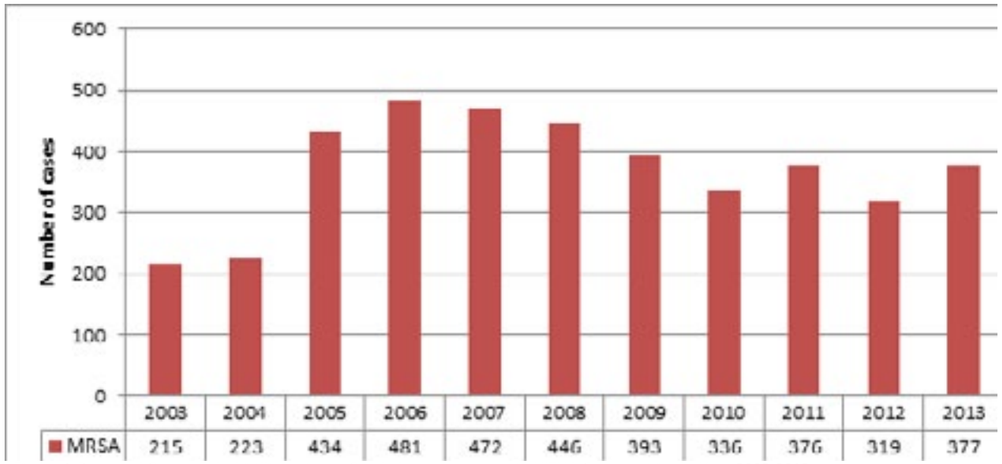


Figure 4. Reported Cases of Methicillin-resistant Staphylococcus aureus in NITHA Communities by Year, 2003-2013

Other Communicable Diseases

Cases of other communicable diseases have occurred sporadically in NITHA communities. Number of reported cases for this year remained within the usual annual occurrence. Thirteen confirmed cases of Influenza (flu), a vaccine preventable infection were reported in the latter part of 2013. Pertussis, another vaccine preventable infection caused by bacteria had one reported case. Invasive types of bacterial infection, such as Invasive Group A Streptococcal Disease (IGAS) and Invasive Pneumococcal Disease are also occurring in NITHA communities. The CDC Nurse worked with the frontline nurses in tracing contacts for treatment and follow up.

Achievements

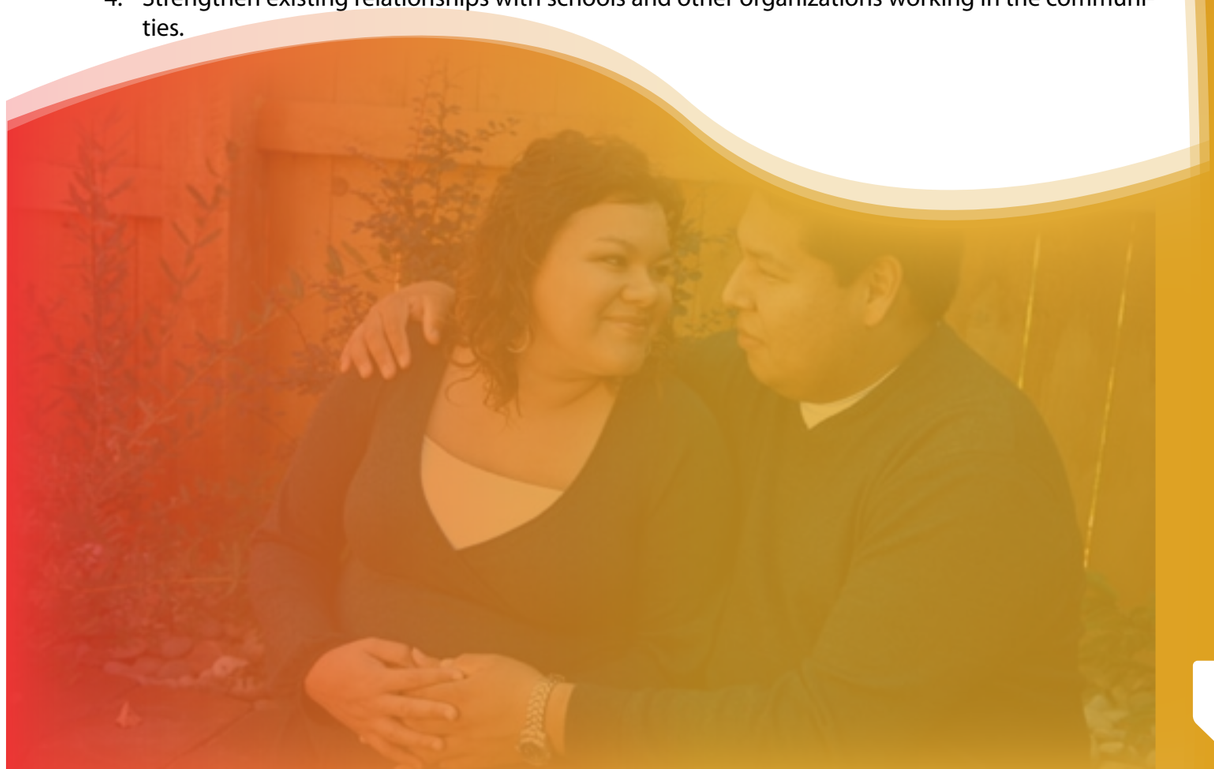
1. Involvement of Elders in planning and in disease prevention and control activities; being the most respected persons in the communities, their words are honored and their wisdom is always a benefit to prevention and control program in the community.
2. Information campaigns in communities benefited everyone. It created a higher level of awareness and empowerment. Doubts were cleared and myths were corrected.
3. Participation in conferences and workshops for knowledge / information updating. New knowledge gained from the attendance is applied and / or cascaded down to the Partnerships.
4. Collaboration / coordination with other agencies for services / information / materials are useful for the CD program. Materials like pamphlets and posters were given out to the communities.

Challenges

1. Difficulty of tracing cases and contacts. The purpose of tracing cases and contacts is to get them tested and / or treated so that further spread of infection is controlled. Some people however, use other names or aliases making their identity difficult. Many infected cases do not give adequate information about their contacts keeping them untracked, untested and untreated. These individuals will remain sources of infections that will continually infect others during the course of their interaction, unless proper testing and treatment are done to them.
2. Rapid turn-over of nurses / lack of nurses. 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.
3. Confidentiality. Compared to other diseases, STDs and other related infections involve a high 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.

Priorities

1. Intensify information campaigns to improve awareness of the community on communicable diseases especially on the aspect of prevention and control.
2. Engage more Elders in the awareness campaigns. Elders are well respected persons in the community and their wisdom gives more impact to the campaigns.
3. Involve youth in the information drive as many CD cases like the STDs come from the young population.
4. Strengthen existing relationships with schools and other organizations working in the communities.



ENVIRONMENTAL HEALTH ADVISOR

Program Overview

Environmental Health Advisor
Mohamad ElRafihi

The Environmental Public Health Program (EPHP) within the NITHA Partnership works to identify and prevent environmental public health risks that could impact the health of community residents. The EPHP program addresses environmental public health risks in the following nine areas: drinking water quality; housing; wastewater management; solid waste disposal; food safety; facilities inspections; communicable disease control; emergency preparedness and response; and environmental contaminants, research and risk assessment. This program is delivered by Environmental Health Officers (EHOs) working for Meadow Lake Tribal Council and Prince Albert Grand Council.

The major role/responsibility of the Environmental Health Advisor (EHA) is to provide assistance, advice and support to second level EHOs in the management of environmental public health risks affecting Partner communities. The EHA ensures timely notification, reporting and follow-up of reported enteric diseases and animal bite incidents and develops appropriate communication strategies including policies, procedures and practices that can be used by Partner communities to address and prevent communicable disease transmission and protection of public health. The EHA also acts as a consultant to the NITHA Medical Health Officer and NITHA Executive Council on environmental health issues.

Achievements

During the period under review, the EHA participated in a number of meetings, both internal and external. These meetings provided the opportunity for NITHA to identify and discuss issues, provide input in the development of guidelines and/or policies, ascertain the need for EHO training sessions and professional development and ensure effective communication and coordination with all agencies, Partners and staff. Participation in these meetings also provided the opportunity to network with Federal, Provincial, Municipal and non-government agencies. As an important public health requirement to promote and advocate for healthy lifestyles, the EHA assisted the EHOs by researching best practices to address environmental health issues, preparing or providing relevant promotional and educational material. The EHA also provided coverage within the Partnership upon request or in emergency situations.

The EHA also provided communicable disease support to community nurses and EHOs for notifiable foodborne, waterborne and zoonotic diseases. This support is essential to ensure that timely reporting and follow-up is conducted as mandated by provincial legislation. During the 2013-2014 fiscal year, several food recalls were issued by the Canadian Food Inspection Agency (CFIA). The EHA ensured that Partner communities received timely notification of these important food recalls.

The EHA sits on the Saskatchewan Biomonitoring Study Steering Committee overlooking the on-going project to gather baseline data on the prevalence of contaminants in the population (i.e. pregnant women) residing in areas of future oil-sands development in Northern Saskatchewan. The EHA will keep the Partnership informed of further study developments or any significant findings and recommendations that may have an impact on the health of residents in affected Partner communities.

During the period under review, the EHA and our Partner EHOs attended Annual Water Program Review meetings hosting representatives from the Water Security Agency, Population Health Unit and Aboriginal Affairs and Northern Development Canada (AANDC). These meetings provided a forum for sharing information on drinking water and sewage disposal systems, discussing issues and solutions, with the common goal of providing safe drinking water and safe disposal of wastewater. Some of the systems within the NITHA Partnership are shared with neighbouring communities. The EHA will continue to sit on those meetings and support EHOs and Partner communities in addressing and managing related issues or concerns.

Work continues with Partner EHOs, communities and NITHA program staff to support the EPHP. Providing education and information on environmental health issues plays an important role in assisting communities in identifying and preventing public health risks that could impact the health of community residents.

Only a small percentage of diseases that cause enteric illnesses are reportable under *The Public Health Act* and *Disease Control Regulations*.

The EHA continues to provide education, support and assistance on timely reporting and follow up of enteric diseases to Community Health Nurses. The NITHA Epidemiologist and the Environmental Health Advisor participate on the provincial working group tasked with updating the Provincial Communicable Disease Control Manual. The EHA will continue to keep Partner communities informed on changes to NITHA Enteric Disease Notification Forms and the Provincial Communicable Disease Control Manual.

Enteric diseases continue to be the least notifiable communicable disease reported in NITHA communities. Twenty one confirmed enteric cases were reported in 2013 (see figure 1).

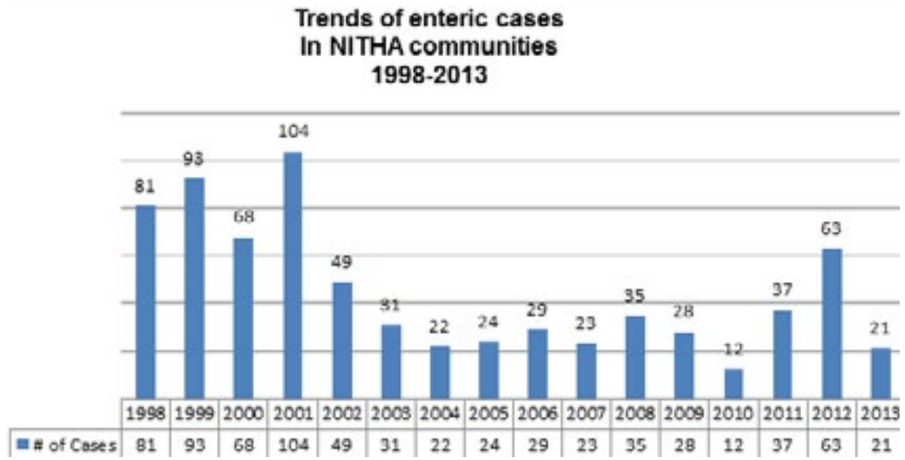


Figure 1: Trend of reported enteric diseases in NITHA communities per calendar year

One of our Partner communities experienced an outbreak of diarrhea that affected 18 people in April 2013. The etiologic agent responsible for the outbreak has not been identified. However, education around hand washing and the prevention of communicable disease transmission was provided and the outbreak was declared over after a period of 22 days.

Animal bites, especially dog bites, are a concern in many of our communities and pose unique health challenges. Animal bites are a health concern for several reasons; the most serious disease of concern is the transmission of rabies.

The NITHA Partnership received a total of 120 reports of animal bite incidents that required follow-up during the 2013 calendar year (see figure 2), indicating a slight decrease in cases reported during the previous year. Dogs were involved in 114 of the reported bite incidents while cats, bats, squirrels and muskrats accounted for the remaining six bite incidents (see figure 3). Of the 114 dog bites, 10.5% (n=12) involved the head and facial areas while 30% (n=35) involved children under 10 years of age. Of the total animal bites reported during the year under review, 3 cases received Rabies Post-Exposure Prophylaxis and 4 cases refused treatment.

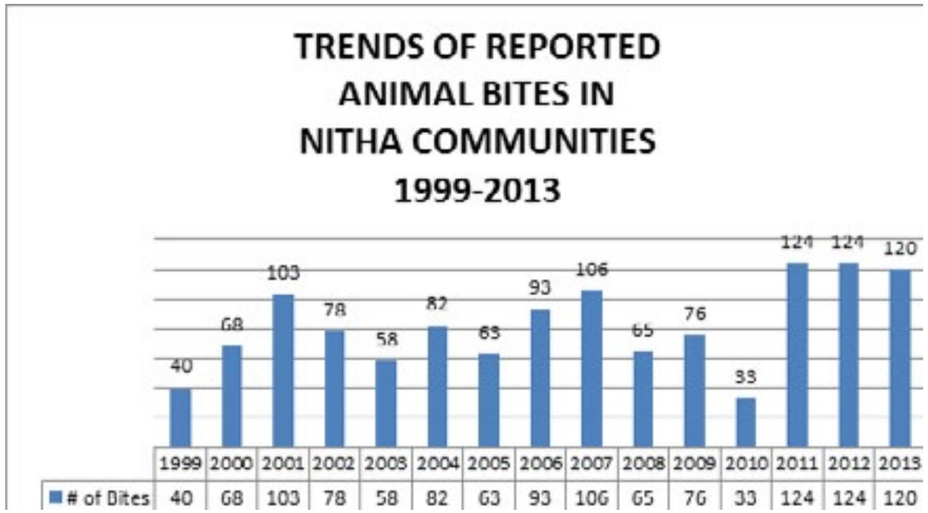


Figure 2: Trends of reported animal bites in NITHA communities per calendar year

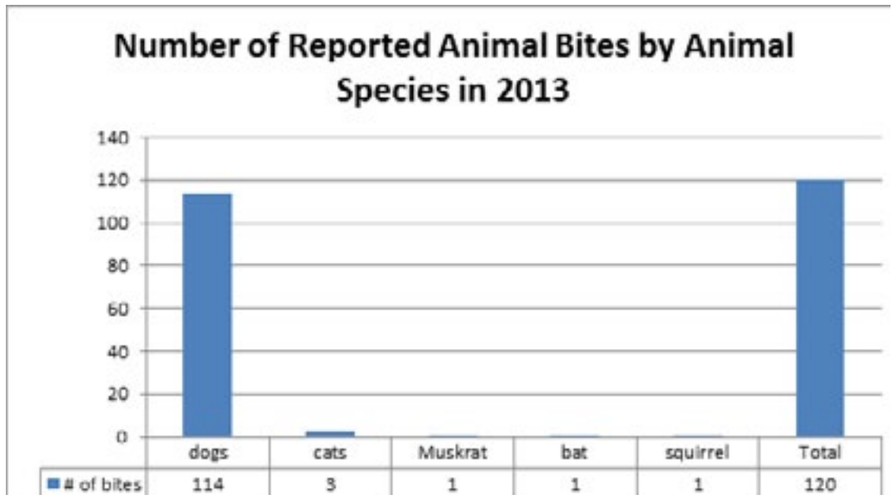


Figure 3: Number of reported animal bites by species

Challenges

1. Prompt reporting of animal bite and enteric cases by Partner communities continues to be a challenge.
2. Inadequate completion of investigation forms by frontline nurses constitutes a challenge for EHA in providing timely recommendations.

Priorities

1. Coordinate rabies training session for EHOs within the NITHA Partnership who will then provide training to community volunteers to assist with packaging and shipping of animal carcasses for rabies testing from remote communities where applicable.
2. 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.
3. Develop and update animal bite/rabies policy, protocol, forms and procedures and ensure that Partner communities have equal and adequate access to resources to address and manage reported animal bites incidents efficiently and effectively.
4. Develop an animal control by-law template that can be used by Partner communities as a means to enforce dog population control and encourage responsible dog ownership in Partner communities.
5. 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 EPH Program.

HEALTH PROMOTION ADVISOR

Program Overview

Health Promotion Advisor
Linda Gilmour Kessler

The goal of the NITHA Health Promotion program is to provide comprehensive support to the NITHA Partners in the area of Health Promotion. The Health Promotion Advisor (HPA) role is to work with the NITHA Partners and other partners to develop health promotion strategies; Mentor and collaborate with NITHA Partners to identify and plan capacity building opportunities to build the health promotion skills; provide support, guidance, and advice regarding health promotion to the NITHA Partners; and develop partnerships at the local, provincial and federal levels to ensure evidence based health promotion practice.

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 resulted in the NITHA communities having some of the lowest health status in Canada.

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 health promotion strategies are multi-faceted, long term and require multi-sectorial partnerships and strategies.

Photo courtesy of NHCP

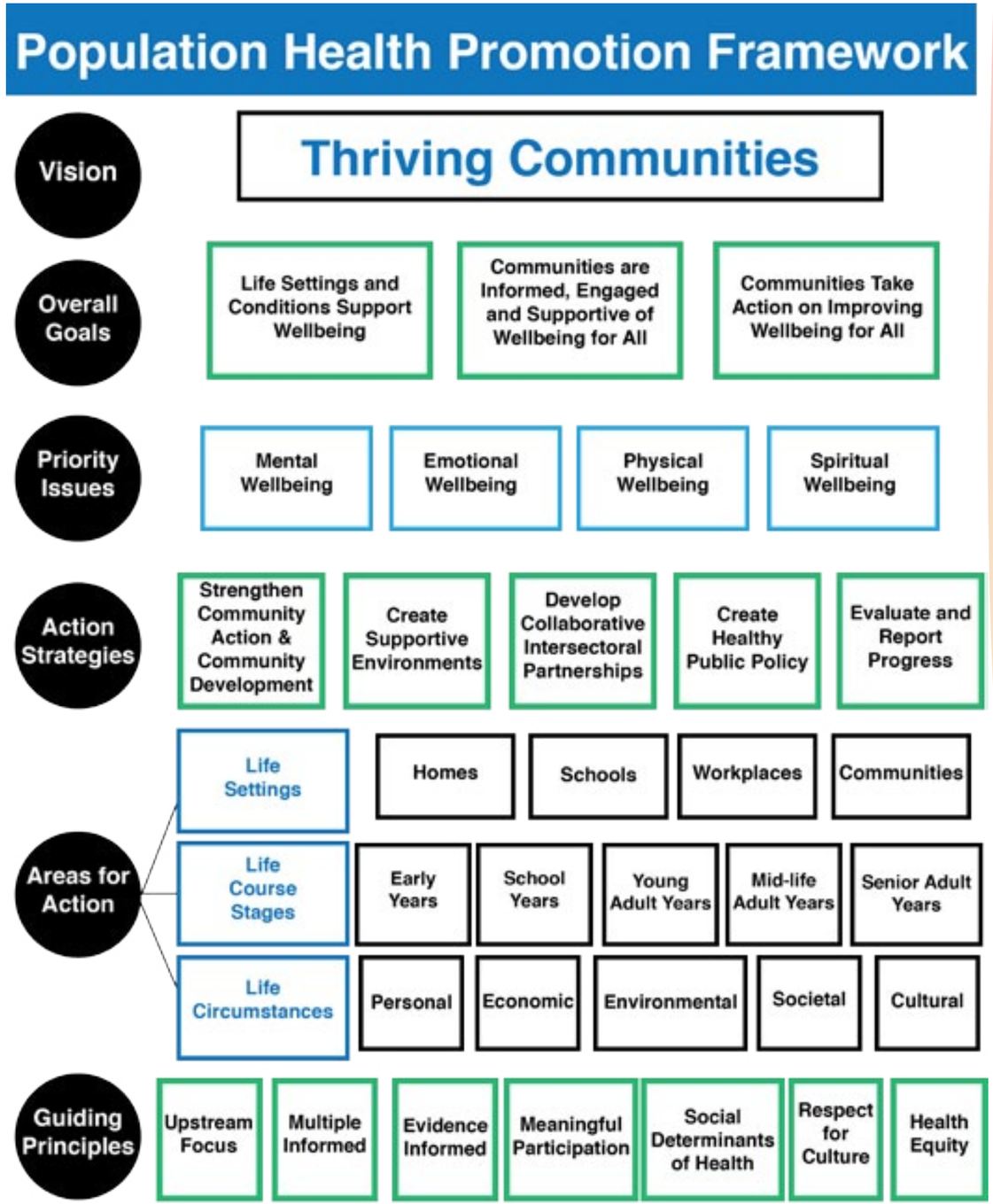


Figure 1: Saskatchewan Population Health Promotion Council 2014

Adapted from: A Population Health Promotion Strategy for Saskatchewan - Healthier Places to Live, Work and Play
Doug Ramsay, Health Promotion Coordinator, Regina Qu'Appelle Health Region (2013)

Achievements

During the year under review, the HPA provided leadership and worked collaboratively with the NITHA Partners to plan, develop, and implement north-wide health promotion strategies and initiatives.

The NITHA HPA, NITHA Medical Health Officer (MHO) and the NITHA Partners are involved in the Northern Healthy Community Partnership (NHCP). The HPA, along with the Northern Population Heath Unit's Health Promotion Coordinator, co-facilitated the NHCP and supported the action teams to identify priorities, develop, implement and evaluate.

Key achievements include:

- Worked with the NHCP co-chairs (NITHA and Northern Public Health Unit MHOs) to strengthen NITHA's role in the NHCP.
- Conducted an evaluation of the NHCP including member representation and engagement. Engaged additional NHCP action teams and core group members.
- Provided support to NITHA Partners to participate and collaborate as NHCP partners.
- Worked with the MHO's, NHCP core group and action team members to identify health promotion priorities, identify best practices, select, implement and evaluate health promotion initiatives.
- Launched the NHCP website in June 2013.
- Coordinated the development of and distributed monthly radio spots and health promotion theme packages.
- Developed and provided a health equity workshop to NHCP members.
- Planned and conducted a Northern health promotion photo shoot to develop a library of stock photos.
- Initiated a process to obtain funding from the SK Cancer Agency for Northern tobacco reduction, healthy eating and community development. HPA will continue to monitor funding application status during the 2014-2015 fiscal year.

The Northern Tobacco Strategy (NTS) is 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.

Achievements of the HPA as part of the NTS include:

- Completed the development of two tobacco reduction/cessation modules (youth and maternal).
- Trained the NTS members to be train-the-trainers for the modules.
- Supported NTS members who are NITHA Partners to conduct training within their organizations.
- Launched a youth tobacco awareness campaign– What's Tobacco For?
- Planned and held a What's Tobacco For? Community Awareness and Action workshop which targeted NTS members and adult allies/youth that had previously completed a community-based workshop based on the youth tobacco module.
- Developed youth/elder traditional tobacco videos for the NHCP website – Northern Tobacco Strategy section.

The Health Promotion Advisor is a member of the Saskatchewan Tobacco Reduction Coalition. Provincial information is shared with the NTS and used to plan strategies.

The NITHA HPA co-chairs the Building Vibrant Youth (BVY) action team to support NITHA partners who participate on the BVY.

Photo courtesy of NHCP

Achievements of the HPA as part of the BVY include:

- Supported several of the NITHA Partners to conduct the 40 Developmental Asset survey and community action planning in their communities.
- Presented on health promotion/positive youth development at the Embracing Life Workshop (northern youth suicide prevention).
- Obtained an Embracing Life grant to develop a Northern role model campaign.

Figure 3:

Photo courtesy of NHCP

The HPA provides support to NITHA partners who are members of the Healthy Eating Team (HET).

Achievements of the HET include:

- Developed and distributed a Northern Gardening Manual.
- Implemented perinatal and infant nutrition initiatives.
- Initiated work on a nutrition policy template for northern organizations.
- Participated in the development of the Provincial Food Costing Report.
- Planned and implemented a pilot School Nutrition mentoring project (Southend was the First Nation pilot school.

The HPA provides support to NITHA Partners who are members of the Active Communities Team (ACT). This committee will be implementing Northern Physical Activity Month and other new initiatives.

Photo courtesy of NHCP

The HPA provides support to NITHA Partners who are members of the Babies, Books and Bonding Team. The HPA collaborates with NITHA Partners to ensure eligible communities receive books. During the year under review, the Babies, Books and Bonding program expanded to include a package for 4 year olds.

The HPA is a member of the Provincial Population Health Promotion Practitioners Council and was involved in the development of several Health Promotion Framework documents.
On the platform of the Child Health Clinic Resource task group, the HPA participated in the development of several resources for Child Health Clinics.


Photo courtesy of NHCP

Opportunities/future directions

In the 2014-2015 fiscal year, the HPA will continue to work collaboratively with the NITHA Partners and the Northern Health Regions to plan, develop and implement north-wide health promotion strategies and initiatives. There is much to look forward to and there are many opportunities for health promotion to have a positive impact on the health of children, youth, families and communities!

Future activities include:

- Continuing to work with the NITHA Partners to identify health promotion priorities, identify best practices, select, implement and evaluate health promotion initiatives.
- Collaborating with the Northern Population Health's Health Promotion Coordinator, to support the NITHA Partners who are involved in the NHCP health promotion work (Northern Tobacco Strategy, Building Vibrant Youth, Healthy Eating, Active Communities and Babies, Books and Bonding).
- Continuing to develop and maintain internal and external relationships and partnerships to support health promotion initiatives.
- Building health promotion capacity of the NITHA Partners and other NITHA staff to plan, implement and evaluate health promotion initiatives.
- Collaborating with and providing guidance and support to NITHA second level Partners and NITHA staff for health promotion initiatives.

INFECTION CONTROL ADVISOR

Program Overview

Over the past year the Infection Prevention and Control (IPC) program has not only focused on strengthening existing projects but also initiated new ones. The main priority areas were: use of personal protective equipment (PPE), medical device reprocessing, maintaining a clean and safe environment, hand hygiene and infection control during construction.


Infection Control Advisor
Ivan Serunkuma

Achievements

The Infection Prevention and Control Working Group which meets on a quarterly basis guided the specific activities and implementation strategies for the objectives of the IPC program. The program, with the Infection Control Advisor (ICA) as the lead, had several achievements.

An Infection Prevention and Control Policies and Procedures manual (Fig. 1) was released and copies of the manual were distributed to the entire Partnership. The manual provided an opportunity to have all the developed policies in one binder for easy reference. The release of the manual didn't mark the end to the development of polices; more policies will be added to the manual as they are developed. The policies added to the manual during the past year include among others: Mask Fit Testing and Respiratory Protection, Immunization of Health Care Workers, Procedure for Hand Hygiene.

Figure 1: NITHA Infection Control Manual

Education of health care workers on infection control measures continued mainly focusing on topics in the infection control manual. Some of the educational topics provided include: sterilization of medical devices, routine practices of infection control and transmission based precautions, quality assurance in infection control. Education was an ongoing process throughout the year but sharing of information and distribution of materials (DVDs, posters, brochures) were increased during the infection control week.

As a measure to protect health care workers from airborne infections, A *Qualitative Fit test* Mask fit Tester`s training was organized and held on October 8, 2013. This provided the necessary skills to perform Mask Fit Testing for health care workers at risk of acquiring such infections.

The Infection Control Advisor continued offering advice pertaining to renovations of existing health facilities within Partner communities. The advice on facility design enabled the application of effective infection control measures during and after completion of work on the facilities.

Useful infection prevention measures were provided to the Partnership to prevent outbreaks and transmission of serious infections utilizing the MBC radio and other communication means. This was the case during the first two months of this year, when the ICA was involved in information development and dissemination for the prevention of transmission of measles and influenza.

Other activities were informing the Partnership about relevant updates obtained from best practice standards and other authorities in the field of infection control, offering advice on the selection of products for cleaning and disinfection, assisting with the evaluation of procedures for performing various infection control practices, and offering solutions to a variety of infection control issues as requested.

As development of the program continues, an increasing emphasis will be placed on quality improvement, identification of new training needs and sustaining the successes achieved.

The ICA continued work with the HIV program together with the Communicable Diseases (CD) Control nurse with valuable input from the Medical Health Officer. In November 2013, the HIV Working Group held its first meeting. This was an opportunity for group members to get to know each other and discuss how to move forward in order to meet the goals and objectives of the program. A draft NITHA HIV strategy (Fig .2) was developed by the ICA and it`s currently being reviewed by the working group.

Figure 2: Draft NITHA HIV Strategy

The work being done on the strategy by the working group is very promising giving an assurance that when completed, the strategy will be an invaluable tool in achieving a comprehensive response to HIV/AIDS.

Education sessions on HIV were provided with the aim of improving awareness. Areas of focus for these activities 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 participation of the ICA in the organization of the Aboriginal AIDS awareness week activities provided another opportunity to share information.

An HIV information brochure was developed and released to provide quick and readily accessible information to community members. The brochure provides basic information about HIV transmission, prevention, disclosure, stigma and discrimination and other topics.

Figure 3: HIV Information Brochure

Priorities

The IPC manual will be availed on NITHA website for easy access, development and implementation of a hand hygiene program will continue, an environment of care assessment will be performed and more policies will be developed. More work will be done to facilitate orientation of new staff on Infection Prevention and Control. To improve awareness of important infection control issues, emphasis will be placed on development of surveillance tools with pertinent infection control indicators to report on. The HIV strategy will be completed in the coming year and this will streamline HIV preventive efforts in the Partnership such as education, increased testing, and behavioural change messages among other initiatives.

Challenges

People living with HIV continue to face stigma and discrimination. This has significant impact on HIV testing, treatment and other services. Stepping up HIV awareness activities and encouraging everyone's involvement will reduce stigma.

The development of resistance to antibiotics complicates treatment of infections and the resistant organisms can still be spread from one person to another. The fact that health care services are accessed in different health care settings located in various areas in the entire province (or out of the province) can sometimes make it difficult to track the origin of these and other healthcare associated infections.

TB ADVISOR

Program Overview

The *Saskatchewan Provincial TB Strategy*, 2013-2018 was released in June 2013. NITHA played an active role in the development of the strategy and will take the lead in the implementation of the strategy in Partner communities. The major highlight of the provincial strategy as it relates to NITHA is the sub *Strategy for Tuberculosis Management in High Incidence Communities*. Four NITHA Communities are piloting this strategy which focuses on the development and implementation of a number of program enhancements that are tailored to the specific needs and issues of that community.

The support of the High Incidence TB Strategy and contact tracing were the priority activities of NITHA TB program in 2013-2014. The workload was extremely heavy this year due to an increased number of cases and a new protocol requiring contact tracing of smear negative, culture positive TB cases. A total of 47 community visits were made, 34 by the NITHA TB nurses and another 13 by contracted nurses.

Achievements

Tuberculosis in NITHA Partner First Nations:

In 2013 there were 39 cases of suspect or confirmed active Tuberculosis in NITHA communities (see figure 1). This is a 30% increase above the previous 5-year average of 30 cases. This year, in contrast to last year when our highest incidence communities had quiet years with only one or two cases each, the majority of cases were in our high incidence communities.

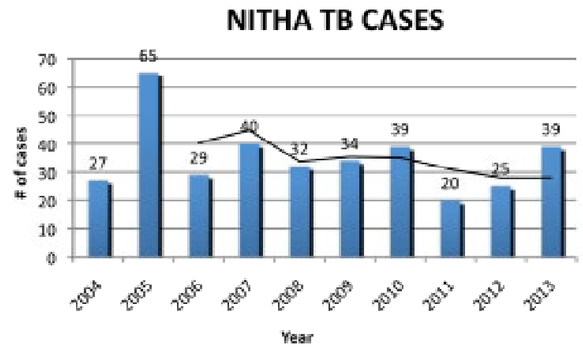


Figure 1: Number of NITHA TB cases per year (2004-2013)

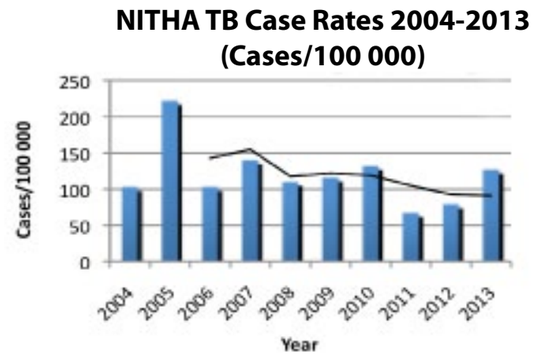

TB Advisor
Sheila Hourigan


TB Nurse
Eileen Oliveri


TB Nurse
Janine Brown


Program Administrative Assistant
Cindy Sewap

Cindy provides support to the TB Staff working in the Public Health Unit and is a member of the office support team.



*Based on CWIS population figures
Figure 2: NITHA TB Case rates per year (2004-2013)

The age distribution of 2013 Active and Suspect Tuberculosis cases is highlighted in Table 1 below.

Table 1: Age distribution of 2013 TB active cases

Age (in years)	# of cases
0-4 yrs	5
5-14 yrs	3
15-24 yrs	9
25-34 yrs	2
35-64 yrs	17
65+ yrs	3
Total	**39**

The age group contributing the greatest number of cases again this year was the middle age group, age 35-64. Cases in this age group frequently had significant risk factors for progression to disease including diabetes, alcohol and drug abuse and smoking.

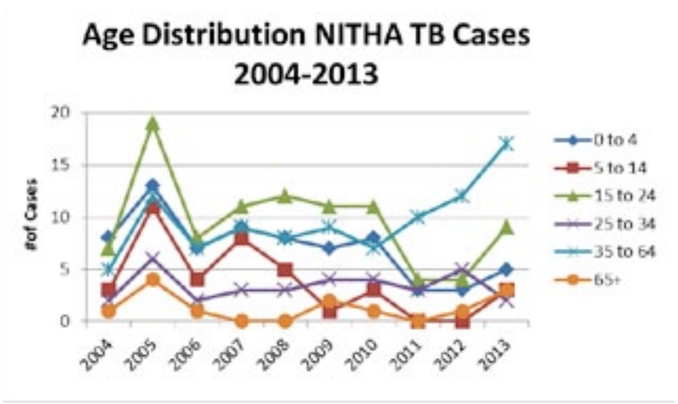


Figure 3: Age distribution of TB cases per year (2004-2013)

Figure 4 below shows that between 2008 and 2013, 87% of all TB Cases were contained in 9 communities with 1 community contributing more than 20% of all NITHA TB cases. Focusing additional resources in these communities has the potential to reduce the burden of disease significantly.

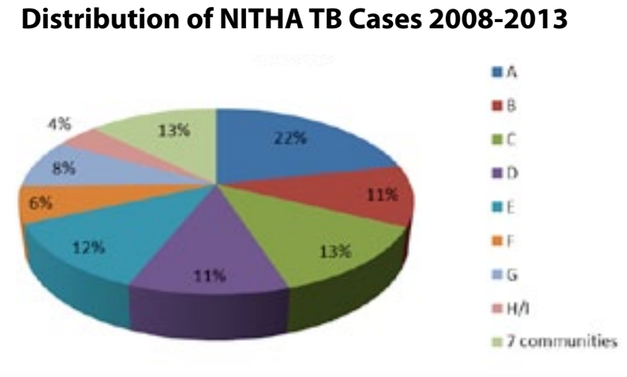


Figure 4: Distribution of TB cases by communities

The breakdown according to the type of disease is captured in Table 2.

Table 2: Type of TB infection by age group

Type of Disease	Smear Positive Pulmonary	Smear Negative Pulmonary	Extra Pulmonary	Disseminated
Adult 15& over	12	17	1	1
Child 0-14	1	7	0	0
Total	**13**	**24**	**1**	**1**

Thirteen out of 39 or 33% 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.

The most common risk factor for progression to disease present in all cases was recent exposure: 21 out of 39 cases. Though the data on risk factors is not complete at the time of compiling this report, other documented risk factors in the 2013 TB cases were smoking (9), alcohol overuse (9), marijuana use (5) and diabetes (1). There were no TB cases associated with HIV during the year under review.

Professional and Community Education and Support

Community Health Nursing

During the year under review, NITHA TB nurses provided orientation on various aspects of the TB program to 31 nurses at the community level. Twenty-seven nurses attending the Orientation and Skills Training program participated in a presentation on early detection and treatment of TB.

Telephone consultation continues to be an important means of supporting nurses as they encounter day-to-day challenges presented by the TB program and their clients. Beginning in September 2013,

due to workload constraints, NITHA TB nurses no longer conducted the screening in the preschool age group in the 13 communities reaching the threshold for enhanced screening (3-year average annual rate of smear positive TB > 15/100 000). The community health nurses (CHN) in these communities were charged with the responsibility of completing this screening. As well the CHNs in all communities were responsible for the school entry Tuberculin Skin Test (TST) screening on all eligible children.

While the NITHA TB nurses continue to take the lead role in contact tracing the CHNs are frequently called upon to begin compiling the list of contacts when a smear positive case is diagnosed. We also rely on the CHN to ensure that any children under age 5 years are skin tested immediately if the NITHA nurse cannot be in the community within a week of the diagnosis of the index case. Any contacts that the NITHA TB nurses are unable to test or to conduct a symptom inquiry on are also followed-up by the CHN. Thus, the CHN has an integral role in managing contact tracing and their support is invaluable. The NITHA TB nurses visited communities to assist with contact tracing on 31 occasions this year, nearly double the number of visits required in the previous year.

TB Program Workers:

Seven new TB program workers were trained and 4 received updates or additional orientation at the community level.

In one of the high incidence pilot sites NITHA assisted the community in securing funding for a TB worker to work in an expanded role. This expanded role is supported by the NITHA TB nurse and includes community education, screening and education of high risk clients.

Training TB workers, which focuses on the Directly Observed Therapy (DOT) program is the most important way NITHA supports TB workers in the communities. There was a provincial TB worker workshop held in September with 23 workers from NITHA communities participating.

Case management issues were supported on 30 occasions while the NITHA Nurse visited the communities. In all case management issues we work closely with the Provincial TB Prevention and Control team as they manage client care from the clinical perspective.

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 20 contact traces required in NITHA Partner communities in 2013 (compared to 11 in 2012), 13 infectious traces looking for spread and 3 primary traces looking for a source. In addition, there were 4 contact traces conducted on smear negative, culture positive cases as a result of a new protocol implemented by TB Prevention and Control, Saskatchewan in November 2013. In the past these cases were not subject to contract tracing as they were deemed less likely to transmit the disease. Between April 1, 2013 and March 31, 2014, NITHA Nurses made 31 community visits to conduct contact tracing. 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. More than 1000 individuals were assessed by the NITHA nurses.

The TB program continued to assess risk factors in contacts, as part of the contact tracing protocol that was newly implemented in 2012. Risk factors are important for assessing a person who has been in contact to TB risk for progressing to active tuberculosis and can help TBPC physicians to prioritize assessment and preventative treatment. The assessment by the TB nurses of contact's risk factors was not done previously. While this has added considerably to the workload of contact tracing there is significant benefit to this approach.

The NITHA TB nurses with the support of the CHNs in the communities have been successful in meeting the contact tracing timeline targets that have been identified by the NITHA TB program and which are supported by both the provincial TB program and the Canadian National TB standards. Specifically, all contact lists were compiled within one week of the diagnosis of the index cases, children under 5 years of age skin were tested and referred to TBPC within 1 week, and 80% of the remaining contacts were tested within 2 weeks. NITHA is currently working with our other provincial stakeholders to achieve other contact tracing targets such as assessment and institution of treatment or preventive therapy within 30 days.

Childhood Screening Program:

This 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. The communities have thus far reported on screening 60 children in this age group. None had a positive skin test for an infection rate of 0%. (See figure 5). Low incidence communities were not required to screen any children at this age.

CHNs are also responsible for the testing of children at school entry. Only children who have not had a BCG vaccination are eligible for this screening. Testing on 46 students has been reported to NITHA to date. No child had a significant skin test, for a rate of infection of 0%. Previous rates, when children who had BCG vaccination were also included in the screening, averaged around 5%.

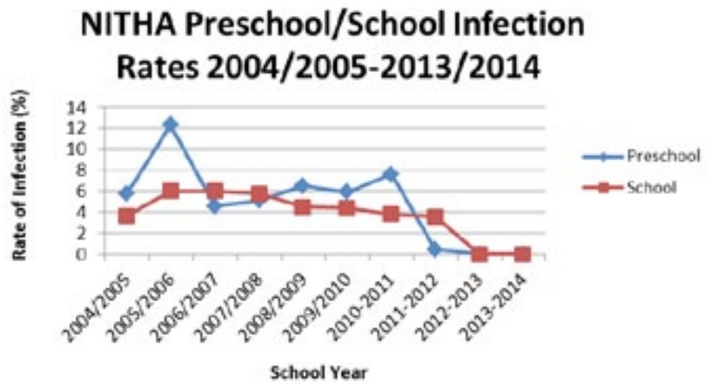


Figure 5: NITHA Preschool/School TB infection rates by School year

Surveillance:

Collecting and analyzing TB data to identify disease and infection trends as well as monitoring program activities are important to ongoing tuberculosis program planning and evaluation. Data analysis this year was focused on the high incidence communities to develop a profile that could assist the community in understanding how TB affects their community.

High Incidence Strategy:

The development of the *Strategy for the Management of Tuberculosis in High Incidence Communities* continued throughout the spring of 2013 under the auspices of the Public Health Working Group of the Saskatchewan Population Health Council. The NITHA TB program participated actively in its development and has taken the lead role for implementation in 3 of the 4 communities who are piloting this strategy. The fourth community is involved in a joint project with a neighboring off reserve community which is being led by the Regional Health Authority.

The overall Saskatchewan TB strategy has recognized that the distribution of TB is not uniform within the province and there are certain communities that are disproportionately affected. Thus, a key element of the overall strategy is the focusing of resources and efforts into these high incidence communities.

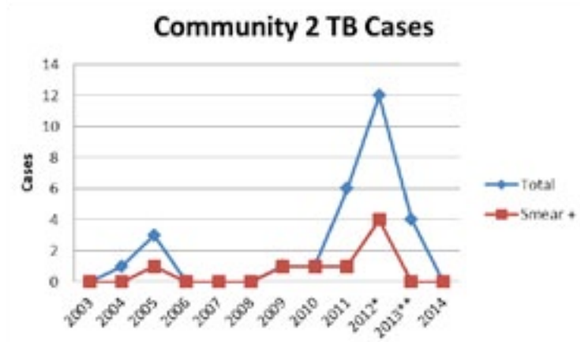
The NITHA TB Advisor began coordinating meetings via teleconference of the stakeholders for each of the communities in the fall of 2013. Each community has identified its team members which include: health staff, leadership and other community members, health authority and tribal council supervisors, NITHA staff, including our Medical Health Officer, TB advisor and TB nurses, TBPC Saskatchewan, including TB physicians, TB nurse clinician and program managers, and FNIHB representatives.

During the strategy sessions the team for each community looks at the particular issues that relate to TB affecting their community under several broad areas. These areas include: community engagement, community awareness, early case detection through contact tracing and screening, active surveillance of high risk individuals, latent TB infection management, monitoring of direct observed therapy, infection control and health determinants. From there various strategies that are appropriate to the individual community are being developed. This development is ongoing and the strategies are at various stages of implementation.

The strategy is meant to be a long term initiative spanning until 2018. For NITHA to implement the strategy fully and effectively we will require additional nursing resources. We are hopeful that FNIHB will ensure we get the needed support to enable the strategy to have its desired impact on the incidence of tuberculosis in Partner communities.

Out Break Management

<u>Community 2</u>



2012* includes 2 off reserve smear + cases, but not smear - cases
2013* includes epidemiologically linked case in other FN

Figure 6: Number of TB cases in Community 2 (2003-2014)

This community, which experienced an outbreak beginning in 2011, has had no further cases since June of 2013 (see figure 6). In March of 2014 there was a case from an urban centre that had epidemiologic links to the outbreak and contact tracing in the community was required. However, there have been no secondary cases in the community to date. This community is now participating in the high incidence strategy development and implementation. Hopefully these efforts, when sustained over the long term, will prevent such outbreak from occurring in the future.

Challenges

1. Lack of resources to fully support the high incidence strategy and manage the heavy contact tracing workload.
2. Low mobile clinic attendance. In order to support improved client follow-up we need to identify factors affecting attendance and either develop strategies to alleviate, or work with stakeholders to develop alternative means of service delivery (e.g. Telehealth).
3. Community level case management and DOT accountabilities. Turnover and shortages of nursing staff negatively impact case management at the community level and there is only so much NITHA can do given our resources and distance from the communities. NITHA is working with other stakeholders to fully articulate accountabilities with a goal of improving service delivery.

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. Support of high incidence strategies.
3. Outbreak management in terms of early identification and management will remain a priority for the NITHA TB program because of the need for coordination and heavy resource requirements.

Administrative Unit

Receptionist/Office Assistant
Samantha Bear

Samantha is the voice and face of the organization as she greets visitors and takes calls while working at the front desk. She is also part of the office support team.

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

HUMAN RESOURCE ADVISOR

Program Overview

The Human Resources Advisor works with the Personnel Finance Assistant to support the NITHA Partnership to plan, implement, and operate human resource programs aimed at addressing Human Resource issues as a collaborative approach.

During this fiscal year the Human Resource Advisor position became vacant in August 2013, at which time the role was assumed by myself the Executive Director. The position was filled in February 2014 although the successful candidate is not expected to join our team until July 2014.

Achievements

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

- NITHA works with the Partnership to reach targeted applicants by placing job advertisements of vacant positions in the Partnerships on our website.
- The Partnership has also continued to support NITHA in having their representatives actively participate in NITHA's resume screening meetings and interviews.
- Initiated a contract with HR downloads to support the organization in developing Human Resource policies and procedures as well as Job Descriptions.
- Began reviewing and revising existing Personnel Management Regulations.

HR Strategic Planning and Recruitment – During the last fiscal year NITHA was successful in filling a hard to recruit position of Medical Health Officer, which had been vacant for 3 years. We 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. The following positions were filled:

POSITION FILLED	DATE FILLED
Medical Health Officer	August 2013
Environmental Health Advisor	February 2014
Mental Health and Addictions Advisor	December 2013
Human Resource Advisor	February 2014
Receptionist	March 2014
Administrative Assistant	March 2014
Executive Assistant to MHO	October 2013

The position of Director of Community Services was also vacated in November 2013; we are presently reviewing this position and how it fits in the organization. At the present time NITHA has no vacant positions.

At NITHA we engage in a continuous stream of necessary actions to maintain and enhance people's skills and competency, because we believe everyone has room for improvement. We have constantly ensured that employee skills are updated through our employee professional development program. 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:

- Occupational Health and Safety training for all staff
- First Aid and CPR training for all staff
- Corporate Employee Orientation for new hires
- Job specific training for new hires
- Employee Group Benefits and Pension Plan Training for staff

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, the 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 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.

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 all have roles in ensuring that HR policies are effectively executed. HR 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 second (2) 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 they had an office inspection by a Federal OH&S officer, which included training for the committee to complete this process internally next year. The inspection was passed along with the annual fire inspection and at this time we have no outstanding OH&S concerns or grievances.

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. The goal will be to complete this binder in the next fiscal year and to share it with the Partnership. NITHA will be in a position to assist the Partnerships in establishing similar programs.

Employee Wellness - The Wellness and Social Committee at NITHA provides information about wellness resources and services to assist in identifying and supporting the health, safety and well-being of staff. It is also responsible for coordinating all 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 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 will establish 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

- Establish a 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.
- Revise the existing Personnel Management Polices and the General Procedures Manuals.

The Northern Inter-Tribal Health Authority Leadership, Management and staff wishes to thank the following former employees of the organization for their contributions to the success of NITHA. NITHA bid farewell to the following staff in 2013-14:

Bev Peel
Director of Community Services - Nov 2013

Tolu Babalola
Human Resource Advisor - Aug 2013

Cyndy Lee
Mental Health & Addictions Advisor - Aug 2013

Brenda Ziegler
Environmental Health Advisor - Aug 2013

Jacqueline Natamogan
Term Program Administrative Assistant - Aug 2013

Maxine Ballantyne
Program Administrative Assistant - Dec 2013

Tricia Morin
Receptionist Office Assistant - Aug 2013

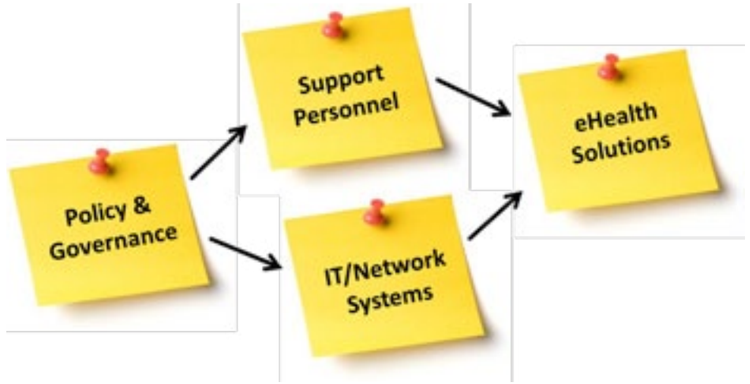
Robert Hunt
Term Privacy Officer - Mar 2014

eHEALTH ADVISOR

Program Overview

eHealth Advisor
Charles Bighead

The working group is comprised of technical representatives from the Partners and meets several times a year to discuss ehealth issues and to make eHealth related recommendations to the NITHA Executive Council. The main accomplishment of the working group this year was the development of a long term eHealth plan. A few NITHA Working Groups (ex. Nurse Managers WG) were consulted regarding community needs and the responses were organized into four interrelated areas:



The plan would be responsive to the needs identified by NITHA Working Groups and would also address the business requirements and challenges that are necessary for eHealth such as information governance, funding, support system, and privacy.

Another accomplishment of the working group was to guide the recruitment process of a consultant for the Electronic Medical Record (EMR) Information Governance project. Although funding was approved late in the year, the project started relatively quick after a consultant was recruited through an RFP process.

In January the working group began making plans for 2014-2015 and discussed collective proposals. The group drafted a job description for an eHealth/Telehealth Coordinator position in anticipation of FNIH funding one position for each Partner in the New Year.

ORGANIZATIONAL HEALTH PLAN

During the summer the NITHA eHealth Working Group began working on the eHealth components for the NITHA Organizational Health Plan. eHealth will have seven main goals:

1. Protect First Nations information assets
2. Manage common eHealth services
3. Advocate for eHealth funding
4. Utilize provincial eHealth systems where appropriate
5. Develop custom eHealth database systems
6. Implement the OCAP principles
7. Engage First Nations about eHealth initiatives

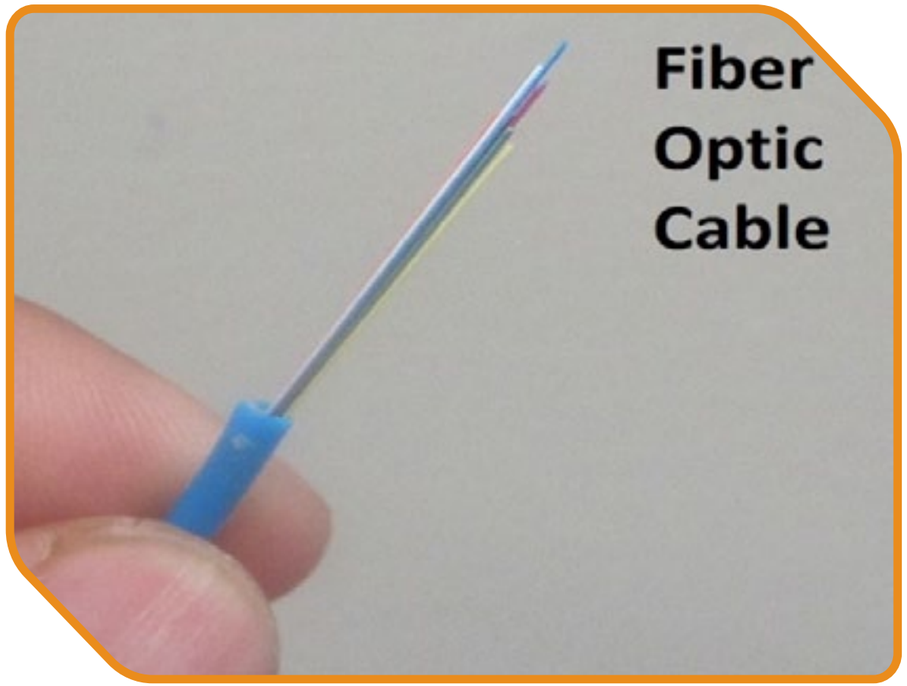
After a few revisions by the NITHA Executive Council and FNIH, the eHealth components were approved and the eHealth plan will be applied over the next five years.

TELEHEALTH

NITHA received funding to support First Nations with becoming official Saskatchewan Telehealth sites. Achieving "official" status is necessary if First Nations want to access provincial services remotely using telehealth (ex. clinical consults with specialists, participating in continuing professional education training).

The technical requirements to become official Telehealth sites are (1) First Nations must upgrade their CommunityNet connections to support High Definition video conferencing, and (2) Service Agreements (i.e. manufacturer warranties) must be in place for the Telehealth equipment.

NITHA was able to complete upgrade to about half of the CommunityNet connections this year. Not all upgrades were completed because of delays with trenching fiber optics cables to many First Nations health facilities. The remaining sites should be completed by the summer of 2014.

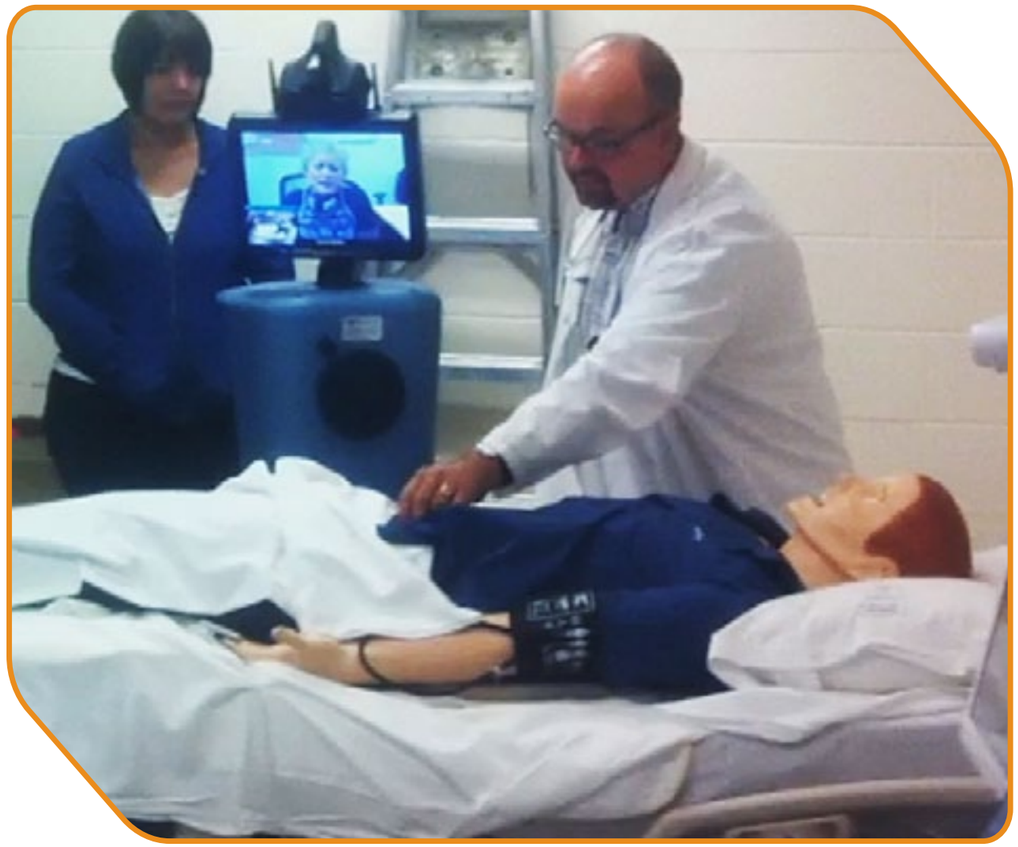


NITHA acquired services agreements for all the Telehealth equipment and consolidated management of those agreements through a single vendor. Those agreements will be valid till February/March 2017. Although the technical requirements for Telehealth are being met, it is still a challenge to utilize the Telehealth equipment because First Nations do not have dedicated "Telehealth Coordinator" positions unlike the provincial system. Fortunately Health Canada have indicated they will start funding Telehealth coordinator positions and NITHA has been assisting the Partners with developing that job description and proposal writing.

REMOTE PRESENCE

Remote Presence is a specialized type of Telehealth whereby robotic equipment with video conferencing capabilities is remotely controlled by an operator. The operator may be an educator for distance nursing education or a doctor seeing a patient. NITHA helps to coordinate First Nations participation in a few information sessions about the technology.

The technology is being piloted in Pelican Narrows as an option for much needed doctor's services and is being supported by the Northern "Docs" (Northern Medical Services).



Demo of "Pert" the Robot

EMR INFORMATION GOVERNANCE PROJECT

Late in the year NITHA was approved for funding for an Electronic Medical Record (EMR) Information Governance project. The objectives of the project were to:

- Identify options for how First Nations could exercise Ownership and Control of First Nation data in a shared EMR.
- Identify the terms and conditions for sharing client health information to support better health outcomes while preventing unauthorized use of First Nation data.

The inputs from various Northern First Nations and non-First Nations organizations were collected through one-on-one interviews and a two day workshop held in Prince Albert on March 12th and 13th. The final report identifies options for First Nations data trustee models, terms for a data sharing agreement, and a recommended plan for implementing an EMR. The final report will be disseminated early in the New Year.

EMR Workshop Breakout Group

PRIVACY

NITHA created a draft set *Privacy and Information Security Policies and Procedures for the Protection of the Personnel Health Information* (PHI). The purpose of the policies is to serve as a standard template that can be applied by First Nations Health Organizations to strengthen First Nations capacities to protect PHI, to align with external stakeholders privacy obligations (ex. RHAs and HIPA), and to ready First Nations for electronic information systems (ex. PANORAMA, EMR).

These policies were the culmination of several years' work with expert privacy consultants (Dr. David Flaherty, Seccuris Inc.) and recommendations by the provincial privacy commissionaire (Gary Dickson). A legal review of the policies were done by McKercher LLP who concluded that "NITHA's master policy reflects the necessary precautions that a trustee of PHI in Saskatchewan is currently expected to take when permitting access, amendment, or transfer of PHI".

Over the next year, NITHA will assist the Partners with review, revision and adoption of the policies. The challenge will be availability of First Nations staff to participate in the review and ratification process because of regular job demands.

PANORAMA

NITHA received funding to support Panorama related readiness activities. The eHealth Advisor continues to represent northern First Nations on the First Nations Deployment of Panorama in Saskatchewan (FNDPS) Information Governance Working Group (IGWG) and the Information Technology Working Group (ITWG).

One of the notable principles developed by the IGWG is "*the primary purposes of Panorama are to support the care of individuals* and *to support public health surveillance*. The agreement of the community is required for the use/disclose of information for secondary purpose such a program evaluation or research". The intent of this principle to prevent unauthorized use for First Nations aggregate data. As IG work continues in the New Year, any development of a "Data Sharing Agreement" must take into account First Nations ownership and control of their data in the Panorama system.

NITHA has been advocating an IT support service model for Panorama that is positioned in the North with First Nations. By placing the support service close to where it is needed the effect should be a better, more responsive support system. The challenge will be securing the funds to support this model.

In the latter part of the year, the NITHA Partner hosted privacy workshops for Panorama. NITHA used this opportunity to promote the draft Privacy and Information Security Policies & Procedures.

For the New Year, NITHA will continue to represent First Nations in the FNDPS project in preparation for Immunization module of Panorama which is expected to roll out sometime in 2015.

SIMS

NITHA supported Lac La Ronge Indian Band, Stanley Mission and Red Earth First Nations with implementation of the Saskatchewan Immunization Management System (SIMS). NITHA helped secure funding (new computers, trainer, and data back entry) and coordinate the process for First Nations to gain access and start using SIMS.

Late in the year two other communities have confirmed their intent to use SIMS. This will likely be the last opportunity for any First Nations to access SIMS because Panorama will replace SIMS sometime in 2015 (note – immunization data from SIMS can be transferred to Panorama so data re-entry will not be necessary).

ADVANCED IT SUPPORT

The NITHA Sr. Network Technologist provides detailed technical advice to the NITHA eHealth Advisor on new and emerging technologies.

The Network Technologist also provides advanced IT support to the NITHA Partner IT personnel as required. Typically a lot of knowledge, research and self-study is required to solve complex problems or implement new technologies. The Network Technologist is making preparations to teach Cisco for the new IT personnel within the Partnership in the new year.

The Network Technologist installed a new server system at the NITHA Office that implemented "virtual machine" technology which greatly improved server performance, reliability and disaster recovery. In the new year the old phone system will be updated with new equipment and a unified communications (UC) system. UC will provide staff with a variety of new features such as sending and receiving a fax from a computer and participating in video conferencing meeting from a computer or smartphone. All implementations of new technologies at NITHA are meant to prove and showcase technologies for the Partners' consideration.

Senior Network Technologist
Eric Xue

OTHER

NITHA provided $75,000 to each Partner to support an IT position. IT personnel are not funded positions but are critical for supporting and advancing eHealth systems.

NITHA met with PAGC leadership to advocate for more IT human resources. At the present staffing level it's a challenge to provide timely support to the communities.

NITHA assisted PAGC and LLRIB with acquiring funds to implement "Websense" which is specialized software designed to monitor and control employee internet activities. Inappropriate use of the internet is a security threat and lowers work productivity.

FNIH has a national standards development project for healthcare and are including standards specific to eHealth. A draft set of ehealth standards have been developed and NITHA is advocating for the inclusion of essential standards such as those related to human resourcing and funding.

Various regional eHealth working groups and committees with First Nations, Federal and Provincial participants have been amalgamated into a single Regional eHealth Working Group. This group is still being established.

PAGC, LLRIB and James Smith First Nations have started using the eCBRT tool this year. The primary purpose of the tool is to make data collection and annual CBRT reporting as easy as possible for the communities.

FINANCE MANAGER

Program Overview

Transfer Agreement Funding

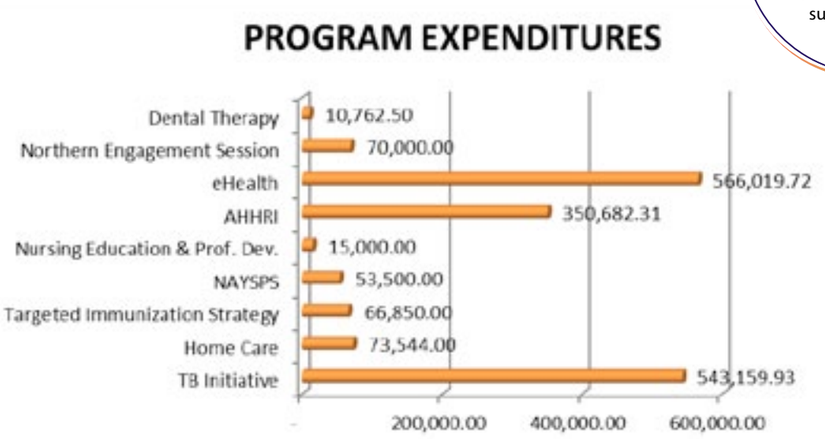
NITHA's 2013/2014 current year's Health Canada transfer agreement funding which was granted extension and expired March 31, 2014. NITHA's entering into a new 5 year agreement with Health Canada which will expire March 31, 2019. The new agreement will combine both transfer funding and SET agreement funding into one agreement.

This year's transfer funding amount was $2,610,997 for this fiscal year. The Transfer Agreement funds are used to support the Public Health Unit (PHU), the Community Services Unit (CSU) and NITHA Administration.

Transfer Funding	$2,576,829
Environmental Health	34,168
TOTAL TRANSFER FUNDING	$2,610,997

SET Agreement Funding

SET Agreement funding is provided by Health Canada and is targeted towards specific programs and service needs of the Partner communities. The total SET agreement funding was in the amount of $1,263,624. NITHA's Program expenditures including the SET agreement expenditures are portrayed in the chart below.



Finance Manager
Lisa Lepine

Personnel & Finance Assistant
Glenna Thomas

Glenna provides administrative support to both the Human Resource Advisor and the Finance Manager. She is also a member of the office support team.

SET Agreement Funding

Throughout the year, the detailed budgeted financial statements by program area are presented and reviewed by the NITHA Executive Council on a quarterly basis. The detailed budgeted financial statements then go to the Board of Chiefs for review and approval. And a new budget for 2014-2015 was approved by the Board of Chiefs in February 2014 for the upcoming fiscal year.

NITHA's received interest revenue of $50,122 and it was allocated to the Scholarship Fund as it is each year. In 2013, NITHA distributed $25,150 in scholarships' to applicants pursuing a health career. NITHA's Annual General Meeting was held on October 16th, 2013, where recognition was made to this year's scholarship recipients.

Also at NITHA's AGM was the presentation of the audited statements and an opinion was stated by Deloitte LLP to the NITHA Executive Council and the NITHA Board of Chiefs. The opinion stated the financial statements were presented fairly, in all material respects.

During the year, NITHA completed a five year Operational Health Plan. NITHA's 2014-2019 Operational Health Plan was completed and approved by the Board of Chiefs and Health Canada.

NITHA Partners' through the Northern Lights Community Development Corporation assisted in funding $104,429 for the start-up of a new Dental Therapy program aiming towards improving oral health of community members in the Partnership.

2013-2014 Financial Statements

The 2013-2014 audited financial statements unveil the financial portrait of this past year's programs and services provided to the Partners and 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

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

FINANCIAL STATEMENTS

March 31, 2014

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, 2014 and the statements of revenue, expenses 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, 2014 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 Accountants

June 25, 2014
Prince Albert, Saskatchewan

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF REVENUE, EXPENSES AND CHANGES IN FUND BALANCES
for the year ended March 31, 2014

	Budget 2014	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2014**	Total 2013
	(Unaudited)	(Schedule 1)					
REVENUE							
Contributions, transfers and projects							
Health Canada - transfer agreements	$ 2,630,688	$ 2,610,997	$ -	$ -	$ -	**$ 2,610,997**	$ 2,630,688
Health Canada - contribution agreements	1,259,295	1,263,624	-	-	-	**1,263,624**	1,600,060
Northern Community Lights Development Corporation	-	104,429	-	-	-	**104,429**	-
Administration fees (Note 8)	84,000	131,509	-	-	-	**131,509**	56,418
Expense recoveries	3,000	17,452	-	-	-	**17,452**	99,325
Gain (loss) on sale of capital assets	-	-	-	-	(1,333)	**(1,333)**	10,261
Interest	-	-	-	50,122	-	**50,122**	62,109
Transfer from deferred revenue	336,929	336,929	10,000	-	-	**346,929**	420,631
Transfer to deferred revenue	-	(93,666)	-	-	-	**(93,666)**	(336,929)
	4,313,912	4,371,274	10,000	50,122	(1,333)	**4,430,063**	4,542,563
EXPENSES							
Health Canada programs	5,012,141	4,232,836	-	25,150	-	**4,257,986**	4,141,198
Expenses funded by appropriated surplus	-	-	660,860	-	-	**660,860**	683,676
Amortization of capital assets	-	-	-	-	158,596	**158,596**	257,723
	5,012,141	4,232,836	660,860	25,150	158,596	**5,077,442**	5,082,597
NET (DEFICIT) SURPLUS	$ (698,229)	138,438	(650,860)	24,972	(159,929)	**(647,379)**	(540,034)
FUND BALANCES, BEGINNING OF YEAR		(386,190)	4,101,426	444,226	433,632	**4,593,094**	5,133,128
TRANSFER TO CAPITAL FUND		(26,076)	-	-	-	**(26,076)**	(188,678)
TRANSFER FROM OPERATING FUND		-	-	-	26,076	**26,076**	932,740
TRANSFER TO APPROPRIATED SURPLUS		-	-	-	-	-	(744,062)
FUND BALANCES, END OF YEAR		$ (273,828)	$ 3,450,566	$ 469,198	$ 299,779	**$ 3,945,715**	$ 4,593,094

See accompanying notes

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF FINANCIAL POSITION
as at March 31, 2014

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2014**	Total 2013
CURRENT ASSETS						
Cash and cash equivalent	$ 290,857	$ 3,450,566	$ 469,198	$ -	**$ 4,210,621**	$ 4,979,223
Accounts receivable	173,987	-	-	-	**173,987**	85,311
Prepaid expenses	8,637	-	-	-	**8,637**	12,095
	473,481	3,450,566	469,198	-	**4,393,245**	5,076,629
CAPITAL ASSETS (Note 4)	-	-	-	299,779	**299,779**	433,632
	$ 473,481	$ 3,450,566	$ 469,198	$ 299,779	**$ 4,693,024**	$ 5,510,261
CURRENT LIABILITIES						
Accounts payable and accrued charges	$ 653,643	$ -	$ -	$ -	**$ 653,643**	$ 570,238
Deferred revenue (Note 5)	93,666	-	-	-	**93,666**	346,929
	747,309	-	-	-	**747,309**	917,167
FUND BALANCES						
Unappropriated deficit	(273,828)	-	-	-	**(273,828)**	(386,190)
Appropriated surplus (Note 6)	-	3,450,566	-	-	**3,450,566**	4,101,426
Surplus appropriated for scholarships (Note 7)	-	-	469,198	-	**469,198**	444,226
Equity in capital assets	-	-	-	299,779	**299,779**	433,632
	(273,828)	3,450,566	469,198	299,779	**3,945,715**	4,593,094
	$ 473,481	$ 3,450,566	$ 469,198	$ 299,779	**$ 4,693,024**	$ 5,510,261

See accompanying notes

SIGNED ON BEHALF OF THE BOARD:

Chair

Board Member

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF CASH FLOWS
for the year ended March 31, 2014

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2014**	Total 2013
CASH FLOWS FROM (USED IN) OPERATING ACTIVITIES						
Net (deficit) surplus	**$ 138,438**	**$ (650,860)**	**$ 24,972**	**$ (159,929)**	**$ (647,379)**	$ (540,034)
Adjust items not affecting cash						
Loss (gain) on sale of capital assets	-	-	-	1,333	**1,333**	(10,261)
Amortization of capital assets	-	-	-	158,596	**158,596**	257,723
	138,438	(650,860)	24,972	-	**(487,450)**	(292,572)
Changes in non-cash working capital						
Accounts receivable	(88,676)	-	-	-	**(88,676)**	(69,640)
Prepaid expenses	3,458	-	-	-	**3,458**	(6,312)
Accounts payable and accrued charges	83,405	-	-	-	**83,405**	(386,704)
Deferred revenue	(253,263)	-	-	-	**(253,263)**	(107,940)
	(116,638)	(650,860)	24,972	-	**(742,526)**	(863,168)
CASH FLOWS FROM (USED IN) CAPITAL ACTIVITIES						
Purchase of capital assets	-	-	-	(26,076)	**(26,076)**	(198,939)
Proceeds from disposal of capital assets	-	-	-	-	-	10,261
	-	-	-	(26,076)	**(26,076)**	(188,678)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(116,638)	(650,860)	24,972	(26,076)	**(768,602)**	(1,051,846)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	433,571	4,101,426	444,226	-	**4,979,223**	6,031,069
TRANSFER TO CAPITAL FUND	(26,076)	-	-	-	**(26,076)**	(188,678)
TRANSFER FROM OPERATING FUND	-	-	-	26,076	**26,076**	932,740
TRANSFER (TO) FROM APPROPRIATED SURPLUS	-	-	-	-	-	(744,062)
CASH AND CASH EQUIVALENTS, END OF YEAR	**$ 290,857**	**$ 3,450,566**	**$ 469,198**	**$ -**	**$ 4,210,621**	$ 4,979,223
CASH AND CASH EQUIVALENTS CONSISTS OF:						
Cash					**$ 535,155**	$ 498,282
Short-term investments					**3,675,466**	4,480,941
Cash and cash equivalents					**$ 4,210,621**	$ 4,979,223

See accompanying notes

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2014

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 equity 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 equity 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

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 undertaken was a 5-year health transfer agreement, which expires in March 31, 2019.

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2014

4. CAPITAL ASSETS

	Cost	Accumulated Amortization	Net Book Value **2014**	Net Book Value 2013
Computers	$ 940,007	$ 867,744	**$ 72,263**	$ 133,345
Software	68,081	34,041	**34,040**	56,734
Equipment and furniture	376,663	291,734	**84,929**	102,565
Leasehold improvements	407,156	361,019	**46,137**	50,728
Vehicles	278,964	216,554	**62,410**	90,260
	$ 2,070,871	$ 1,771,092	**$ 299,779**	$ 433,632

5. DEFERRED REVENUE

	2014	2013
Dental Therapy	**$ 93,666**	$ -
Aboriginal Human Resources	**-**	336,929
Glaxosmith Kline Project	**-**	10,000
	$ 93,666	$ 346,929

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:

	2013 Opening Balance	Transfers	Expenses	**2014 Ending Balance**
Capacity development iniatives	$ 300,808	$ -	$ -	**$ 300,808**
Capital projects	841,000	-	8,020	**832,980**
E-Health solutions	340,000	300,000	339,010	**300,990**
Special projects	360,000	310,000	313,830	**356,170**
Strategic planning and long-term planning	2,259,618	(600,000)	-	**1,659,618**
	$ 4,101,426	$ 10,000	$ 660,860	**$ 3,450,566**

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. The transfer from the Operating Fund recorded in each year represents the interest earned less scholarship expenditure incurred in that fiscal year as follows:

	Amount
2003	$ 5,555
2004	22,140
2005	17,180
2006	22,658
2007	34,843
2008	116,065
2009	82,997
2010	16,793
2011	38,743
2012	55,393
2012 payments	(13,000)
2013	62,109
2013 payments	(17,250)
2014	50,122
2014 payments	(25,150)
	$ 469,198

8. ADMINISTRATION FEES

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

	Schedule	**2014**	2013
TB Initiative	5	**$ 39,655**	$ -
Home Care	6	**6,698**	12,143
Nursing Innovation Investments	7	**-**	1,165
Targeted Immunization Strategy	8	**3,126**	-
National Aboriginal Youth Suicide Prevention Strategy	9	**5,311**	2,913
Nursing Education	10	**1,008**	1,246
Aboriginal Human Resource	11	**18,735**	-
E-Health Solutions / Panorama	12	**50,958**	38,951
Northern Engagement Session	15	**6,018**	-
		$ 131,509	$ 56,418

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2014

9. 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:

	2013	2013
Prince Albert Grand Council	**$ 188,081**	$ 161,270
Meadow Lake Tribal Council	**$ 224,386**	$ 229,644
Peter Ballantyne Cree Nation	**$ 251,081**	$ 208,130
Lac La Ronge Indian Band	**$ 185,981**	$ 178,708

At March 31, 2014, there was $113,186 (2013- $61,842) of receivables and $57,166 (2013- $60,706) 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.

10. FINANCIAL INSTRUMENTS

Credit Risk

The Authority is exposed to credit risk from the potential non-payment of accounts receivable. 70% of the accounts receivable is due from Canada Revenue Agency, 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, 2014, the most significant financial liabilities are accounts payable and accrued charges.

Schedule 1

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
SUMMARY OF OPERATING FUND REVENUE, EXPENSES AND SURPLUS FROM PROGRAMS PRIOR TO INTERFUND TRANSFERS
for the year ended March 31, 2014

	Schedule	Health Canada Transfer	Health Canada Contributions	Other Revenue	Administration Fees	Transfer From Deferred Revenue	Total Revenue	Expenses	**Surplus (Deficit) 2014**	Surplus (Deficit) 2013
TRANSFER AGREEMENTS										
Public Health Unit	2	$ 730,551	$ -	$ (139)	$ -	$ -	$ 730,412	$ 793,023	**$ (62,611)**	$ 84,849
Administration	3	1,193,493	-	3,297	131,509	-	1,328,299	1,126,867	**201,432**	179,696
Community Services Unit	4	686,953	-	-	-	-	686,953	581,623	**105,330**	95,167
		2,610,997	**-**	**3,158**	**131,509**	**-**	**2,745,664**	**2,501,513**	**244,151**	359,712
SET AGREEMENTS										
TB Initiative	5	-	419,250	-	-	-	419,250	543,158	**(123,908)**	(38,275)
Home Care	6	-	73,544	-	-	-	73,544	73,544	-	-
Nursing Innovation Investments	7	-	-	-	-	-	-	-	-	-
Target Immunization Strategy	8	-	66,850	-	-	-	66,850	48,655	**18,195**	33,906
NAYSPS	9	-	53,500	-	-	-	53,500	53,500	-	-
Nursing Education	10	-	15,000	-	-	-	15,000	15,000	-	-
Aboriginal Human Resource	11	-	-	13,754	-	336,929	350,683	350,683	-	(56)
E-Health Solutions / Panorama	12	-	565,480	540	-	-	566,020	566,020	-	36,052
HIV/STI	13	-	-	-	-	-	-	-	-	(40,351)
CASET - HSIF	14	-	-	-	-	-	-	-	-	(6,418)
Northern Engagement Session	15	-	70,000	-	-	-	70,000	70,000	-	-
		-	**1,263,624**	**14,294**	**-**	**336,929**	**1,614,847**	**1,720,560**	**(105,713)**	(15,142)
OTHER AGREEMENTS										
Dental Therapy Program	16	-	-	104,429	-	(93,666)	10,763	10,763	-	-
TOTAL		**2,610,997**	$ **1,263,624**	$ **121,881**	$ **131,509**	$ **243,263**	$ **4,371,274**	$ **4,232,836**	$ **138,438**	$ 344,570

Schedule 2

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PUBLIC HEALTH UNIT
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	**2014**	2013
REVENUE			
Health Canada - transfer agreement	**$ 806,155**	**$ 730,551**	$ 782,169
Expense recoveries	**1,000**	**(139)**	6,108
	807,155	**730,412**	788,277
EXPENSES			
Meetings and workshops	**7,500**	**2,491**	2,928
Personnel	**792,973**	**741,593**	670,150
Professional fees	**4,000**	**3,507**	-
40 developmental assets	**12,000**	**6,287**	-
Program materials and supplies	**18,060**	**22,252**	14,539
Travel and vehicle	**29,500**	**16,893**	15,811
	864,033	**793,023**	703,428
(DEFICIT) SURPLUS	**$ (56,878)**	**$ (62,611)**	$ 84,849

Schedule 3

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ADMINISTRATION
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - transfer agreement	$ **1,137,580**	$ **1,193,493**	$ 1,219,118
Health Canada - CHP OTF	**-**	**-**	30,500
Administration fees	**84,000**	**131,509**	56,418
Expense recoveries	**1,000**	**3,297**	87,436
	1,222,580	**1,328,299**	1,393,472
EXPENSES			
Bank charges	**3,000**	**3,515**	4,003
Equipment lease and maintenance	**39,000**	**41,149**	34,064
Facility costs	**139,914**	**136,552**	126,443
Meetings and workshops	**174,490**	**149,679**	80,941
Personnel	**849,110**	**603,815**	746,734
Professional services	**65,452**	**78,104**	81,012
Community Health Plan	**-**	**-**	30,000
Telephone and supplies	**104,000**	**90,674**	83,287
Travel and vehicle	**34,427**	**23,379**	27,292
	1,409,393	**1,126,867**	1,213,776
(DEFICIT) SURPLUS	**(186,813)**	**201,432**	179,696
NET TRANSFER TO CAPITAL FUND	**-**	**(7,881)**	(125,240)
	$ **(186,813)**	$ **193,551**	$ 54,456

Schedule 4

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNITY SERVICES UNIT
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - transfer agreement	$ **686,953**	$ **686,953**	$ 629,401
Expense recoveries	**1,000**	**-**	1,605
	687,953	**686,953**	631,006
EXPENSES			
Meetings and workshops	**8,750**	**1,335**	1,897
Personnel	**684,055**	**457,109**	435,621
Professional services	**12,000**	**12,000**	12,000
Program costs	**110,000**	**100,003**	74,755
Program materials and supplies	**3,500**	**1,275**	2,185
Travel and vehicle	**20,710**	**9,901**	9,381
	839,015	**581,623**	535,839
(DEFICIT) SURPLUS	$ **(151,062)**	$ **105,330**	$ 95,167

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TB INITIATIVE
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada	**$ 419,250**	**$ 419,250**	$ 396,550
Expense recoveries	**-**	**-**	185
	419,250	**419,250**	396,735
EXPENSES			
Administration fees	**39,655**	**39,655**	-
Equipment lease and maintenance	**341**	**375**	341
Facility costs	**1,538**	**1,650**	1,538
Meetings and workshops	**500**	**-**	-
Personnel	**374,938**	**360,529**	363,606
HI Community Strategy/Screening	**25,500**	**15,619**	-
TST/Contract Screening Nursing Support	**30,000**	**37,561**	-
TB Community Based ED	**22,700**	**20,362**	-
Incentives	**5,500**	**2,438**	3,429
Outbreak services	**20,000**	**18,091**	29,116
Telephone and supplies	**9,000**	**9,317**	8,776
Travel and vehicle	**28,900**	**37,561**	28,204
	558,572	**543,158**	435,010
DEFICIT	**$ (139,322)**	**$ (123,908)**	$ (38,275)

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HOME CARE
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	**$ 73,544**	**$ 73,544**	$ 169,557
Other Revenue	**-**	**-**	1,183
	73,544	**73,544**	170,740
EXPENSES			
Administration fees	**7,354**	**6,698**	12,143
Meetings and workshops	**1,500**	**1,758**	1,036
Personnel	**40,008**	**37,614**	55,900
Program costs	**19,587**	**22,334**	81,713
Program supplies	**50**	**-**	17,903
Travel and vehicle	**5,095**	**5,140**	2,045
	73,594	**73,544**	170,740
SURPLUS	**$ (50)**	**$ -**	$ -

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING INNOVATION INVESTMENTS
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	$ -	$ -	$ 12,815
	-	-	12,815
EXPENSES			
Administration fees	-	-	1,165
Personnel	-	-	1,676
Program costs	-	-	9,974
	-	-	12,815
SURPLUS	-	-	-

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TARGETED IMMUNIZATION STRATEGY
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	**$ 60,000**	**$ 66,850**	$ 70,000
EXPENSES			
Administration Fees	**5,785**	**3,126**	-
Equipment lease and maintenance	**24,230**	**28,755**	4,550
Meeting and workshops	**-**	**-**	25,599
Personnel	**-**	**914**	1,676
Professional fees	**2,000**	**5,283**	3,933
Program supplies	**11,485**	**10,577**	336
	43,500	**48,655**	36,094
SURPLUS	**$ 16,500**	**$ 18,195**	$ 33,906
TRANSFER TO CAPITAL FUND	**(16,500)**	**(18,195)**	(37,214)
	$ -	**-**	(3,308)

Schedule 9

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NATIONAL ABORIGINAL YOUTH SUICIDE PREVENTION STRATEGY
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	**$ 53,500**	**$ 53,500**	$ 53,500
EXPENSES			
Administration fees	**5,350**	**5,311**	2,913
Meetings and workshops	**-**	**-**	721
Program costs	**48,150**	**48,189**	49,866
	53,500	**53,500**	53,500
SURPLUS	**$ -**	**$ -**	$ -

Schedule 10

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING EDUCATION
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	**$ 15,000**	**$ 15,000**	$ 15,000
EXPENSES			
Administration fees	**1,500**	**1,008**	1,246
Personnel	**12,600**	**13,022**	6,287
Program costs	**-**	**-**	5,415
Program supplies	**900**	**970**	2,052
	15,000	**15,000**	15,000
SURPLUS	**$ -**	**$ -**	$ -

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ABORIGINAL HUMAN RESOURCE
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	$ -	$ -	$ 418,906
Expense recoveries	-	13,754	-
Transfer from deferred revenue	336,929	336,929	53,202
	336,929	350,683	472,108
EXPENSES			
Administration fees	33,693	18,735	-
Meetings and workshops	3,870	3,340	18,488
Professional fees	-	-	32,663
Program costs	476,995	328,005	418,910
Program supplies	2,975	603	2,103
	517,533	350,683	472,164
DEFICIT	$ (180,604)	$ -	$ (56)

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
E-HEALTH SOLUTIONS/PANORAMA
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada	$ 568,001	$ 565,480	$ 463,732
Expense recoveries	-	540	2,808
	568,001	566,020	466,540
EXPENSES			
Administration fees	51,636	50,958	38,951
Meeting and workshops	-	-	5,038
Personnel	80,000	97,847	127,974
Professional fees	40,000	41,100	18,798
Program costs	386,365	368,527	232,151
Telephone and supplies	5,000	4,110	2,372
Program supplies	5,000	3,478	5,204
	568,001	566,020	430,488
SURPLUS	$ -	$ -	$ 36,052
TRANSFER TO CAPITAL FUND	-	-	(36,486)
	$ -	$ -	$ (434)

Schedule 13

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HIV / STI CONFERENCE
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
Health Canada - contribution agreement	$ -	$ -	$ -
EXPENSES			
Meetings and workshops	-	-	375
Personnel	-	-	37,057
Program supplies	-	-	1,617
Travel and vehicle	-	-	1,302
	-	-	40,351
DEFICIT	$ -	$ -	$ (40,351)

Schedule 14

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
CASET - HSIF
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014 (Unaudited)	2014	2013
REVENUE			
	$ -	$ -	$ -
	-	-	-
EXPENSES			
Travel and vehicle	-	-	6,418
DEFICIT	$ -	$ -	$ (6,418)

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NORTHERN ENGAGEMENT SESSION
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014	2014	2013
	(Unaudited)		
REVENUE			
Health Canada	$ 70,000	$ 70,000	$ -
	70,000	70,000	-
EXPENSES			
Administration fees	6,252	6,018	-
Meetings and workshops	11,666	8,782	-
Personnel	8,000	11,153	-
Travel and vehicle	44,082	44,047	-
	70,000	70,000	-
SURPLUS	$ -	$ -	$ -

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
DENTAL THERAPY
SCHEDULE OF REVENUE AND EXPENSES
for the year ended March 31, 2014

	Budget 2014	2014	2013
	(Unaudited)		
REVENUE			
Northern Lights Community Development Corporation	$ -	$ 10,763	$ -
EXPENSES			
Facility Costs	-	10,763	-
SURPLUS	$ -	$ -	$ -

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

Physical Address: Chief Joe Custer Reserve #201
2300 - 10th Avenue West
Cottage 11
Prince Albert, SK
S6V 5S4

Tel: 306-953-0670
Fax: 306-922-0593

NORTHERN INTER-TRIBAL HEALTH AUTHORITY

www.nitha.com