



## PROMOTING WELLNESS





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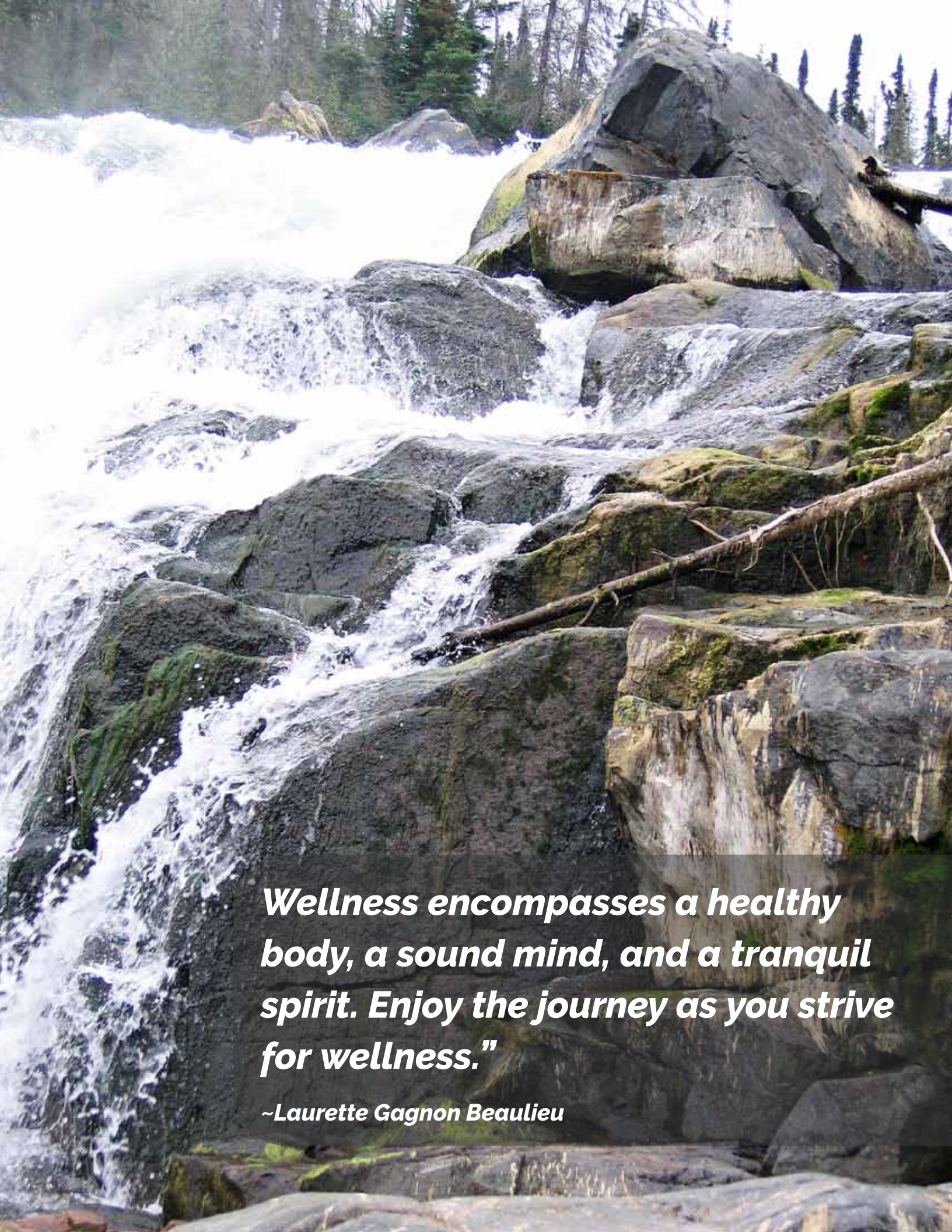
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A photograph of a waterfall cascading over large, dark, mossy rocks. The water is white and turbulent as it falls. In the background, there are evergreen trees and more rocks. A fallen log lies across some of the rocks in the foreground.

***Wellness encompasses a healthy  
body, a sound mind, and a tranquil  
spirit. Enjoy the journey as you strive  
for wellness."***

***~Laurette Gagnon Beaulieu***



## CHAIRPERSON MESSAGE

I am honored to introduce this year's Northern Inter-Tribal Health Authority Annual Report for 2015/16. As Chairperson of the NITHA Board of Chiefs I represented Peter Ballantyne Cree Nation and joining me were Grand Chief Ron Michel, Prince Albert Grand Council, Tribal Chief Eric Sylvestre, Meadow Lake Tribal Council and Dr. Tammy Cook-Searson, Chief of the Lac LaRonge Indian Band. We also had alternate representatives attend our meetings on a regular basis, from PBCN was Vice Chief Harold Linklater, from PAGC Vice Chief Brian Hardlotte, from MLTC Vice Chief Dwayne Lasas and from the Lac La Ronge Indian Band was Councillor Leon Charles. The Executive Council welcomed Rick Kuzyk representing the Lac La Ronge Indian Band, and remaining consistent were Al Ducharme PAGC, Arnette Weber-Beeds PBCN and Flora Fiddler representing MLTC as Directors of Health.

*“When genuine, the more powerful you become, the gentler you will also be”*

*~Author Unknown*



This year the Partnership began discussions with First Nations Inuit Health Branch (FNIH). Two large gatherings were held which brought in many community members. The first was held June 10 & 11, 2015 in Prince Albert and welcomed presentations from FNIH, Athabasca Health Authority, Bigstone Cree Nation from Alberta,

Weeneebayko Health Authority of James/Hudson Bay as well as British Columbia First Nation Health Authority. The initial gathering resulted in the request for more information and discussions to be had. In response to those findings, a subsequent gathering bringing together over 200 + representatives from all areas within the

Partnership took place. In attendance at the March 17 & 18, 2016 Future of Health Services Gathering were community members such as Chiefs, Council Members, Health Directors, Elders and Front Line Workers. The gathering acknowledged that not all NITHA Partners were in support of full transfer of health services at this time; however, they were interested in continuing discussions that work towards narrowing the health funding inadequacies experienced throughout the Partnership. Community consultations are expected to continue exploring FNHI's Proposal at the individual Partner's request.

*"Nurturing yourself is not selfish – it's essential to your survival and your well-being."*

~Renee Peterson Trudeau

The year also marked a challenging time in the area of Emergency Response as the Partnership experienced a forest fire season that afflicted much of the North, none of which has been seen in many years. Many communities were under evacuation order and many community members were evacuated due to poor air quality. Amongst the hardest hit was the communities of the Lac La Ronge Indian Band. A forest fire review is underway to identify ways in which to improve response in such situations. Although this was a trying time, the members and the leaders came together and the strength of the Partnership was evident. Despite the seriousness, and at times critical nature of the fires, our communities lost minimal homes. Special recognition to Dr. Tammy Cook-Searson, Chief of the Lac La Ronge Indian Band; she was a key support to her membership and strength at a dark time.

NITHA also worked towards streamlining programs and services for the Partnership and underwent some restructuring that welcomed new positions and staff to the organization. This year's annual report is themed "Promoting Wellness". This simple, yet encompassing statement, fits all areas of NITHA and is really what NITHA is all about. I give to you the 2015/16 NITHA Annual Report.

Tiniki,

Chief Peter A. Beatty  
Board Chairperson



## EXECUTIVE DIRECTOR ADDRESS

This annual report represents the Northern Inter-tribal Health Authority's activities and results for the fiscal year ending March 31, 2016. 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 2015-2016 fiscal year was my 3rd year as the Executive Director and proved to be exciting and rewarding. We continue to work towards implementing our 5 year Community Health Plan which laid the foundation for the development of annual work plans of the staff within the organization.

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

1. Development of policies, procedures, protocols and standards.
2. Collection and Analysis of statistical data.
3. Development of tools 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 guide our service delivery and the development of annual 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 2015-16 fiscal year were as follows:

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

#### The assigned proxy for the Chiefs were as follows:

- Vice-Chief Brian Hardlotte, PAGC
- Vice-Chief Dwayne Lasas, MLTC
- Councillor Leon Charles, LLRIB
- Vice-Chief Harold Linklater, PBCN

**The Council of Elders for the 2015-16 fiscal year were as follows:**

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

The Board of Chiefs are provided with expertise, advice and recommendations from the NITHA Executive Council on the development, implementation and monitoring of the services provided at NITHA, they meet on a quarterly basis. **The Executive Council for the 2015-16 fiscal year was as follows:**

- Al Ducharme, PAGC
- Flora Fiddler, MLTC
- Rick Kuzyk, LLRIB
- Arnette Weber-Beeds, PBCN

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

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

**ACHIEVEMENTS:**

NITHA has spent considerable time on the offer from FNIHB Regional to assume an expanded role for Northern Saskatchewan First Nations Health Services. To begin the process we engaged a researcher to find out how other First Nations have taken on a larger role from FNIHB regional offices and the pro and cons of this process, which was completed March 2016. We began the process by hosting the 1st gathering on June 10th, and 11th, 2015, complete community information sessions completed with a 2nd Gathering March 15th and 16th in Prince Albert. We are presently analyzing the information gathered to determine the next steps in the process.

NITHA did a review of the positions within the organization which lead us to increase our staff compliment by adding a Manager of Public Health and a Nutritionist. We also did an external review of the TB nursing program which provides us with some clear direction from the Partner Nursing Managers. This review made 26 recommendations which we are presently working towards implementing within the program.

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

**PRIORITIES**

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

- External Evaluation of NITHA as an organization.
- Continue working on developing a political advocacy strategy for transfer sustainability.
- Continue working towards rejuvenating the School of Dental Therapy.
- Developing a comprehensive analysis of the shortfalls in the NIHB program
- Develop a Child/Youth strategy for the Partnership.
- Developing a Traditional Medicine Strategy.

Respectfully Submitted,



Mary Carlson  
Executive Director



**Mary Carlson**  
Executive Director



**Heather Bighead**  
Executive Assistant to the ED



## ABOUT NITHA

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

### *What is Third Level?*

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

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

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

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

## SERVICES WE PROVIDE

### Public Health

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

### Community Services

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



## OUR **VISION, MISSION & PRINCIPLES**

### **Vision**

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

### **Mission**

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

### **Principles**

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

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

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

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

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

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

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

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

NITHA works collaboratively by engaging and empowering.

## THE **PARTNERSHIP**



### Prince Albert Grand Council

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



### Meadow Lake Tribal Council

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



### Peter Ballantyne Cree Nation

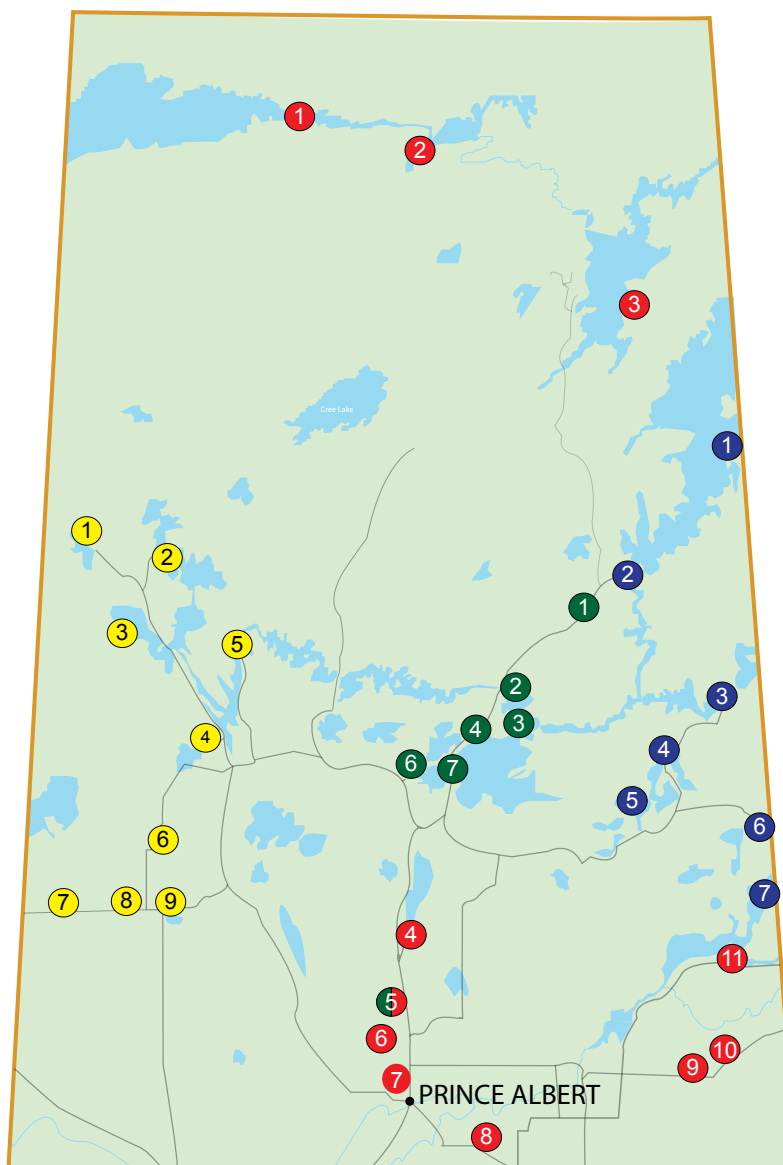
PO Box 339  
2300-10th Avenue West  
Prince Albert, SK S6V 5R7  
Phone: (306) 953-4425  
Fax: (306) 922-4979



### Lac La Ronge Indian Band

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

# PARTNERSHIP COMMUNITIES



## Peter Ballantyne Cree Nation

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



## Meadow Lake Tribal Council

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



## Prince Albert Grand Council

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



## Lac La Ronge Indian Band

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



## BOARD OF **CHIEFS (BOC)**

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 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. 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.



**Chief Peter A. Beatty**

Chairperson  
Peter Ballantyne Cree Nation



**Chief Tammy Cook-Searson**

Vice Chairperson  
Lac La Ronge Indian Band



**Tribal Chief Eric Sylvestre**

Board of Chiefs Member  
Meadow Lake Tribal Council



**Grand Chief Ron Michel**

Board of Chiefs Member  
Prince Albert Grand Council

## BOARD OF **CHIEFS ALTERNATES**



**Vice Chief Brian Hardlotte**

BOC Alternate  
Prince Albert Grand Council



**Vice Chief Dwayne Lasas**

BOC Alternate  
Meadow Lake Tribal Council



**Vice Chief Harold Linklater**

BOC Alternate  
Peter Ballantyne Cree Nation



**Councillor Leon Charles**

BOC Alternate  
Lac La Ronge Indian Band

## EXECUTIVE **COUNCIL (NEC)**

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



**Rick Kuzyk**

Lac La Ronge Indian Band



**Arnette Weber-Beeds**

Peter Ballantyne Cree Nation

*"Health is a state of body. Wellness is a state of being."*

~J. Stanford

## GUIDED BY **OUR ELDERS**

Elders play an integral role at the Board of Chiefs, Executive Council Meetings, and at the working group tables. Four Elders, each representing the Partners is present and engaged at the Board of Chiefs meetings and one elder at all Executive Council and working group 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.



**Elder Mike Daniels**



**Elder Vitaline Read**



**Elder Rose Daniels**



**Elder Marylyn Morin**



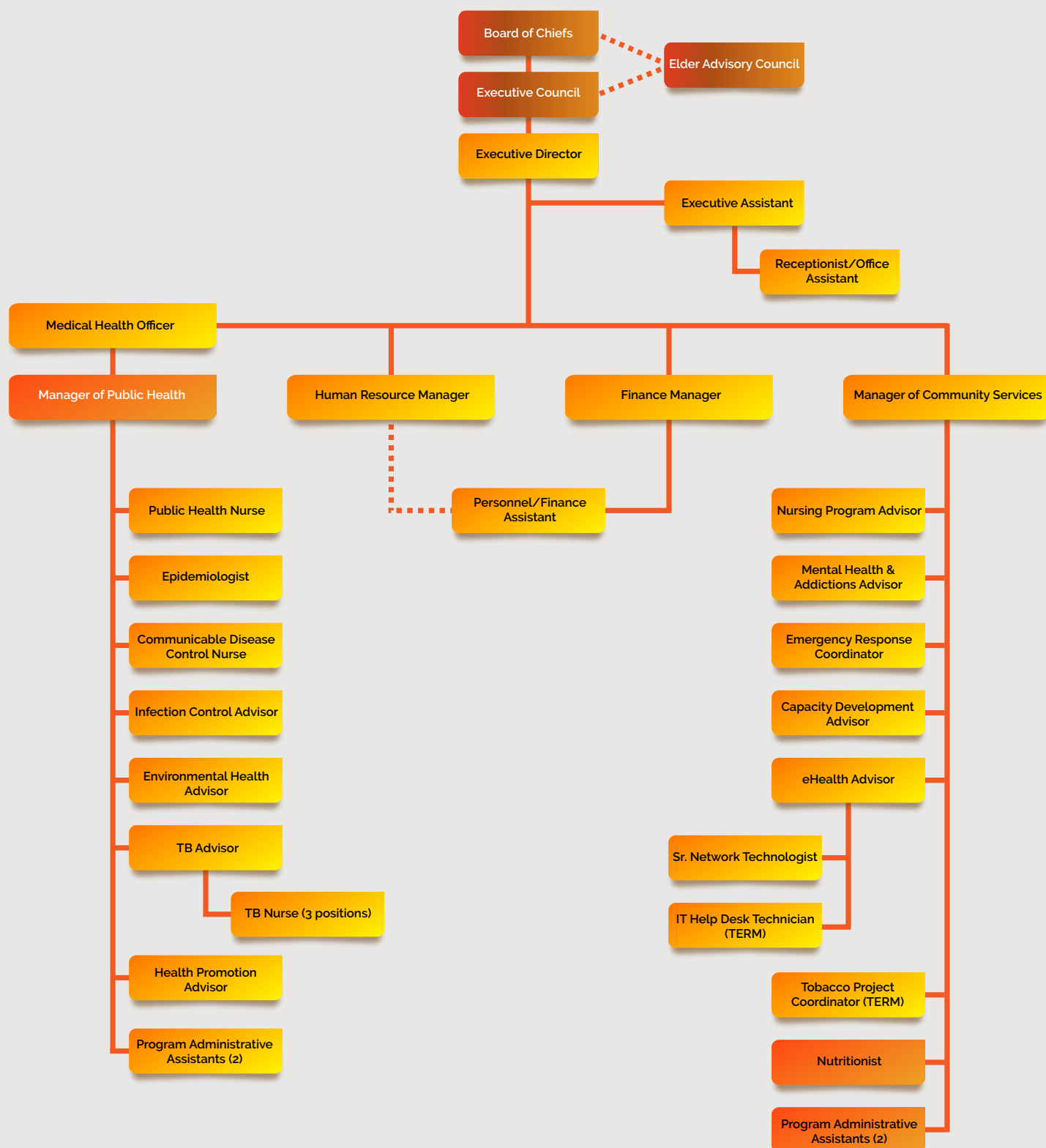
**Elder Gertie Montgrand**



**Elder John Cook**



# NITHA ORGANIZATIONAL CHART



# 2015 NITHA SCHOLARSHIP **RECIPIENTS**

## NITHA Health Careers Scholarship Fund

The NITHA Health Careers Scholarship is awarded annually to students who are pursuing a career in areas related to health. This year the amount of the scholarship awarded was increased to \$3,000. In 2015, there were 11 applicants who met all the criteria and were the successful recipients. These scholarship recipients will be invited to attend the NITHA Annual General Meeting in the fall of 2016. Congratulations and all the best to each recipient as they continue to move forward in achieving their goals.

The deadline for applications for the NITHA Health Careers Scholarship is September 30 of every calendar year.



**Cara Bear**  
LLRIB- La Ronge  
Program: BSc Nursing



**Alana Ross**  
PAGC- Red Earth  
Program: BSc Nursing



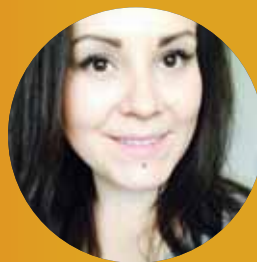
**Brayden Sauve**  
PAGC- James Smith  
Program: Doctor of Medicine



**Brenda Lepage**  
MLTC- English River  
Program: BSc Nursing



**Nelson Martell**  
MLTC- Waterhen Lake FN  
Program: BSc Nursing



**Tenille Smith**  
PAGC- Montreal Lake  
Program: BSc Nursing



**Karmen Naytowhow-Bird**  
PAGC- Montreal Lake  
Program: BSc Nursing



**Colleen Daniels**  
PAGC- Hatchet Lake  
Program: BSc Kinesiology



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



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



**Margaret Cook**  
PBCN- Southend  
Program: BSW (Mental  
Health & Addictions)

# COMMUNITY SERVICES UNIT

The Community Services Unit provides program support and knowledge in the areas of Capacity Development, Mental Health & Addictions, Emergency Preparedness, Capacity Development, Tobacco Project and Nursing Education/Training.

NITHA'S seven pillars serve as a guide for support and services the Unit staff provides the NITHA partnership. In addition, the NITHA Unit Staff engages the Partners through coordinated working groups with Partner staff on a quarterly basis. These working group meetings are forums for discussing issues and solutions affecting the Partner Organizations and serve as direction for NITHA Unit staff in how to best support them in finding solutions to those issues. In addition, these working groups offer an opportunity for the partner organizations to have input into the work that occurs at NITHA for the Partnership.

The Manager of Community Services handles the day to day management of programs and operations, as well as supervision of employees in the Community Service Unit. The focus is on the directing and supporting the planning, negotiations, proposal writing and implementation of program with the units.

The Manager of Community Services began in January 2016. During this first quarter, the Manager began building relationships with the Partners with an orientation tour in the month of January 2016; by attending meetings of each of the Unit's Working Group Meetings, Unit Meetings, General Staff Meetings, Management Meetings, Executive Council Meeting and Board of Chiefs Meetings. In addition, the Manager attended the NITHA Strategic Planning Session in Saskatoon in February, 2016. The Manager of Human Resources and Executive Director provided direction to the CSU for the first 9 months of 2015-16.



**Val Fosseneuve**

Manager of Community Services



**Shianne Mercredi**

Program Administrative Assistant

*"Take care of your body, It's the only place you have to live."*

~Jim Rohn



# NURSE PROGRAM **ADVISOR**

## Program Overview

The Nursing Program Advisor continues to work with the NITHA Nurse Managers in the activities associated with formalizing *a process to deal with the Transfer of Medical Function, nurses' 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 with the NITHA Nurse Managers and Saskatchewan Registered Nurses Association (SRNA), we continue to follow the progress of registered nurses (RN) and their applications, reviews and eligibility to license as RNs with Additional Authorized Practice (AAP). Dec. 1, 2016 licensure as RN with AAP is required to work within the RN Scope of Practice in Primary Care settings in the north. There are concerns regarding the low numbers of casual and relief nurses applying for licensure. This group plays a major role in the delivery of nursing services in the north and will affect ongoing service delivery.

RN Specialty Practice refers to the skills, treatments and interventions within RN scope of practice that have specialized competencies which are obtained beyond entry to practice RN education. The competencies enable the performance of specialty practices to support the RN with AAP and the RN generalist working in the north. NITHA has contracted 2 RNNP to develop a manual of specialty practice that will assist Northern Nurses to practice in an expanded role. The Manual for Northern Nursing will provide consistency across the north in the area of Specialty Practice.

A contract to address the *development of options for long term and special care throughout NITHA* was completed. The Six *Options* described in the final report and business plan are as follows:

- Considerations for Senior Housing on Reserve
- On reserve Personal Care Homes
- Consideration for more available Mental Health / Group Homes on reserve
- Discussions regarding Special Care Homes closer to Home Communities
- Engaging the Regional Health Authorities in service partnerships
- Expediting FNIHB Non Insured Health Benefits approval for supplies

The above two Strategic Initiatives require significant time yet are critical in NITHA's role in supporting the NITHA Partner Communities.



**Fay Michayluk**

Nurse Program Advisor

## Achievements

The Orientation Skills Training sessions were held two times in 2015-16.

- Nov/Dec– 8 participants
- Feb /March–8 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 and mentorship of new nurses and nurses requiring updates is arranged by the individual NITHA Partner Organization. NITHA financially supports the Partners in part for the preceptor and mentorship program.

NITHA contracts Dr. Leo Lanoie, who has worked with us for 20 years and who provides medical reviews and clinical support for nurses in the field.

The teaching materials and procedures are reviewed annually to ensure current practice and updates are incorporated into the teaching modules.

NITHA Working Groups: NITHA Nurse Managers – Monthly teleconferences, four times a year face to face/video conferencing meetings are held. NITHA Home Care Managers – four teleconferences, two face to face/video conferencing meeting are held.

March 24 & 25, 2015 - End of Life Conference – Home Care Nurses (funded by FNIHB/hosted by NITHA) 46- registered, 18 of the total were from NITHA Partners.

October 5-7, 2015 – NITHA NURSING Conference – 38 – registered. Oct 6 one day meeting with the SRNA – 80 registered. This one day workshop focused on the SRNA bylaw changes and the introduction of the Specialty Practice documents and participants worked through developing protocols.

October 27, 28, 29, 2015 – Home Health Aid Conference – 100-registered daily attendance 90 – 95. All evaluations indicated attendees were very pleased with the conference.

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 monthly
- HCWG sub- committee on Palliative Care End of Life Care
- HCWG sub- committee on HIV and Blood Borne Infections
- HCWG sub- committee on the development of a new Home Health Aid Manual



FNIHB Regional Community Health Nursing Network Committee: Meets four times a year and provides an opportunity for National updates and program reviews.

Pharmacy & Therapeutics Committee – Chaired by Dr. Ndubuka provides support and reviews the Northern Formulary re medications and stock supplies for northern primary care centers. Considers the FNIHB National Formulary. Ensures regulations as they relate to Federal Controlled Drug and Narcotics Act are followed.

NITHA Representative on External Committees:

- Provincial Committee on Lower Extremity Wound Management Pathway Development
- Provincial Screening Committee on Colorectal Cancer and other Cancer Screening
- SRNA Senior Nursing Forum Committee member. In person and meet three times a year
- National Home and Community Care Committee. Teleconference monthly, three face to face at different sites in Canada.
- National Practice Advisory Home Care Nursing, teleconference quarterly
- FNIHB Regional Specialty Practice Committee

## Priorities

1. Continue to support the Orientation Skills Training to ensure all northern nurses have current Transfer of Medical Function in place in order to apply for the Prior Learning Assessment Review for RN Additional Authorized Practice certification.
2. Continue to support the NITHA Partners in the development and implementation of a Northern Nursing Practice Manual to support the delivery of nursing services in the northern primary care sites and consideration of the development of an ongoing Skills Lab for skills certification.
3. Continue to work closely on the development of clear direction for the delivery of Home Care services relating to HIV, Palliative Care and End of Life Care.
4. Involvement with discussion on the potential implementation of the InterRAI data collection system in Saskatchewan.
5. Continue to work addressing the OPTIONS outlined in the report regarding Continuum of Care for NITHA Partners.
6. Facilitate the plans and delivery of the NITHA Home Care Nurse and Home Health Aid Workshop planned for Aug 2016.
7. To plan and facilitate a NITHA Nursing Conference for October 16.



# MENTAL HEALTH AND ADDICTIONS **ADVISOR**

## Program Overview

The goal of the Mental Health and Addictions program is to develop a broad structure including models and approaches to service delivery that encompass prevention, assessment, education, intervention, treatment, and aftercare within mental health and addiction services; to also provide support to Partner communities who have their own distinctive, home-grown programs and service delivery systems. This support will incorporate models (evidence based) that are culturally appropriate and create an environment of community response within which healing can occur.

The Mental Health and Addictions (MHA) Advisor began in April of 2015 by building relationships with the Partners through an orientation tour to each region, the MHA Working Group quarterly meetings, work with regional Mental Wellness teams, training of trainer activities, advisory, discussion and information sharing.

**The key areas established for third level support in mental health and addictions (MHA) are to:**

- Strengthen the capacity of First Nations to deliver culturally appropriate and responsive mental health and addiction services.
- Identify best practices and best fit for the Partners community needs.
- Offer educational opportunities and help to access clinical supervision which are responsive to community needs.
- Work with the Partners front line MHA workers and their supervisors/representatives to determine what is needed in their communities.
- Support communities in strengthening processes and improving accountability and outcomes.



**Joanna McKay**

Mental Health & Addictions Advisor

## Achievements

Re-establishment of the Mental Health and Addictions working group with all partners participating. "Excellent discussions and networks are being built toward growing safety and cultural activity, events, and practice in communities, out of the recognition that "culture heals". The belonging, identity, connections to land and place and people, along with the positive and hopeful sense that results from community and cultural experiences cannot be over stated. We know that working 'from' our strengths and building strong positive foundations that integrate well to our holistic and cultural understandings of health, healing and wellness are approaches that work, feel natural, can



involve/embrace our whole community, and are therefore much more lasting and sustainable. We also know that for 'healing' to happen, we must provide both safety (safer communities, safe places, safe people) and good connections/relationships. This work has begun and looks very hopeful. \* Completed workshops with MLTC and community counsellors, and PBCN and Health services team. Attended the Community Cultural 'Gathering' with LLRIB, and orientation with the Holistic Wellness Centre Team at PAGC. \* Ongoing research, program/manuals/protocols/toolkits/training development, advice and discussions are now growing areas of continuing work that seeks to help 2nd level advisors and managers in their work.

### **Relationship and networks with other agencies:**

In addition to good collaborations with Partners, NITHA advisors, the Medical health Officer and the others in the Public health and Community services unit teams, MHA Advisor is participating in the following:

**Federally** – FNIHB – Mental Wellness Teams – Knowledge Exchange – regular reports and information sharing, also connected with The Thunderbird Foundation, The National Collaborating Centre for Aboriginal Health, AFN, and others.

**FSIN** – FNARF (First Nations Addiction Research Foundation) & GAP (Northern Gambling Strategy through the Gambling Awareness Program with Northern Lights casino and CAMH (Canadian Mental Health Association) working groups – NIHB (Non Insured Health Benefits) systems navigator.

**Provincially** – Have connected with 4 Regional health Authority MHA leads for ongoing networking and discussion of our needs and shared concerns – Participate in the 'reference group' for a 4 ministry working group (Health, Education, Justice, Soc. Services) whose goal is to implement the provincial MHA 10 year Action Plan - Participate in activities and meet with the Saskatchewan Prevention Institute - Participate in the Maternal Mental health Committee – with NITHA's MHO participate in the 'new' Northern Alcohol Strategy reference group

**Northern Saskatchewan** – participate in the ELC (Embracing Life Committee), and Northern Healthy Communities Partnership

## **Challenges & Priorities**

\*Isolation and remoteness. \*Need of MHA Advisor to build strong relationships, yet inability of Advisor to travel often or broadly. \*Tele-conference meetings may not be well integrated. As a result we hope to trial some video conferencing soon. \*Continuity of administrative supports, and 'short staffed' is challenging to all of us from time to time. Regional Health Authority leads have also all noted difficulties in first filling Mental Health and Addictions positions, and then in trying to retain those hires. Priority moving forward continues to honour the work plan established and by contributing to the community wellness initiatives of our partners.

# EMERGENCY RESPONSE **COORDINATOR**

## Program Overview

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

## Achievements

NITHA's Emergency Response Working Group continues to meet regularly with 4 scheduled meetings per year. Working Group communication has significantly increased and critical Partner feedback is becoming more efficient. Second level Emergency Response Coordinators are necessary for the safety of our population but are not funded by FNIHB. Consequently, NITHA provided \$75,000 per partner to enable them to hire a full-time ERC at the 2nd level.

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 following outlines the current process and progress on "in house" Instructor training.

- Approximately 500 First Aid and CPR/AED providers, 10 First Aid and CPR/AED Instructors, 20 First Responders, and 7 Emergency Medical Responders 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."
- Once these instructors gain a minimum two years of experience as Instructors, they are eligible to upgrade to First Responder Level Instructors. One instructor has met the prerequisites and is currently eligible to increase his instructor capacity to First Responder.



**Patrick Hassler**

Emergency Response Coordinator



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

Evacuations are an inevitable fact of living in flood and fire zones. 2015 contained the largest and longest fire response and evacuations in Saskatchewan History seeing approximately 14,000 people displaced from their homes. NITHA responded to this situation with the manpower at hand and contributed in the following ways:

1. The NITHA Medical Health Officer (MHO) provides public safety recommendations such as how to handle sensitive or chronic populations if a communicable disease outbreak occurs and provide recommendations in the areas of surveillance, training, public safety, stakeholder liaison, health specific actions, etc.
2. The NITHA Emergency Response Coordinator provides support, advice and facilitation to the 2nd level Health Partners in regards to emergency response, preparedness, mitigation and recovery.
3. The NITHA Mental Health and Addictions Advisor provides support and advice to 2nd level personnel on critical incident stress debriefing, responder health recommendations, evacuee support, etc.
4. The NITHA Environmental Health Advisor provides support and advice to 2nd level personnel on air quality, food handling concerns, specific environmental emergency information, best practice etc.
5. Other NITHA staff provide support in areas of manpower such as nursing staff, volunteering, communicable disease, infectious control and human resources support and advice.

Community Risk Assessments are ongoing. Partnering with Provincial Emergency Management and Fire Safety and FNIHB has provided valuable perspective and underscored both the relevance and importance of this process. Currently, we have completed 14 NITHA Partner communities and will support 2nd level ERC's to continue community risk assessments.

The NITHA ERC assists with the Orientation Skills Training (OST) by providing discussions on advanced vascular access, advanced airway management, emergency resource management, and orientation to the emergency response in the North. The NITHA ERC also advises Partners on training options and assists in the coordination of external programs such as Pediatric Advanced Life Support®, Advanced Cardiac Life Support®, International Trauma Life Support® and Geriatric Emergency Management®.



The NITHA ERC provided changes and new information regarding prehospital spinal immobilisation, life threatening arrhythmias in children and ALTE (apparent life threatening event) Nurse Managers Working Group.

The NITHA ERC assisted in Ebola contingency planning by ensuring that the NITHA Partners unique challenges of remoteness and internal capacity are considered when addressing the emergency response needs of Ebola preparedness. The NITHA ERC and FNIHB continue to draft a health annex to the First Nations Emergency Planning manual that will include a level 4 pathogen contingency to ensure that best practice and guidelines from Ebola preparedness are not lost when the momentum of the acute outbreak is diminished.

## Challenges

An annual review of Emergency Response Plans is an industry standard. However, this process has remained sluggish since it requires cooperation and manpower at the 2nd level and community level. NITHA continues to advocate for funding for these positions.

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

Dedicated full-time positions in the area of Emergency Response and Preparedness remains the most significant challenge.

## Priorities

NITHA ERC will be working with 2nd Level coordinators to continue Hazard and Risk Assessment support for those communities still requiring this process. For those that have completed this process and have made progress on contingency planning, the NITHA ERC conduct table top exercises to test and trial current Community All Hazard Plans.

NITHA ERC will continue to support the Partners, in ensuring which community response plans are taking an "All Hazard" approach. 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.

First Responder groups are an extremely important part of the community response and pre-hospital treatment on reserve. 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 and important resources in times of community disasters and pandemics. For these reasons the NITHA ERC will support and assist communities as they build sustainable First Responder initiatives by bringing the training "in house" as well as by engaging stakeholders and Regional Health Authorities.

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

NITHA is in the process of producing a report on the activities surrounding the 2015 wildfires. This report will look at the following;

1. How were communities affected?
2. What were the actions of the various Provincial, Federal and First Nations organisations who responded?
3. Were response and recovery efforts appropriately aligned with established First Nations, provincial, federal policies, processes, capacity and options for emergency management and wildfire fighting?
4. Did the process to evacuate shelter and repatriate residents meet the physical and cultural needs of the affected communities?
5. What lessons can be learned that would inform any improvements to better serve the needs of those affected and enhance the protection of life and property.

This report, when completed, will give guidance and direction for future activities at the 3rd level regarding emergency management throughout the Partnership.

*"Love yourself enough to live a healthy lifestyle."*

~Author Unknown

# CAPACITY DEVELOPMENT **ADVISOR**

## Program Overview

The function of the Capacity Development Advisor is to provide opportunities for Northern First Nations people to engage in certified training in health careers utilizing *Learn Where You Live Models* which, in turn, enable them to remain in their communities while they undertake professional training. Development of these kinds of models requires inter-professional and inter-sectoral collaboration to ensure use of the latest distance technologies. Enabling individuals to remain in their communities, and in many cases, maintaining full time employment, is less disruptive to the individuals' families, communities, and workplaces. The overall goals in this area are to:

- Create a more representative workforce;
- Develop culturally sensitive care responsive to individuals' and communities' needs;
- Expand the competence of First Nations staff in Health Care; and,
- Increase retention of the Labour Force in Northern First Nations communities.

## Priorities

- To develop a core training program for all Community-Based Workers (CBW) using a tiered approach to create credentials that are accredited, transportable, ladderized, and define a Scope of Practice;
- To cultivate a Cultural Competency Training Program that links with the CBW Program in collaboration with Agencies and involve Management Training and Clerical Training that could be linked to the CBW Program;
- To plan for a third Health Human Resources Study in the North; and,
- To continue to work toward the goal of Dental Therapy Training in Northern Saskatchewan.



**Linda Nosbush**

Capacity Development Advisor



## Achievements

### Dental Therapy

Two documents were developed:

- An expanded letter to Terry Zerff Ministry of Health, Director of Workforce Policy, outlining the work of NITHA's Oral Health Working Committee; and,
- A paper entitled *Responding to Oral Health Needs in Northern Saskatchewan: Considering Prevalence of Early Childhood Caries* for problem-solving with the MHO's of Northern Health Regions and Saskatoon District Health.

Continued participation in the *Saskatchewan Oral Health Coalition* and the *Northern Oral Health Working Group*.

### Mental Health and Addictions Certificate Worker Program

In the final year of training students had six full-week, face-to-face sessions (April 27 - May 1, May 31 - June 4, August 25 - 29, and October 5 - 9, 2015; and January 18 - 22, and April 4 - 8, 2016) plus completed their final practicum in June 2016. Of the 15 students who remained in the program, 11 will finish the program by June 30, 2016 which is a 73% success rate. This is the first program of its kind in Canada - one that combines Mental Health and Addictions from a First Nations perspective. Congratulations to our 11 graduates who worked full time while taking this program!

### Cultural Competence

Dialogue and meetings with the following institutions were undertaken:

- Thunderbird Partnership Foundation has welcomed our use of their *Stepping Stones Model* in our work;
- Wanuskewin who will work with us to provide Land-Based Teachings as part of the Cultural Competence course;
- Saskatchewan Indian Cultural Centre (SIFC) will work with us on Traditional Languages and work with Elders.
- First Nations University of Canada (FNUC) - will work with NITHA to develop a Cultural Safety Certificate which will include our the Elder Vignettes already developed;
- Colleges of Medicine and Nursing, University of Saskatchewan will utilize the Cultural Competence Course offered through FNUC as an elective and/or Transfer of Credit for their programs;
- The Cultural Competence Course/s will also become part of the CBW Program.



## Community-Based Worker Program

First Nations Health Centres have employed at least one person (called a Community Health Representative) to act as a bridge between health services and the community. In May 2015, the NITHA Executive Council requested program development for all CBW's. They desired:

- Basic core training to establish a core set of competencies that would establish common ground among all CBW's;
- Post-Secondary Training that provided opportunity for career laddering, that used distance technologies, and that would enable CBWs to learn in their own communities;
- Development of credentials that were transportable, helped to establish a scope of practice as well as standards of practice, utilized Aboriginal teaching and learning practices, and was responsive to and based on First Nations' strengths;
- Training that would enable *upskilling* of existing staff without regular absences from their workplace.

To accomplish these goals three different actions were undertaken: local, regional and national frameworks were examined and compared resulting in the identification of Clusters of Competence required; Post-Secondary Programs were explored to discern the goodness of Fit between what Employers would like and what Post-Secondary Programs offer; and consultations with NITHA Partners, Elders and Program Advisors to discern the Knowledge, Skills, and Attitudes required to support their programs. A paper is being developed to describe these goals.





# eHEALTH ADVISOR

## Program Overview

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

Panorama continues to be utilized by many Northern First Nations. Early in the year the Ministry of Health proposed amendments to the CD Regulations of the Public Health Act to make them the sole trustee of the data within the Panorama system. There would be privacy accountability and administrative benefits but this also impacts First Nations owner and control of their information. NITHA sought legal advice and have also proposed amendments to the CD Regulations in order to protect First Nations data. The Ministry of Health are supportive of these amendments but until this issue is resolved new communities wishing to access Panorama are advised to hold off.

A short term benefits evaluation of Panorama was completed and the results were presented at the eHealth Knowledge Exchange in February. The evaluation shows Panorama has been beneficial to client care and better management of a client's immunization record.

NITHA initiated a two phased project for a "Shared" Electronic Medical Record (EMR) system. The goal is to have a shared EMR system that can be access by both First Nations and non-First Nations providers on a need-to-know basis. Phase one concluded in March 2016 with the activities aimed at addressing the following issues:

- Developing a data sharing agreement
- Understanding the expected improvements to client care and clinical workflows
- Developing a plan to meet the EMR's privacy requirements

A lot of effort was made to properly consult the leadership, clinical and administrative stakeholders from the First Nations pilot sites, the RHAs and the NMS.



**Charles Bighead**

eHealth Advisor

NITHA and MLTC completed reviewing a set of privacy and information security policies which were then ratified by the MLTC leadership. These policies will significantly support protection of personal health information in the EMR.

NITHA implemented an IT Helpdesk. The purpose is to provide a responsive helpline for frontline workers and to relieve the second level IT services with problems that can be resolved over the phone or by remotely controlling a computer.

NITHA purchased advanced firewalls and updated wireless access points for the community health facilities to replace aging network equipment that is starting to fail. The new equipment has many capabilities such as being able to monitor and control usage of the internet by individual staff.

NITHA updated the office phone system with a high-tech Unified Communication System that utilizes CommunityNet. The phone system has a lot of new and useful capabilities and will reduce telecommunications costs in the long term.

The NITHA Partners have all filled the Telehealth Coordinator's positions which will have a major impact with utilization of telehealth at the community level.

FNIH have made changes to the 2015-2106 CBRT Template. The electronic tool utilized by some communities to assist with the CBRT reporting was updated in response to changes to the template.



**Eric Xue**

Senior Network Technologist



**Ali Mirzaei**

IT Help Desk Technician

*"The greatest wealth is health"*

~Virgil



# TOBACCO PROJECT **COORDINATOR**

## Program Overview

During the year under review, the NITHA Tobacco Coordinator (TC) supported and worked collaboratively with Community Tobacco Coordinators at the 2nd level in implementing the six essential elements of the Federal Tobacco Control Strategy (FTCS): Protection, Reduced access to tobacco products, Prevention, Education, Cessation, Data collection and Evaluation.

As part of tobacco awareness campaign, the NITHA Tobacco project Northern Saskatchewan Breathe Easy (NSBE) was developed in July 2015. The overall goal of NSBE project is that northern communities will be free of commercial tobacco misuse while being respectful of the traditional use of tobacco.

In the year 2015/2016, the NSBE working group focused on the prevention, education and cessation based on feedback from partner communities indicating that they needed more awareness on the harmful effect of commercial tobacco use, second/ third hand smoking. Having identified these needs, the TC developed relevant resources that are culturally appropriate, locally oriented and culturally responsive to NITHA communities.

Effective communication is very vital in this project. The TC has continuously conducted literature reviews and environmental scans to identify best practices on tobacco cessation strategies and current tobacco policies. TC has continuously ensured that the NITHA partners and the community tobacco coordinators are well informed about best practices and strategies on tobacco reduction.

## Achievements

During the period under review, TC 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 and provided the TC opportunities to network with federal, provincial, municipal and non-government agencies.

NSBE working group met regularly with 4 scheduled face-face meetings per year and via teleconferences.

The TC is a member of the National Steering Committee on evaluation of FTCS. This Committee met to review the 2015/2016 FTCS Annual Reporting Form and Workbook.



**Justina Ndubuka**

Tobacco Project Coordinator



The TC attended FTCS's Community of practice meeting in Winnipeg and provided update on our project/ best practices on-behalf of NSBE working group.

In October 8 2015, TC gave a presentation on NITHA project overview and best practices at the NITHA Nursing conference held in Prince Albert.

TC developed a tobacco self-help brochure based on request from frontline health care workers indicating that they required a user friendly document to effectively counsel their patients. The self-help brochure will be translated in local languages.

The NSBE working group worked with the MPH practicum student to develop a comprehensive evaluation framework for NSBE. The objective is to facilitate effective evaluation of the project by providing a detailed reference for what data needs to be collected as well as the methodology, timing, and by whom.

**Awareness campaign:** the NSBE working group planned and implemented multi-component awareness campaign with the goal of increasing awareness of the harmful effects of smoking and exposure to second hand smoke in First Nations on-reserve communities. The working group identified key messages and also developed logo, and specific guidelines to guide our campaign activities. The components of the awareness campaign include:

- Partner specific posters with key messages and pictures of role models from each partner. A total of 50 posters were developed and translated into Cree and Dene. Community non-specific pamphlets with information to supplement the posters were also developed. These pamphlets were also available in Cree and Dene.

- Tobacco awareness promotional items such as T-shirts, water bottles, bracelets, piggy banks, backpacks and notebooks. Over 1500 items were ordered and distributed to NITHA partners.
- The working group have been involved in social media marketing. Facebook and Instagram accounts were setup as part of our tobacco awareness campaign. Postings of anti-tobacco messages centered on health effects/consequences of tobacco; tobacco industry deceptive practices; second hand smoke and its potential harm. Monthly Rota for posting key messages on social media is drafted by TC and shared with Partner Coordinator. The goal is to provide all members of the project team opportunity to participate equally.
- Radio spots: anti-tobacco messages were broadcasted bimonthly, through local community radios stations and MBC radio in English, Dene and Cree.

**Baseline surveys:** Baseline survey on smoke free public places, pre/post maternal and youth population have been completed in NITHA communities. Data analysis is ongoing to be shared with the partners upon completion. The TC also conducted environment scan of tobacco policies in some partners/communities, other FN's communities and provincial.

The TC is continuously partnered with the Canadian Cancer Society (SK Branch) to offer the Smoker's Helpline in Cree and Dene and to advertise the Smoker's Helpline service in Northern SK.

## Challenges

Although the project is on track in some elements in terms of activity implementation, it is unlikely that all intended project objectives will be accomplished by 2017 when project funding sunsets.

Given that smoking/tobacco control is complicated by a range of social, structural and individual level barriers there is a need to apply holistic approach that is long-term, sustainable and proportionate-to-the-need. Tackling social determinants as it related to smoking would be sufficient, predictable, and sustained funding beyond 2017.

Also, partners' communities are at different stages of project implementation.

Giving the diversity in language, tradition and culture of NITHA partners, translating tobacco awareness resources to local language is a challenge.

## Priorities

- In 2016/2017, the TC focus on the following areas:
- Development of Smoking Cessation Mobile App
- Development, implementation and tracking of smoke free policies/bylaws.
- Development of First Nations guide on developing Tobacco policies.

- Conducting environmental scans to determine current use of traditional tobacco in the pilot and non-pilot communities.
- Project evaluation



# PUBLIC HEALTH UNIT

## Program Overview

The PHU provides advice and expertise to the NITHA partnership in various programs including community health assessment, infection and prevention control program, communicable disease surveillance, health protection, disease and injury prevention, health promotion. The TB control program at NITHA provides direct assistance to communities in the partnership to identify, assess, educate, and ensure treatment of confirmed or suspected cases of TB.

During the 2015-2016 fiscal year, the PHU staff worked diligently on their individual work plans to accomplish the unit's mandate of improving the health and wellbeing of the partner communities through a NITHA wide public health strategy. Activities of the PHU program leads were accomplished primarily through a number of working groups within the partnership: Public Health working group, HIV strategy working group, Infection Prevention and Control working group, Population Health Promotion working group, Pharmacy and Therapeutics Committee, and Nurse Manager working group. PHU program leads successfully hosted and attended working groups meetings to discuss pertinent public health issues in collaboration with partner communities as part of a provincial wide approach. We would like to thank NITHA partners and other stakeholders for supporting and working collaboratively with the PHU during the 2015-2016 fiscal year.

## Priorities

- Continuing the improvement of immunization rates within partner communities and development of immunization standard as part of the provincial wide public health strategy
- Continuing the implementation of the TB High Incidence Strategy
- Enhancement of communicable and non-communicable disease surveillance



**Nnamdi Ndubuka**  
Medical Health Officer



**Deanna Brown**  
Program Administrative Assistant



# PUBLIC HEALTH **NURSE**

## Program Overview

The NITHA Public Health Nurse (PHN) provides overall immunization coordination and ongoing education to nurses and other members of the health care team working in the area of immunization. The PHN is responsible for developing, recommending, and providing expert, consultation, and clinical assistance to those implementing public health nursing policies and programs.

In consultation with the partnership, the NITHA PHN focuses on the following areas: Immunization (preschool, school and influenza), Maternal/ Child Health, Prevention, Education and Health Promotion Strategies, vaccine management, Nursing Specialty Practice, Immunization consultation, and other health projects.

## Accomplishments

### Innoculist Examinations

NITHA received 102 innoculist examinations from the partnerships and successfully assessed, graded, and provided written feedback to nurses within 10 business days of receiving the document.

### Immunization

Overall, the Childhood Immunization coverage rates have continued to improve this year compared to the previous year (see table 1, figure 1, 2, 3, and 4).

	2014	2015
1 year old population	89%	91%
2 year old population	83.1%	89%
7 year old population	93%	95%

*Table 1. Average childhood immunization coverage*



**Carrie Gardipy**

Public Health Nurse



## One Year Old Immunization Rates

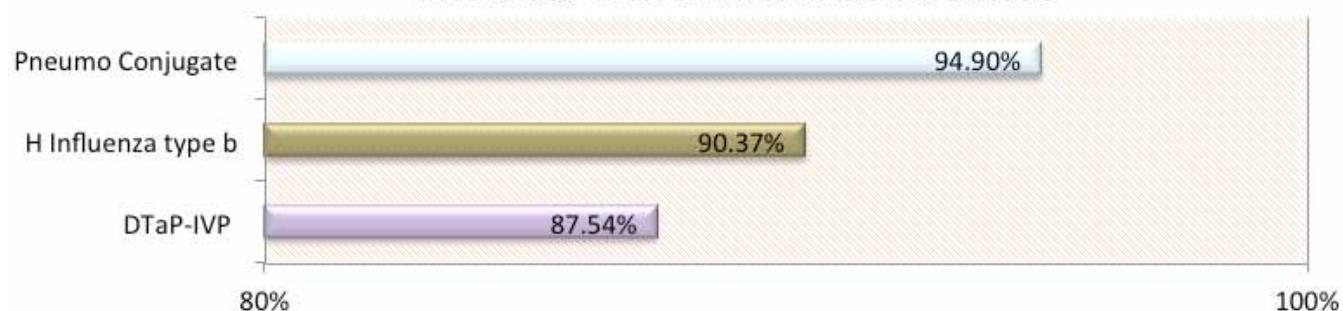


Figure 1. One-year old immunization rates, NITHA 2015

## Two Year Old Immunization Rates

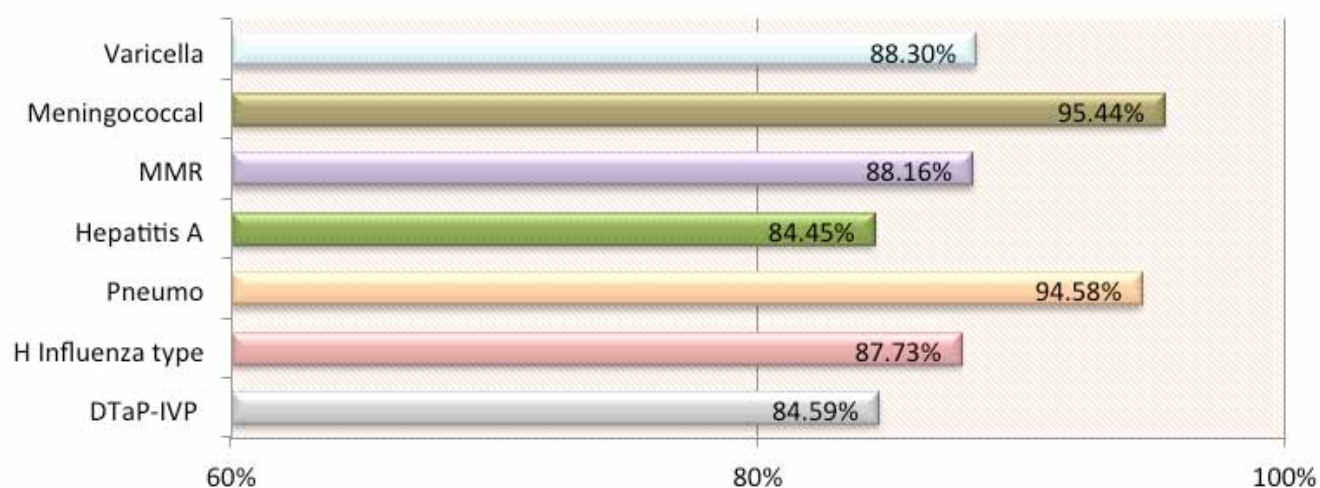


Figure 2. Two-year old immunization rates, NITHA 2015



Figure 3. Two-year old average immunization history

## Seven Year Old Immunization Rates

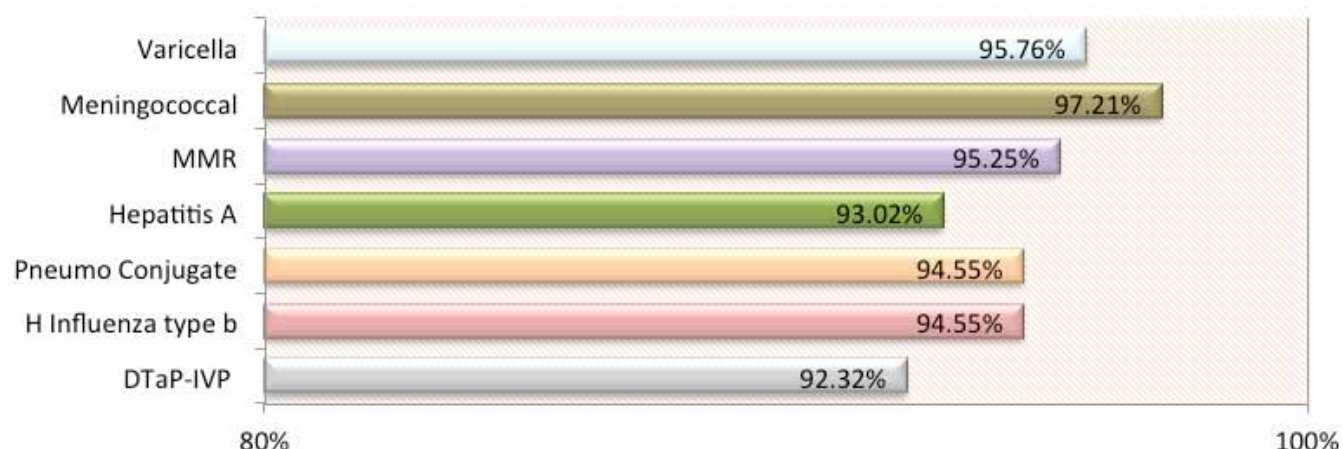


Figure 4. Seven-year old immunization rates, NITHA 2015

Saskatchewan Health launched the Panorama System in February of 2015. There are presently 15 communities within NITHA utilizing the Panorama system: PAGC has 6 of 10 Communities, MLTC has 1 of 9 Communities, LLIBHS has 6 of 6 communities, PBCN has opted out of Panorama for all 3 Communities at this time, and AHA has 2 of 2 Communities.

Overall, the majority of the NITHA Communities on the Panorama system have reported positive feedback during the initial usage of the Immunization module. NITHA's role in Panorama includes trusteeship, training coordination, information dissemination, communications and support. PHN coordinated two Panorama training session for CHNs during the year under review.

At this time, the province and the NITHA leadership are perusing legal consultation regarding the logistics of the Panorama system. NITHA's goal is to assist more communities to utilize the Panorama System once these legal issues have been sorted.

PHN provided daily consultation for Nurses in partner communities in the area of immunization and Public Health Nursing. In collaboration with the MHO, PHN provided recommendations on adverse events related to immunization (AEFI) reported by partner communities. PHN also led the implementation of the vaccine management program and provided vaccine wastage reports to partner communities. The 2015-16 School Immunization Strategy was disseminated to partnership communities prior to the beginning of school year.

## **Nursing Continuing Education and Updates**

The NITHA PHN has enhanced the process for the immunization certification process. Each RN was provided written feedback within the timeframe while their nursing supervisors were kept updated on their performance. Immunization certification lists were sent to each Partner on a quarterly basis. 9 nursing students in the communities were eligible to write the inoculist examination.

PHN supported NITHA partners in training its nursing staff on the Saskatchewan Health/ Child Health Clinic Guideline. A total of 38 staff were trained (30 CHNs, 3 Nurse Managers, 4 CHRs and 1 Physician). PHN also participated actively in updating and revising the Saskatchewan Community Health Nurses Manual in collaboration with FNIHB.

## **Seasonal Influenza Immunization Campaign**

The Provincial Influenza Immunization strategy was disseminated to all partner communities and 2nd Level Partners. The PHN assisted the NITHA MHO in coordinating two teleconferences in the fall of 2015 as part of preparation for the influenza immunization campaign. PHN also organized influenza vaccine clinics for NITHA staff and families during the influenza season.

The interim influenza vaccine report indicated a reduced vaccine uptake within partner communities. This finding was consistent with the provincial picture. Possible factors that might have contributed to this included negative media coverage and issues around vaccine mis-match in the previous year.

## **Master of Public Health Student Practicum Placements**

The PHN provided mentorship to Master of Public Health Students. In coordination with the MHO, PHN and MPH student completed an immunization improvement project with one partner community reporting low immunization coverage rates.

## **Priorities**

- PHN will continue to work with communities with low immunization rates in order to develop improvement strategies.
- Ensuring that nurses within partner communities maintain immunization competencies will remain a priority.
- Promoting and supporting communities that are interested in Panorama will be a priority.



# EPIDEMIOLOGIST

## Program Overview

Epidemiology is the science of studying the patterns, causes, effects of health, and disease conditions in defined populations. It informs policy decisions and evidence-based practices by identifying risk factors for disease and targets for preventive healthcare. The Epidemiologist formulates study designs, data collection, statistical analysis, interpretation, dissemination of research results, and policy decisions.

The NITHA Epidemiologist position provides overall health coordination to include immunization, communicable diseases and non-communicable diseases monitors for the partnership, technical advice, and expertise for policy-making for First Nations.

## Accomplishments

The epidemiologist is responsible for reporting Enteric, Food and Waterborne diseases, respiratory route diseases, diseases transmitted by direct contact, routine vaccination prevented diseases, sexually transmitted infections, animal bites, and boil water advisory to the MHO and the partnerships.

Compiled the NITHA population distribution from 2004 to 2015 and population pyramids for each partner was also developed.

Sexual transmitted infections (STIs) such as chlamydia and gonorrhea are a significant public health concern in NITHA. The reported rates of chlamydia and gonorrhea infections continue to increase.

Young First Nations have the highest reported rates of STIs. Controlling and reducing the number of STIs in the partnership will continue to be a priority for NITHA.

The format for quarterly and year-end reporting were successfully revised from excel document format to publisher utilizing map(s) and ArcGIS program.

Several communicable disease statistical reports were compiled for NITHA partner communities upon request including HIV, Hep C, Influenza, and TB.



**Janet Yang**

Epidemiologist

## Challenges

- The most significant challenge for the Epidemiologist is obtaining current accurate data specific for NITHA communities. These do not include 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.

## Priorities

- Compiling of NITHA Health Status report
- Cleaning and validation of existing database to ensure high quality reporting.

*"The best six doctors anywhere and no one can deny it are sunshine, water, rest, air, exercise, and diet"*

~Wayne Fields



# COMMUNICABLE DISEASE CONTROL **NURSE**

## Program Overview

Communicable diseases (CD) surveillance remains a priority for the NITHA partnership. The rapid spread of the germs and the possible infection of large number of people in the community require the timely response and intervention from the health sector.

The Communicable Disease Control (CDC) Nurse supports the NITHA partners through timely reporting of CDs and providing direct support to frontline health workers. In consultation with the Medical Health Officer, the CDC nurse responded to queries and offered education to community health staff when required.

### Sexually Transmitted and Blood Borne Infections (STBBIs)

Chlamydia and gonorrhoea: STIs continue to be a significant public health concern in the NITHA partnerships. Chlamydia and gonorrhoea continue to top the list of communicable diseases reported by NITHA. During the year under review, a total of 1,118 new cases of chlamydia and gonorrhea were reported to NITHA (see figure 1). However, the new cases may not accurately reflect the true transmission rate occurring in the community because clients may prefer to get tested and treated in off-reserve or urban centers where they would be subsequently reported.

### Reported Cases of Chlamydia & Gonorrhoea, NITHA, 2011 - 2015

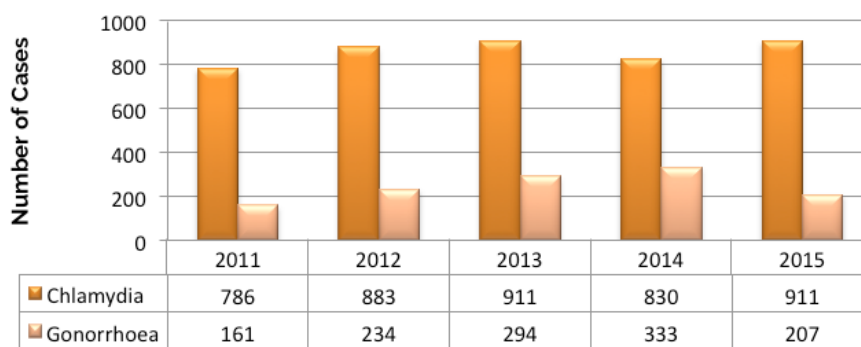


Figure 1. Reported cases of Chlamydia and Gonorrhoea in NITHA Communities, 2011- 2015

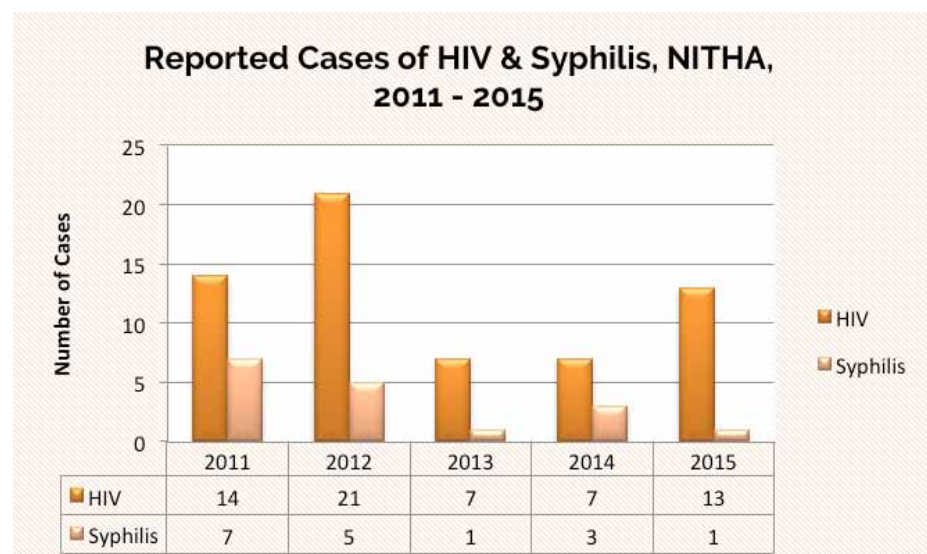


**James Piad**

Communicable Disease Control  
Nurse

**Syphilis:** Syphilis is an STI with more fatal complications and is not as common as chlamydia and gonorrhea. One new case of syphilis was reported to NITHA in 2015.

**Human Immunodeficiency Virus (HIV):** 13 new cases were reported in 2015. This is 85% higher than the average of the last two years (see figure 2). The reason for this increase, might be due to increased testing possibly resulting from increased awareness of the disease. 3 of the HIV positive cases progressed to AIDS. In NITHA partner communities, the most common factor for HIV transmission is injection drug use and the 2nd most common risk factor is heterosexual intercourse.



*Figure 2. Newly diagnosed cases of HIV and Syphilis by year, 2011 - 2015*

The NITHA public health unit continued to emphasize the importance of early HIV diagnosis and treatment in order to prevent health complications and reduce the risk of transmitting HIV to others.

STI rates for NITHA Communities are still high in comparison to the provincial and national levels. The following factors may be linked to the increased number of STIs: 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 and widespread use of illicit drugs.

**Hepatitis B and C:** Hepatitis C (Hep C) and Hepatitis B (Hep B) are chronic infections of the liver caused by the Hep C and B viruses, respectively. In 2015, 46 new cases of Hep C were reported compared to 30 cases in 2014, (a 53% increase) (see figure 3). A majority of the Hep C cases in were acquired by injection use through sharing of needles. No Hep B cases were reported to NITHA in 2015.

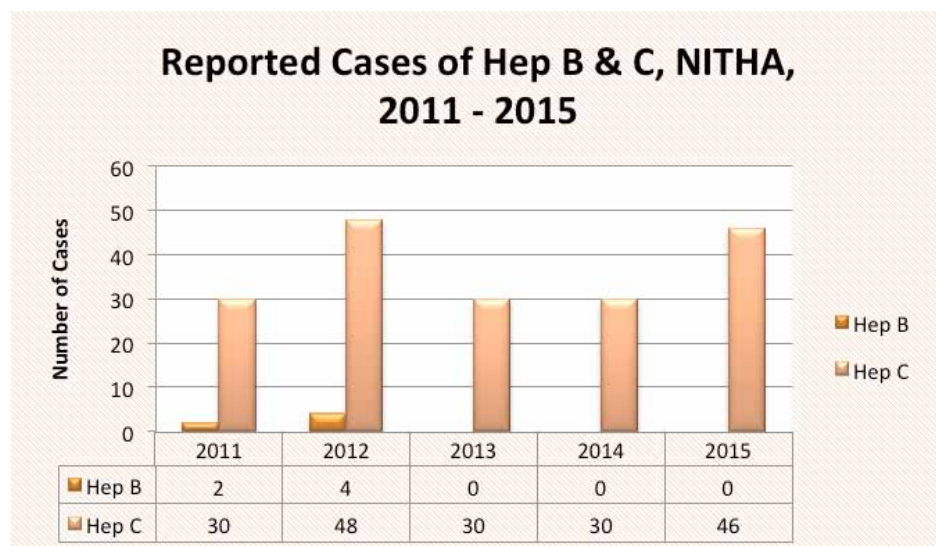


Figure 3. Newly diagnosed Hepatitis B and Hepatitis C cases by year, NITHA, 2011 - 2015

**Community Acquired Methicillin Resistant Staphylococcus aureus (CMRSA):** Methicillin Resistant Staphylococcus aureus (MRSA) infection has always been a challenge in NITHA communities. 418 new cases were reported in 2015 (see figure 4). A slight reduction from 2014 has been observed. There can be more cases but infected individuals cannot be determined because not everyone will have symptoms. In terms of prevention of C-MRSA, NITHA continues to recommend and promote frequent handwashing, daily personal hygiene, non-sharing of personal items and correct and appropriate use of antibiotics.



Figure 4. Reported cases of Methicillin-resistant Staphylococcus Aureus (MRSA) by year, NITHA, 2011 - 2015

## Other Communicable Diseases

Other CDs reported in 2015 were: 13 Influenza, 19 invasive *Streptococcus pneumoniae* infection, 2 diphtheria, 2 *Hemophilus influenza*, 1 mumps. Except for the influenza and *Streptococcus pneumoniae* cases, all contacts were located and treated to prevent the development of illness and further spread to other individuals.

## Accomplishments

1. Engaged Elders in planning and disease prevention and control activities.
2. Participated in awareness campaigns in the communities that empowered individuals to build community capacity.
3. Participated in conferences and workshops for knowledge exchange and professional development. 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 useful to CD programs; pamphlets and posters provided to the communities as requested.

## Challenges

1. Ongoing difficulty of tracing cases and contacts. Proper testing and treatment should be done with both the case and contact to control further spread of infectious disease.
2. Incomplete contact information.
3. Rapid turn-over of nurses. Considering the important roles of nurses in disease prevention and control, their absence could impact on follow-up of patients and contacts in the areas.
4. Confidentiality. Compared to other diseases, STIs and other related infections involve maintaining a higher level of confidentiality. NITHA continues to promote confidentiality and privacy at all levels in the partnership.

## Priorities

1. Continuous information campaign to sustain level of awareness on communicable diseases at the community level, especially on the aspect of prevention and control.
2. Continuous engagement of elders in the awareness campaigns.
3. Involve youth in the information drive.
4. Establish new relationships and strengthen existing ones among key stakeholders.



# INFECTION CONTROL **ADVISOR**

## Program Overview

The NITHA Infection Prevention and Control (IPC) Program focuses on the infection prevention in health care facilities within the NITHA partnership communities. The Infection Control Advisor (ICA) accomplished several activities in the past year.

## Accomplishments

**Education** of health care workers on infection control measures was completed. Presentations on relevant topics in IPC were offered via telehealth and in person. Community staff had access to the online NITHA IPC manual and the online IPC course created in partnership with St. Elizabeth's.

**Janitorial Workshop on Environmental Cleaning:** Provided training on environmental cleaning to janitorial staff in order to increase their IPC knowledge.

**Mask Fit tester's training:** The Emergency Response Coordinator offered training on Mask Fit testing on behalf of the ICA. This Qualitative Fit test Mask fit Tester's training provided participants with the necessary skills to perform Mask Fit Testing for health care workers at risk of acquiring airborne infections such as tuberculosis.

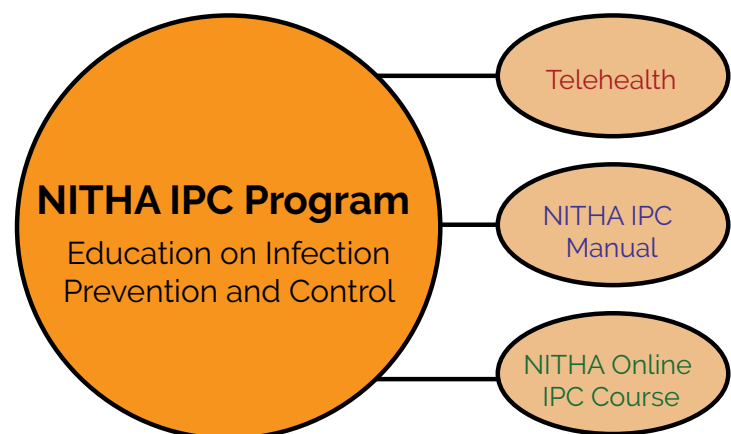
**Infection Prevention and Control Online course:**  
A significant amount of time was spent to develop an online Infection Prevention and Control module. The modules are highly interactive, user-friendly, and allows multiple learning methods.

**Facility Assessments:** The ICA provided technical support for PAGC in the assessment and inspection of potential accommodation centers for evacuees affected by the wild fire situation in Northern Saskatchewan last year.

The ICA developed and distributed needle recovery tool kits for all 33 communities to use for collection and disposal of abandoned used needles.



**Ivan Serunkuma**  
Infection Control Advisor







## Challenges

Resistance to antibiotics and the spread of antibiotic resistant organisms is a challenge requiring a solution with a multifaceted strategy. Education combined with antibiotic stewardship will assist in reducing the occurrence of antibiotic resistance. Following consistent IPC practices will lessen the risk of transmitting antibiotic resistant microorganisms within the communities.

## Priorities

Support the health centers through community visits to strengthen IPC practices, revision of the IPC manual to ensure relevant updates, and quality assurance /improvement in Infection Control.



# ENVIRONMENTAL HEALTH **ADVISOR**

## Program Overview

The EHA is responsible for the timely reporting and follow up of Zoonotic and Enteric communicable diseases (CD) as per the provincial legislation. The EHA supports the Environmental Health Officers (EHOs) and Community Health Nurses (CHNs) within the four partners through conveying available training sessions, developing promotional and/or educational materials, drafting policies, problem solving, providing data collection tools, and communicating new public health trends to protect and prevent the potential spread of CD and/or environmental public health risks within the community.

The EHA and EHOs in the partner communities conduct the following environmental health activities as required: drinking water, food safety, health and housing, waste water, solid waste disposal, facility inspections, communicable disease control, emergency preparedness and response, environmental contaminants, research and risk assessment.

## Accomplishments

The EHA attended the following conferences: Canadian Institute of Public Health Inspectors Annual Education, National CIPHI Conference, Dog bite prevention initiative, Ticks and West Nile Virus, Radon and The Association to Lung Cancer, Youth test shopper program, the EHO student practicum training updates, Career fairs in Prince Albert, and the First Nations Energy Forum. The training provided the EHA with the opportunity to deliver contributions on legislation proposals, guidelines, policies, to develop and disseminate research on the evidenced based practice guidelines for the EHOs and the partner communities to reduce environmental health risks. The EHA collaborated with the Public Health Inspectors (PHIs) at the Prince Albert Parkland Health Region (PAPHR) during the wildfire evacuations on sanitation concerns and provided inspection services to assist local PHIs.



**Treena Cottingham**

Environmental Health Advisor

EHA also completed work plan priorities including the development of the environmental health components for the on-line Infection Control Module in partnership with St. Elizabeth's, on-line training for WHIMIS and Transportation of Dangerous Goods (TDG).

EHA tracked and followed up on all cases of animal bite and enterics reported during the year under review. 164 animal bites were reported (see figure 1), indicating approximately 14% increase compared to the previous year; 154 (94%) were dog bites, 25% of the bites occurred in children under 10 years of age, and 3 cases required Rabies Post Exposure Prophylaxis. Enteric cases continue to be low among NITHA communities (see figure 2).

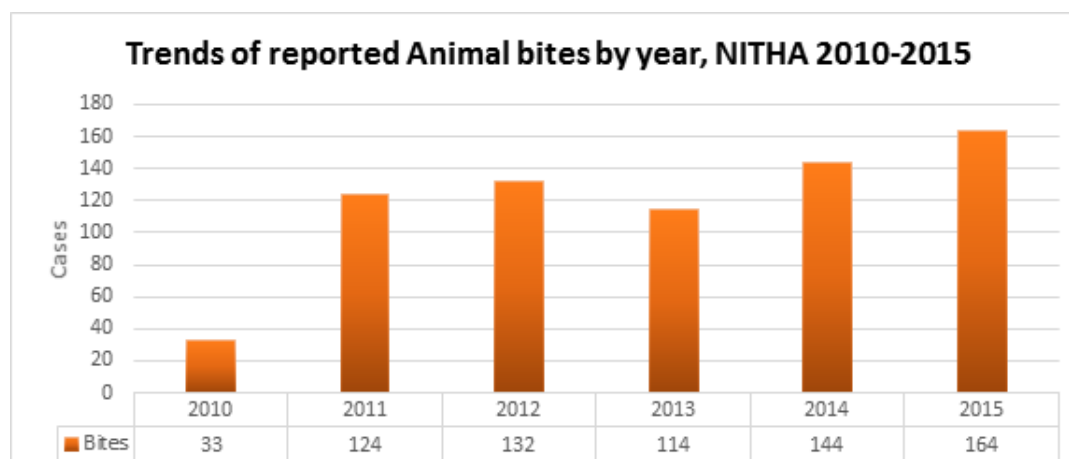


Figure 1: Trends of animal bite cases in NITHA communities from 2010-2015

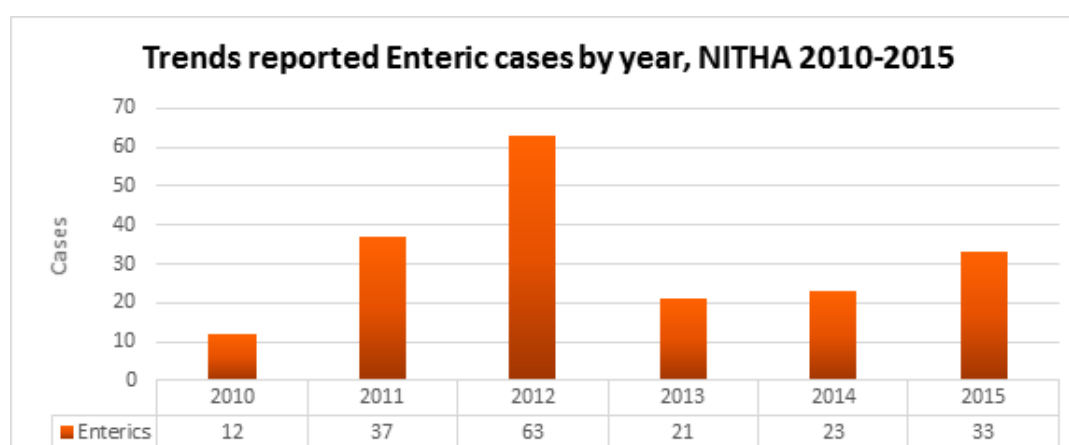


Figure 2: Trends of enteric cases in NITHA communities from 2010-2015

## Challenges

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

## Priorities

Continue to strive for provincial reporting requirements. Update the Infection Control Guidelines for Community Members and Health Centers booklet. Create a Biomedical Waste handling policy.

# TUBERCULOSIS PROGRAM

## Program Overview

The NITHA TB nurses conducted 26 community visits to 7 NITHA communities in order to provide ongoing support for contact tracing, outbreak management, the *Strategy for the Management of Tuberculosis in High Incidence Communities*, and to educate community health nurses (CHNs) and TB program workers. During the fiscal year, there were 2 TB nurses to assist in the communities as our 3rd TB nurse resigned. After a review of the program, the 3rd TB nurse position is currently being recruited.

### TB in NITHA Partner First Nations:

In 2015, 28 cases of suspected or confirmed active TB were reported in NITHA communities (see figure 1) which is similar to the 2014 cases and consistent with the 5 year trend of approximately 30 cases per year. In 2015, there were 9 cases present in NITHA communities; 7 of the 28 cases were present in one partner community currently experiencing a TB outbreak since July 2014. Another 10 of the total cases were in 4 of the communities designated as high incident TB communities.

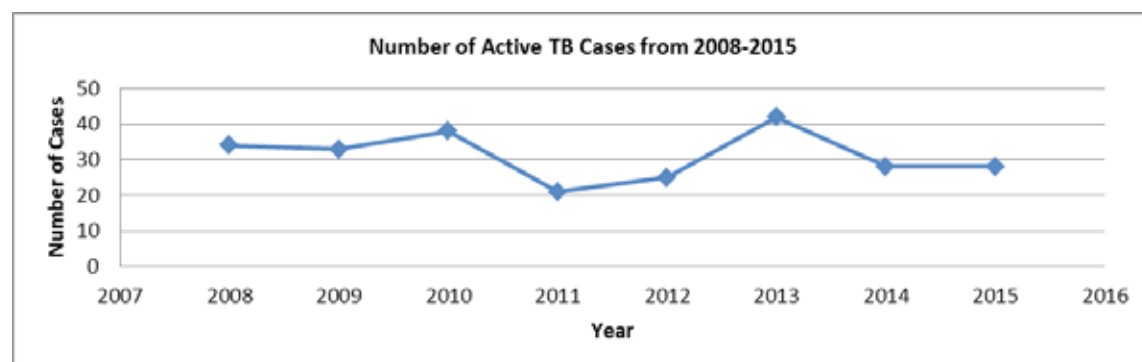


Figure 1: Number of Active TB Cases 2008-2015

In 2015, the age groups with the highest number of TB cases were 15-24 and 45-54 year old groups (see Figure 2).

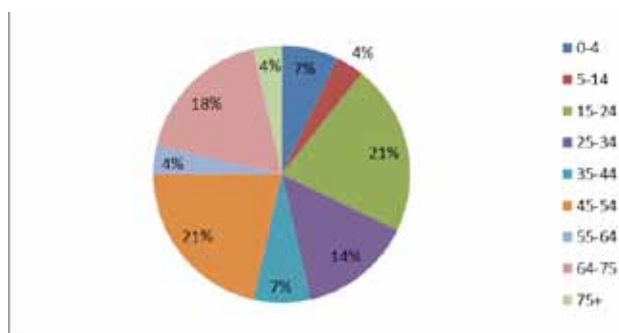


Figure 2: Percentage of distribution for active and suspected TB cases in 2015, n=10



**Sheila Hourigan**

TB Nurse Advisor

Age (in years)	Total # of cases	Male	Female	Rate per 100 000*
0-4	2	0	2	46
5-14	1	0	1	9
15-24	6	5	1	55
25-34	4	2	2	47
35-44	2	1	1	29
45-54	6	3	3	108
55-64	1	0	1	32
65-74	5	1	4	325
75+	1	1	0	118
<b>Total</b>	<b>28</b>	<b>13</b>	<b>15</b>	<b>106</b>

Table 1: Total number of TB Cases by age group, gender, and incidence rate, n =10

The majority of clients diagnosed with TB are in the group of 64-75 years of age with a rate of approximately 325/100,000 (see Table 1). Nationally, the largest TB burden in the Aboriginal population is in the 64-75 years of age and the 75+ years of age group. It is important to note the high incidence rate in the 45-54 years old group in NITHA communities because this trend is not present in the national data or reported in the existing literature.

Community 1 had the most TB cases with an ongoing TB outbreak at the time of reporting. However, the number of cases in community 1 is declining (see Figure 3).

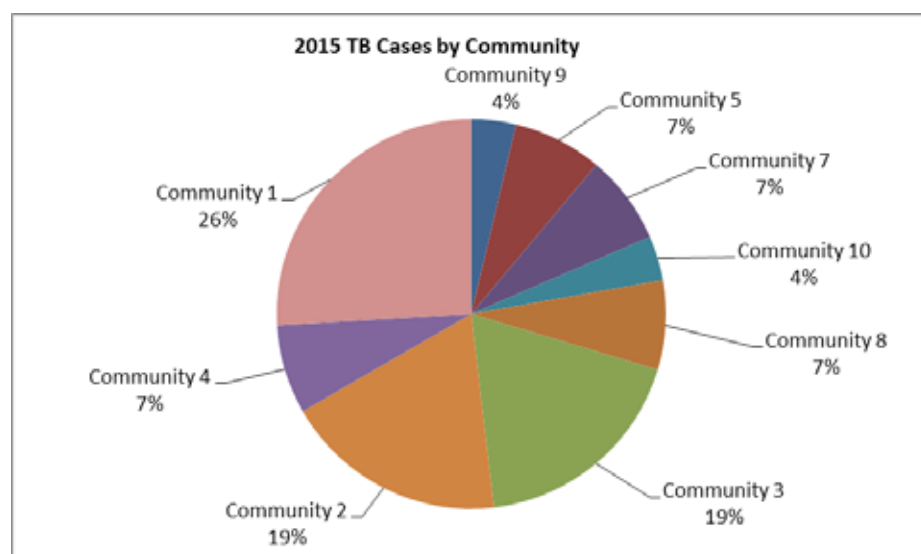


Figure 3: Breakdown of TB cases by NITHA community in 2015, n=10



From 2008 to 2015, 85% of NITHA TB Cases were diagnosed in 8 communities and 1 community contributed to 20% of the TB cases (see Figure 4). Four of the five high incidence communities are piloting *The High Incidence TB Strategy* while the other is experiencing a tuberculosis outbreak.

### Distribution of NITHA TB Cases 2008-2015

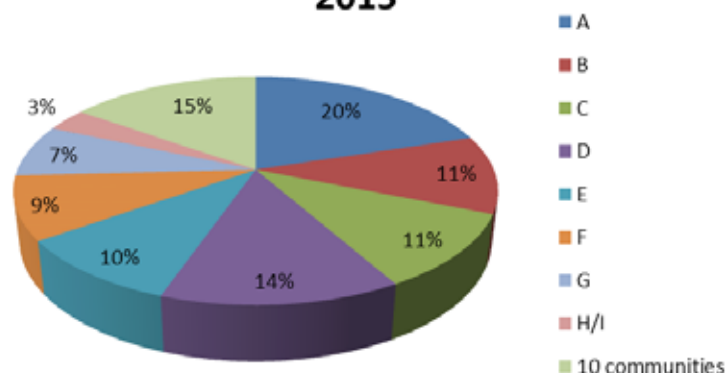


Figure 4: Distribution of TB Cases by NITHA community in 2008-2015

In 2015, 13 out of the 26 (50%) newly diagnosed TB cases were smear positive at the time of diagnosis. This indicates an advancement of the disease and an increased risk of transmission at the time of diagnosis (see figure 5). The higher percentage of smear positive cases may be related to the increased number of cases in the age category of over 64 years of age. There were 5 cases this year in the age category of over 64 years of age compared to 1 or 2 cases in previous years. Additional strategies to increase early detection of TB in this vulnerable group must be developed.

### % Smear+

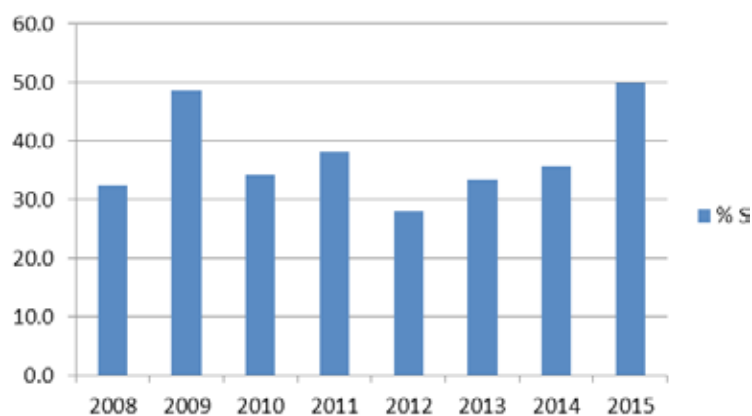


Figure 5: Percentage of smear positive TB Cases in 2008-2015

The most common risk factor for active TB cases was contact, followed by alcohol consumption and smoking (see figure 6). A common risk factor for young age groups was exposure to TB. Risk factors for older adults were smoking, alcohol use, and diabetes. Determining common risk factors among TB patients can assist health care providers to guide screening and preventative therapy efforts.

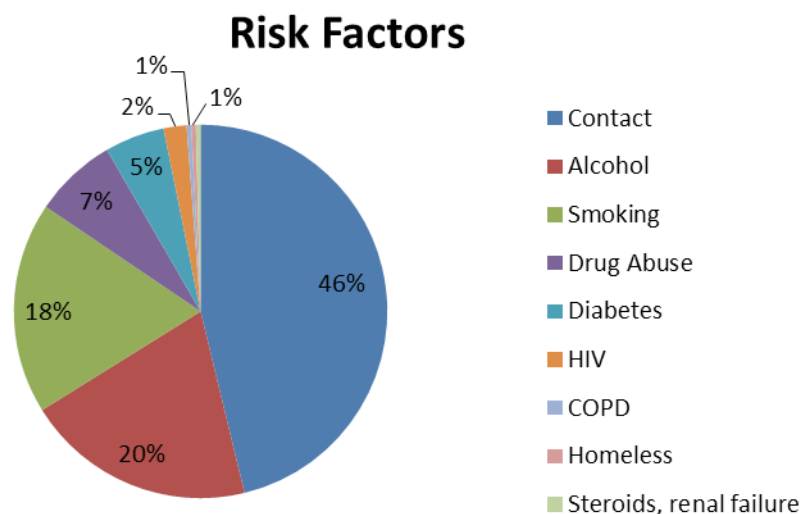


Figure 6: Risk factors for TB cases from 2008-2015

## Accomplishments

### Education and Training

The TB program provided orientation to 34 CHNs, delivery of occupational skills training and continue to provide daily telephone consultation to CHNs for emerging TB cases and contact investigations.

16 new TB program workers were trained and 8 received updates or additional orientation at the community level. The TB workers attended the annual TB Programs working workshop in Saskatoon.

### Case Management Support:

Case management is the responsibility of the CHNs along with the TB prevention and Control Program of Saskatchewan. The NITHA TB program supports case management by troubleshooting at the community level and through the provision of client incentives or enablers.



### **Contact Tracing:**

The primary emphasis of the NITHA TB programs is to support contact tracing. In 2015, there were 22 contact traces required with a total 646 contacts assessed.

### **Childhood Screening Program:**

The enhanced childhood screening program for all communities with a 3-year average annual incidence of smear positive TB cases greater than 15/100 000 population was delegated to a community level responsibility. Six of the 12 communities have thus far reported on screening 82 children in this age group with positive tests.

Nine schools within NITHA Partnership reported school entry screening with 70 children tested only one had a positive TB skin test.

### **Surveillance:**

With support from MPH practicum students, improvements to the NITHA TB program case database were accomplished. This has greatly enhanced our ability to analyze TB data and make the necessary program recommendations.

### **High Incidence Strategy:**

4 NITHA communities are pilot sites for implementing the *Strategy for the Management of Tuberculosis in High Incidence Communities*. The focus for this year was the promotion of treatment for latent TB infection. With input from the community, the high incidence strategy group developed and distributed educational and promotional materials. Evaluation of the progress to date for this strategy is planned for the coming year.

### **TB Program Review:**

The TB Program underwent a program review in order to determine options for program improvement. This review was conducted by an external organization and by engagement of nurse managers and TB Support staff across the Partnership. There were 8 areas that were reviewed with the NITHA Nurse Manager, TB nurses and TB Workers. Overall the report determined that the TB program is a robust and proven component of NITHA's contribution to the Partnership. It recommended that the TB program must remain a 1st, 2nd and 3rd level program and was ripe for repositioning. The review made 25 recommendations in the following areas:

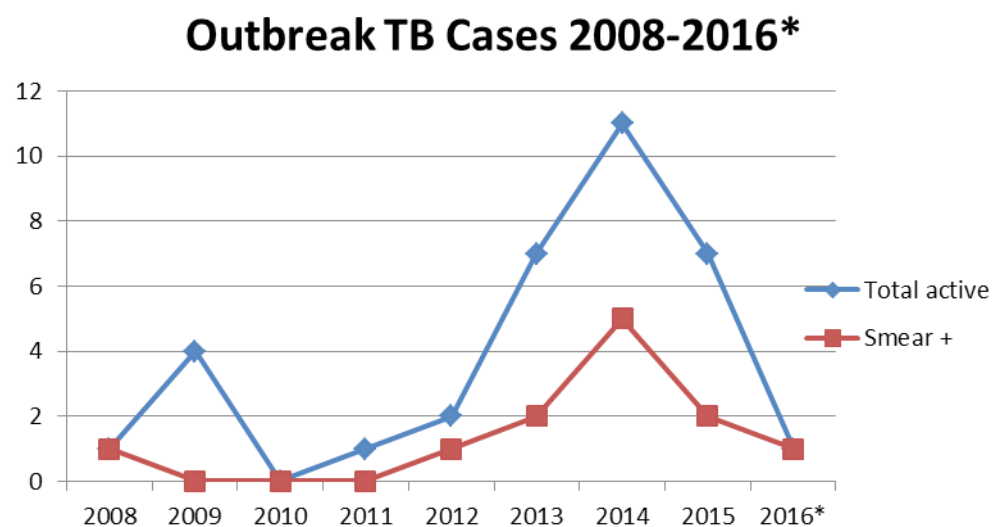
1. Prevention - 3 recommendations
2. TB Worker Program - 6 recommendations
3. TB Incentive Program - 3 recommendations

4. High Incidence Community Services - 4 recommendations
5. Contact Tracing - 3 recommendations
6. Mobile TB Clinic - 1 recommendation
7. Communication - 2 recommendations
8. TB Nurses 3 recommendations

NITHA is currently working towards the implementation of these recommendations to improve the TB Program.

### **Outbreak Management:**

NITHA and its partners have been actively engaged in managing an outbreak in a community since July of 2014 (see Figure 7).



*Figure 7: Outbreak Cases (2016\* to date)*

It appears there has been a significant decline in the number of new TB cases. The outbreak management team continues to meet via teleconference every 3 months. Treatment of latent TB infection remains a priority for the management of the outbreak in order to prevent active TB in those who have been exposed.

Age Group	2014		2015		2016 to date	
	TLTBI	GAP	TLTBI	GAP	TLTBI	GAP
0-14 years	2	10	7	6	0	3
15-34	15		25		8	
35+	23		36		10	
<b>Total</b>	<b>40</b>	<b>10</b>	<b>68</b>	<b>6</b>	<b>18</b>	<b>3</b>

*Table 2: Treatment of Latent TB infection and GAP preventative therapy in outbreak community.*

## Challenges

1. Unfilled nursing position to support the communities since May of 2015.
2. Maintaining focus on the high incidence strategy when concurrently managing an outbreak and managing a large number of contact investigations.

## Priorities

1. Contact tracing will remain a top priority for the program as it is the most important means available to us to find and prevent TB.
2. Ongoing support of high incidence strategies and outbreak management.
3. Increasing awareness of all communities about high-risk groups for progression from latent TB infection to active TB disease, especially elders, diabetics and people living with HIV.



**Eileen Oliveri**

TB Nurse



**Barbara George**

TB Nurse - English River



**Cindy Sewap**

Program Administrative Assistant



## ADMINISTRATIVE UNIT

The Administration Unit is comprised of the Executive Director, Executive Assistant, Finance Manager, Human Resource Advisor, the Personnel and Finance Assistant and the Receptionist Office Assistant. The unit is responsible for the overall ongoing daily operations of the organization. The administration staff work as a team to provide the following:

- keeping the leadership updated on the progress of programs and service that have been requested of the Partnership
- keeping accurate financial records and presenting quarterly financial statements to the leadership
- implementing financial decisions following established policies
- development and maintenance of financial and HR policies
- recruitment and retention for the North



**Glenna Thomas**

Personnel / Finance Assistant



**Danielle MacDonald**

Reception - Main Line





# HUMAN RESOURCE **ADVISOR**

## Program Overview

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

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

## Achievements

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

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



**Tara Campbell**

Human Resource Advisor

## Staff Vacancies

NITHA began its year fully staffed consisting of a total of 30 employees. During the past year, we had seen 3 vacancies in staff positions as well as the creation of 2 new positions. The addition of the 2 new positions would mean that NITHA has the potential to have 32 staff. As of March 31, 2016 NITHA continues to have 3 vacant positions of TB Nurse, Nutritionist and Program Administrative Assistant.

NITHA had a total of 60 applicants apply for the following 5 positions that were filled in the 2015-2016 fiscal year:

POSITION TITLE	DATE FILLED
1. Reception/Office Assistant	November 2015
2. Manager of Community Services	December 2015
3. Program Administrative Assistant	December 2015
4. Manager of Public Health	March 2016
5. Health Promotion Advisor	March 2016

**Employee Group Benefits and Compensation** - Annually, NITHA reviews the plan structure for all benefits available to staff to ensure that they are current and competitive. This past year a review was done of the NITHA employee pension plan structure and transfer of service provider was negotiated. This transfer in providers offered greater flexibility in regards to investments by staff and also provided greater access to their portfolios online. By having access to the employee pension plan online, it has improved the overall maintenance of the pension plan.

**Employee Relations** - 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, and/or to address personal issues that affect them in the workplace. Employees are advised about applicable benefits, regulations, legislation, and policies and their legal rights and protections.

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

**Performance Management** - At NITHA our managers, supervisors and employees work together to plan, monitor and review employees' work objectives and overall contribution to the organization. Our performance management process is a continuous process of setting objectives, assessing progress and providing on-going coaching and feedback.



**HR Policies and Procedures** - The HR Advisor makes it an on-going activity to review, recommend, update and interpret HR policies and procedures. We have been able to share copies of our policy statements with HR professionals in the Partnership to support their policy development activities.

**Employee Wellness** - The HR Advisor continues to advocate and ensure that all staff maintains a healthy work-life balance.

**Promotion and Awareness of NITHA** - Over the past year the HR Advisor set up the NITHA information booth a total of 9 times at various Nursing Conferences and Careers Fairs around the province. The main goal was to promote NITHA and the Partnership, as well as, pursuing health careers, the NITHA Scholarship and nursing in the north. The total number of participants reached for all 9 events was approximately 2200.

## Challenges

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

The capacity development strategies of NITHA in building skills required for various health professions in Northern Saskatchewan still continues to be a "long term goal" that will facilitate First Nation people to take up jobs at NITHA and within the Partnership Organizations. NITHA has established a working group with the Partnership to engage them in identifying the major issues within their organizations as a way to begin the process of address those outstanding issues. NITHA completed an update of Personnel Manual including the approval of 6 policies by the NEC. This process will be an ongoing project.

*"Your body holds deep wisdom. Trust in it. Learn from it. Nourish it. Watch your life transform and be healthy."*

~Bella Bleue

## Priorities

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

## Thank you.

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

- Josephine McKay, Manager of Community Services, May 2015
- Janine Brown, TB Nurse, July 2015
- Linda Gilmour Kessler, Health Promotion Advisor, August 2015
- Linda Rogozinski, Executive Assistant to MHO, September 2015
- Donna Halkett, Receptionist Office Assistant (term), November 2015
- Shianne Mercredi, Program Administrative Assistant, March 2016





# FINANCE **MANAGER**

## Program Overview

The Finance Manager performs professional, advisory and confidential financial duties abiding by the Financial Management Policy and Procedures Manual. The Finance Manager prepares the annual program budgets, provides monthly and annual financial reports, and ensures financial management is consistent with generally accepted accounting principles (GAAP) that meet audit standards. He/she is responsible for the development and maintenance of the financial management policy and procedures manual, developing the appropriate administrative forms and approval processes on all finance procedures.

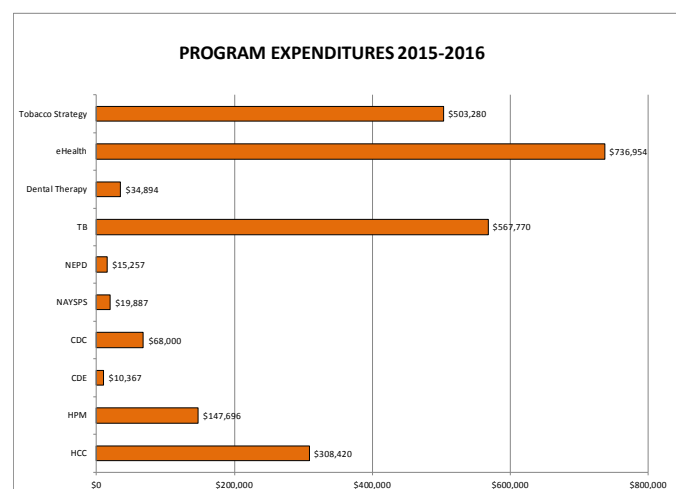
The Northern Inter-Tribal Health Authority operates under a consolidated agreement which contains block, set and flexible funding. This particular agreement is expected to expire March 31, 2019. On a quarterly basis the budgeted vs. actual expenditures by program area are presented to the Board of Chiefs for approval.

BLOCK Funding	\$3,055,331
Flexible Funding	405,931
Set Funding	1,314,265
<b>TOTAL TRANSFER FUNDING</b>	<b>\$4,775,527</b>

## 2015-16 Financial Statements

The 2015-16 Audited Financial Statements unveil the financial portrait of this past year's programs and services provided to NITHA Partners and their communities. Included in the audited financial statements are:

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





# AUDITED FINANCIAL **STATEMENTS**

**NORTHERN INTER-TRIBAL  
HEALTH AUTHORITY INC.**

***FINANCIAL STATEMENTS***

***March 31, 2016***



Deloitte LLP  
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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, 2016 and the statements of revenue, expenditures and changes in fund balances and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

#### Management's Responsibility for the Financial Statements

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

#### Auditor's Responsibility

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

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

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

#### Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Northern Inter-Tribal Health Authority Inc. as at March 31, 2016 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.

**Chartered Professional Accountants, Chartered Accountants  
Licensed Professional Accountants**

September 20, 2016  
Prince Albert, Saskatchewan

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**STATEMENT OF REVENUE, EXPENDITURES AND CHANGE IN FUND BALANCES**  
**year ended March 31, 2016**

	Budget 2016	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	Total 2016	Total 2015
(Schedule 1)							
<b>REVENUE</b>							
Health Canada	\$ 4,419,465	\$ 4,778,205	\$ -	\$ -	\$ -	\$ 4,778,205	\$ 5,455,037
Northern Lights Community Development Corporation	33,197	-	-	-	-	-	-
Administration fees (Note 8)	170,432	199,351	-	-	-	199,351	177,748
Expense recoveries	3,000	-	-	-	-	-	8,160
Gain (loss) on sale of capital assets	-	-	-	-	1,160	1,160	24,108
Interest	-	-	-	28,766	-	28,766	40,168
Transfer (to) from deferred revenue	-	65,737	-	-	-	65,737	(224,144)
<b>EXPENDITURES</b>							
Transfer programs and target programs	4,626,094	5,043,293	-	28,766	1,160	5,073,219	5,481,077
Expenses funded by appropriated surplus	4,806,365	4,814,573	-	-	-	4,814,573	4,335,993
Amortization of capital assets	-	-	873,811	34,500	-	908,311	690,749
	-	-	-	-	125,785	125,785	128,006
	4,806,365	4,814,573	873,811	34,500	125,785	5,848,669	5,154,748
<b>NET SURPLUS (DEFICIT)</b>	\$ (180,271)	228,720	(873,811)	(5,734)	(124,625)	(775,450)	326,329
<b>FUND BALANCES, BEGINNING OF YEAR</b>							
<b>TRANSFER TO CAPITAL FUND</b>		70,795	3,350,829	489,036	361,384	4,272,044	3,945,715
<b>TRANSFER FROM (TO) APPROPRIATED SURPLUS</b>		(39,438)	(95,408)	-	-	(134,846)	(165,503)
<b>TRANSFER (TO) FROM OPERATING FUND</b>		308,420	(308,420)	-	-	308,420	(570,682)
		-	(308,420)	-	134,846	(173,574)	736,185
<b>FUND BALANCES, END OF YEAR</b>	\$ 568,497	\$ 2,073,190	\$ 483,302	\$ 371,605	\$ 3,496,594	\$ 4,272,044	



**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**STATEMENT OF FINANCIAL POSITION**  
**as at March 31, 2016**

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	Total 2016	Total 2015
<b>CURRENT ASSETS</b>						
Cash and cash equivalents	\$ 1,412,653	\$ 2,073,190	\$ 483,302	- \$	<b>3,969,145</b>	\$ 3,367,620
Accounts receivable	30,926	-	-	-	<b>30,926</b>	1,471,962
Prepaid expenses	12,423	-	-	-	<b>12,423</b>	8,591
	<u>1,456,002</u>	<u>2,073,190</u>	<u>483,302</u>	<u>-</u>	<u><b>4,012,494</b></u>	<u>4,848,173</u>
<b>CAPITAL ASSETS (Note 4)</b>						
	-	-	-	371,605	<b>371,605</b>	361,384
	<u>1,456,002</u>	<u>2,073,190</u>	<u>483,302</u>	<u>371,605</u>	<u><b>4,384,099</b></u>	<u>5,209,557</u>
<b>CURRENT LIABILITIES</b>						
Accounts payable and accrued charges	\$ 635,432	- \$	- \$	- \$	<b>635,432</b>	\$ 619,703
Deferred revenue (Note 5)	252,073	-	-	-	<b>252,073</b>	317,810
	<u>887,505</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u><b>887,505</b></u>	<u>937,513</u>
<b>FUND BALANCES</b>						
Unappropriated surplus	568,497	-	-	-	<b>568,497</b>	70,795
Appropriated surplus (Note 6)	-	2,073,190	-	-	<b>2,073,190</b>	3,350,829
Surplus appropriated for scholarships (Note 7)	-	-	483,302	-	<b>483,302</b>	489,036
Invested in capital assets	-	-	-	371,605	<b>371,605</b>	361,384
	<u>568,497</u>	<u>2,073,190</u>	<u>483,302</u>	<u>371,605</u>	<u><b>3,496,594</b></u>	<u>4,272,044</u>
	<u>1,456,002</u>	<u>2,073,190</u>	<u>483,302</u>	<u>371,605</u>	<u><b>4,384,099</b></u>	<u>5,209,557</u>

**SIGNED ON BEHALF OF THE BOARD:**

*Grand Chief P. M. M. M.* **Chair**

**Board Member**



**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**STATEMENT OF CASH FLOWS**  
**year ended March 31, 2016**

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	2016	2015
<b>CASH FLOWS FROM (USED IN) OPERATING ACTIVITIES</b>						
Net surplus (deficit)	\$ 228,720	\$ (873,811)	\$ (5,734)	\$ (124,625)	\$ (775,450)	\$ 326,329
Adjust items not affecting cash						
(Gain) Loss on sale of capital assets	-	-	-	(1,160)	(1,160)	(24,108)
Amortization of capital assets	-	-	-	125,785	125,785	128,006
Changes in non-cash working capital	228,720	(873,811)	(5,734)	-	(650,825)	430,227
Accounts receivable	1,441,036	-	-	-	1,441,036	(1,297,975)
Prepaid expenses	(3,832)	-	-	-	(3,832)	46
Accounts payable and accrued charges	15,729	-	-	-	15,729	(33,940)
Deferred revenue	(65,737)	-	-	-	(65,737)	224,144
	1,615,916	(873,811)	(5,734)	-	736,371	(677,498)
<b>CASH FLOWS FROM (USED IN) INVESTING ACTIVITIES</b>						
Purchase of capital assets	-	-	-	(136,006)	(136,006)	(201,391)
Proceeds from disposal of capital assets	-	-	-	1,160	1,160	35,888
	-	-	-	(134,846)	(134,846)	(165,503)
<b>NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS</b>	1,615,916	(873,811)	(5,734)	(134,846)	601,525	(843,001)
<b>CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR</b>	(472,245)	3,350,829	489,036	-	3,367,620	4,210,621
<b>TRANSFER FROM OPERATING FUND TO CAPITAL FUND</b>	(39,438)	(95,408)	-	134,846	-	-
<b>TRANSFER FROM OPERATING FUND TO APPROPRIATED SURPLUS</b>	308,420	(308,420)	-	-	-	-
<b>CASH AND CASH EQUIVALENTS, END OF YEAR</b>	\$ 1,412,653	\$ 2,073,190	\$ 483,302	\$ -	\$ 3,969,145	\$ 3,367,620
<b>CASH AND CASH EQUIVALENTS CONSISTS OF:</b>						
Cash					\$ 2,250,938	\$ 1,658,353
Short-term investments					1,718,207	1,709,267
					\$ 3,969,145	\$ 3,367,620





**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**NOTES TO THE FINANCIAL STATEMENTS**  
**March 31, 2016**

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**1. DESCRIPTION OF BUSINESS**

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

**2. SIGNIFICANT ACCOUNTING POLICIES**

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

***Fund Accounting***

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

- i) The Operating Fund accounts for the Authority’s administrative and program delivery activities,
- ii) The Appropriated Surplus Fund accounts for funds allocated by the Board of Directors to be used for a specific purpose in the future,
- iii) The Surplus Appropriated for Scholarships Fund accounts for funds allocated by the Board of Directors to be used for payment of scholarships in the future, and
- iv) The Capital Fund accounts for the capital assets of the Authority, together with related financing and amortization.

***Cash and Cash Equivalents***

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

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**NOTES TO THE FINANCIAL STATEMENTS**  
**March 31, 2016**

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**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 public sector accounting standards for government not-for-profit organizations requires management to make estimates and assumptions that affect reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Key components of the financial statements requiring management to make estimates includes allowance for doubtful accounts, the useful lives of capital assets and accrual for accumulated sick leave. Actual results could differ from these estimates.

**3. ECONOMIC DEPENDENCE**

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



**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**NOTES TO THE FINANCIAL STATEMENTS**  
**March 31, 2016**

**CAPITAL ASSETS**

	Net Book Value			
	Cost	Accumulated Amortization	2016	2015
Computers	\$ 956,367	\$ 904,938	\$ <b>51,429</b>	\$ 60,501
Software	92,999	78,966	<b>14,033</b>	16,504
Equipment and furniture	502,801	380,316	<b>122,485</b>	108,937
Leasehold improvements	162,112	54,912	<b>107,200</b>	89,959
Vehicles	198,207	121,749	<b>76,458</b>	85,483
	<u>\$ 1,912,486</u>	<u>\$ 1,540,881</u>	<u>\$ <b>371,605</b></u>	<u>\$ 361,384</u>

**DEFERRED REVENUE**

	2016	2015
Dental Therapy	\$ <b>3,244</b>	\$ 38,138
Communicable Disease Emergencies	<b>16,883</b>	-
CDC - Immunization	<b>16,010</b>	-
NAYSPS	<b>33,613</b>	-
Tobacco Control Strategy	<b>182,323</b>	279,672
	<u><b>252,073</b></u>	<u>317,810</u>

**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:

	2015 Opening Balance	Transfers	Expenses	2016 Ending Balance
Capacity development initiatives	\$ 246,116	\$ -	\$ 161,217	\$ <b>84,899</b>
Human resources initiatives	42,080	-	8,130	<b>33,950</b>
Nursing initiatives	46,170	-	-	<b>46,170</b>
Capital projects	526,163	(95,408)	22,836	<b>407,919</b>
E-Health solutions	300,000	-	300,000	-
Emergency preparedness	300,000	-	300,000	-
Home care, End of Life, Physical Assessment	36,086	-	6,270	<b>29,816</b>
Communicable Disease (including EBOLA & eLearning Module)	78,870	-	75,358	<b>3,512</b>
Strategic planning & long-term planning, and Future Deficits	<u>1,775,344</u>	<u>(308,420)</u>	<u>-</u>	<u><b>1,466,924</b></u>
	<u>\$ 3,350,829</u>	<u>\$ (403,828)</u>	<u>\$ 873,811</u>	<u>\$ <b>2,073,190</b></u>

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**NOTES TO THE FINANCIAL STATEMENTS**  
**March 31, 2016**

**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.

<u>Beginning Balance</u>	<u>Interest</u>	<u>Expenses</u>	<u>Ending Balance</u>
\$ 489,036	\$ 28,766	\$ 34,500	\$ 483,302

**8. ADMINISTRATION FEES**

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

	<u>Schedule</u>	<u>2016</u>	<u>2015</u>
Health Planning and Management	5	28,194	-
Home Care	6	14,758	9,972
Communicable Disease Emergencies	7	2,725	9,005
Communicable Disease Control	8	6,000	6,967
National Aboriginal Youth Suicide Prevention Strategy	9	3,000	3,352
Nursing Education	10	1,015	1,046
TB Initiative	11	56,000	49,755
Aboriginal Human Resource	12	-	13,887
Dental Therapy Program	13	3,814	7,661
E-Health Solutions / Panorama	14	72,609	66,891
Tobacco Control Strategy	15	11,236	9,212
		\$ 199,351	\$ 177,748

**9. COMMITMENTS**

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





**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**NOTES TO THE FINANCIAL STATEMENTS**  
**March 31, 2016**

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**10. RELATED PARTY TRANSACTIONS**

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

	<u>2016</u>	<u>2015</u>
Prince Albert Grand Council	\$ 357,385	\$ 224,863
Meadow Lake Tribal Council	\$ 283,642	\$ 247,723
Peter Ballantyne Cree Nation	\$ 380,432	\$ 253,942
Lac La Ronge Indian Band	\$ 289,172	\$ 196,352

At March 31, 2016, there was \$19,689 (2015- \$43,353) of receivables and \$116,104 (2015- \$57,166) of payables with the Authority's partners listed above. These transactions were made in the normal course of business and have been recorded at the exchanged amounts.

**11. FINANCIAL INSTRUMENTS**

***Credit Risk***

The Authority is exposed to credit risk from the potential non-payment of accounts receivable. 91% of the accounts receivable is due from Health Canada, Meadow Lake Tribal Council and Prince Albert Grand Council.

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

***Interest Rate Risk***

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

***Liquidity Risk***

Liquidity risk is the risk of being unable to meet cash requirements or fund obligations as they become due. The Authority manages its liquidity risk by constantly monitoring forecasted and actual cash flows and financial liability maturities, and by holding cash and assets that can be readily converted into cash. As at March 31, 2016, the most significant financial liabilities are accounts payable and accrued charges.

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**SUMMARY OF OPERATING FUND REVENUE, EXPENDITURES AND SURPLUS FROM PROGRAMS PRIOR TO INTERFUND TRANSFERS**  
**year ended March 31, 2016**

	Schedule	Health Canada Funding	Other Revenue	Administration Fees (Note 8)	Transfer (To) From Deferred Revenue	Total Revenue	Expenditures	Surplus (Deficit) 2016	Surplus (Deficit) 2015
<b>BLOCK FUNDING</b>									
Public Health Unit	2	\$ 871,888	\$ -	\$ -	\$ -	\$ 871,888	\$ 808,895	\$ 62,993	\$ 84,388
Administration	3	1,139,891	-	199,351	-	1,339,242	1,093,198	246,044	124,005
Community Services Unit	4	699,027	-	-	-	699,027	499,955	199,072	239,885
Health Planning & Management	5	17,183	-	-	-	17,183	308,420	(291,237)	455,726
Home Care	6	147,581	-	-	-	147,581	147,696	(115)	36,086
Communicable Disease Emergencies	7	27,250	-	-	(16,883)	10,367	10,367	-	78,871
Communicable Disease Control	8	84,010	-	-	(16,010)	68,000	68,000	-	10,997
NAYSPS	9	53,500	-	-	(33,613)	19,887	19,887	-	-
Nursing Education	10	15,000	-	-	-	15,000	15,257	(257)	-
		3,055,330	-	199,351	(66,506)	3,188,175	2,971,675	216,500	1,029,958
<b>SET FUNDING</b>									
TB Initiative	11	560,000	-	-	-	560,000	567,770	(7,770)	(21,987)
Aboriginal Human Resource	12	-	-	-	-	-	-	-	-
Dental Therapy Program	13	-	-	-	34,894	34,894	34,894	-	-
E-Health Solutions	14	756,944	-	-	-	756,944	736,954	19,990	72,837
		1,316,944	-	-	34,894	1,351,838	1,339,618	12,220	50,850
<b>FLEXIBLE FUNDING</b>									
Tobacco Control Strategy	15	405,931	-	-	97,349	503,280	503,280	-	-
<b>TOTAL</b>		<u>\$ 4,778,205</u>	<u>\$ -</u>	<u>\$ 199,351</u>	<u>\$ 65,737</u>	<u>\$ 5,043,293</u>	<u>\$ 4,814,573</u>	<u>\$ 228,720</u>	<u>\$ 1,080,808</u>



**Schedule 2**

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
PUBLIC HEALTH UNIT  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	\$ 871,888	\$ 871,888	\$ 879,477
Expense Recoveries	<u>1,000</u>	<u>-</u>	<u>1,102</u>
	<u>872,888</u>	<u>871,888</u>	<u>880,579</u>
<b>EXPENDITURES</b>			
Meetings and workshops	22,500	11,903	5,876
Personnel	913,179	760,719	756,059
Professional fees	2,000	-	2,028
Environmental Cleaning Workshop	2,000	1,797	842
40 Developmental Assets	-	-	30
Program materials	21,400	18,117	19,347
Travel and vehicle	<u>19,500</u>	<u>16,359</u>	<u>12,009</u>
	<u>980,579</u>	<u>808,895</u>	<u>796,191</u>
<b>SURPLUS (DEFICIT)</b>	\$ <u><u>(107,691)</u></u>	\$ <u><u>62,993</u></u>	\$ <u><u>84,388</u></u>

### Schedule 3

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**ADMINISTRATION**  
**SCHEDULE OF REVENUE AND EXPENDITURES**  
**year ended March 31, 2016**

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	\$ 1,144,230	\$ 1,139,891	\$ 1,126,815
General Project Cost Recoveries (Admin Fees)	170,432	199,351	177,748
Expense recoveries	<u>1,000</u>	<u>-</u>	<u>3,148</u>
	<u>1,315,662</u>	<u>1,339,242</u>	<u>1,307,711</u>
<b>EXPENDITURES</b>			
Bank Charges	2,000	2,441	1,949
Equipment lease and maintenance	40,000	33,342	36,041
Facility Costs	211,993	218,399	232,789
Meetings and workshops	134,480	88,036	106,754
Personnel	707,878	594,522	642,219
Professional fees	65,425	68,575	54,626
Telephone and supplies	90,000	66,313	88,810
Travel and vehicle	<u>26,500</u>	<u>21,570</u>	<u>20,518</u>
	<u>1,278,276</u>	<u>1,093,198</u>	<u>1,183,706</u>
<b>SURPLUS</b>	37,386	246,044	124,005
<b>TRANSFER TO CAPITAL FUND</b>	<u>-</u>	<u>(2,265)</u>	<u>-</u>
	<u>\$ 37,386</u>	<u>\$ 243,779</u>	<u>\$ 124,005</u>



**Schedule 4**

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
COMMUNITY SERVICES UNIT  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	\$ 699,027	\$ 699,027	\$ 709,926
Expense Recoveries	<u>1,000</u>	<u>-</u>	<u>-</u>
	<u>700,027</u>	<u>699,027</u>	<u>709,926</u>
<b>EXPENDITURES</b>			
Meetings and workshops	7,500	4,097	2,784
Personnel	519,495	409,332	349,770
Professional fees	12,000	11,000	12,000
Program Costs	135,300	67,993	99,082
Program materials	2,000	1,487	1,066
Travel and vehicle	<u>10,000</u>	<u>6,046</u>	<u>5,339</u>
	<u>686,295</u>	<u>499,955</u>	<u>470,041</u>
<b>SURPLUS</b>	\$ <u><u>13,732</u></u>	\$ <u><u>199,072</u></u>	\$ <u><u>239,885</u></u>



## Schedule 5

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
HEALTH PLANNING AND MANAGEMENT  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	\$ 17,183	\$ 17,183	\$ 510,000
	<u>17,183</u>	<u>17,183</u>	<u>510,000</u>
<b>EXPENDITURES</b>			
Administration fee	47,291	28,194	-
Meetings and workshops	388,618	266,076	36,605
Professional fees	37,000	14,150	13,000
Program costs	-	-	-
Travel and vehicle	-	-	4,669
	<u>472,909</u>	<u>308,420</u>	<u>54,274</u>
<b>SURPLUS</b>	-	(291,237)	455,726
<b>TRANSFER TO CAPITAL FUND</b>	-	(17,183)	-
<b>TRANSFER FROM (TO) APPROPRIATED SURPLUS</b>	<u>455,726</u>	<u>308,420</u>	<u>(455,726)</u>
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>



**Schedule 6**

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
HOME CARE  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	\$ <u>147,581</u>	\$ <u>147,581</u>	\$ <u>145,782</u>
	<u>147,581</u>	<u>147,581</u>	<u>145,782</u>
<b>EXPENDITURES</b>			
Administration fee	14,758	14,758	9,972
Meetings and workshops	1,500	2,224	5,167
Personnel	31,500	31,500	27,820
Professional fees	20,000	20,000	10,000
Program costs	75,349	75,165	56,121
Travel and vehicle	<u>4,474</u>	<u>4,049</u>	<u>616</u>
	<u>147,581</u>	<u>147,696</u>	<u>109,696</u>
<b>SURPLUS</b>	-	(115)	36,086
<b>TRANSFER TO APPROPRIATED SURPLUS</b>	<u>-</u>	<u>-</u>	<u>(36,086)</u>
	\$ <u><u>-</u></u>	\$ <u><u>(115)</u></u>	\$ <u><u>-</u></u>

# Schedule 7

## NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC. COMMUNICABLE DISEASE EMERGENCIES SCHEDULE OF REVENUE AND EXPENDITURES year ended March 31, 2016

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	\$ 11,250	\$ 27,250	\$ 175,500
Other Revenue	-	-	2,353
Transfer to deferred revenue	-	(16,883)	
	<u>11,250</u>	<u>10,367</u>	<u>177,853</u>
<b>EXPENDITURES</b>			
Administration fee	7,987	2,725	9,005
Personnel	-	-	9,779
Program costs	-	3,736	-
Mask Fit Testing	6,900	3,906	8,152
IPC eLearning	27,250	-	17,000
EBOLA	47,983	-	55,046
	<u>90,120</u>	<u>10,367</u>	<u>98,982</u>
<b>SURPLUS</b>	(78,870)	-	78,871
<b>TRANSFER TO APPROPRIATED SURPLUS</b>	<u>78,870</u>	<u>-</u>	<u>(78,871)</u>
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>



## Schedule 8

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.**  
**CDC - IMMUNIZATION**  
**SCHEDULE OF REVENUE AND EXPENDITURES**  
**year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	<b>60,000</b>	<b>84,010</b>	74,775
Transfer to deferred revenue	\$ <u>-</u>	\$ <u>(16,010)</u>	\$ <u>-</u>
	<b><u>60,000</u></b>	<b><u>68,000</u></b>	<b><u>74,775</u></b>
<b>EXPENDITURES</b>			
Administration fee	<b>6,000</b>	<b>6,000</b>	6,967
Equipment lease and maintenance	<b>15,107</b>	<b>15,107</b>	14,032
Personnel	<b>34,883</b>	<b>34,883</b>	20,053
Program costs	<b>-</b>	<b>8,000</b>	14,120
Programs materials	<b><u>4,010</u></b>	<b><u>4,010</u></b>	<u>8,606</u>
	<b><u>60,000</u></b>	<b><u>68,000</u></b>	<u>63,778</u>
<b>SURPLUS</b>	-	-	10,997
<b>TRANSFER TO CAPITAL FUND</b>	<u>-</u>	<u>-</u>	<u>(10,997)</u>
	\$ <u><u>-</u></u>	\$ <u><u>-</u></u>	\$ <u><u>-</u></u>

# Schedule 9

## NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC. NAYSPS SCHEDULE OF REVENUE AND EXPENDITURES year ended March 31, 2016

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	53,500	53,500	53,500
Transfer to deferred revenue	\$ -	\$ (33,613)	\$ -
	<u>53,500</u>	<u>19,887</u>	<u>53,500</u>
<b>EXPENDITURES</b>			
Administration fee	5,350	3,000	3,352
Program costs	<u>48,150</u>	<u>16,887</u>	<u>50,148</u>
	<u>53,500</u>	<u>19,887</u>	<u>53,500</u>
<b>SURPLUS</b>	\$ <u>-</u>	\$ <u>-</u>	\$ <u>-</u>



**Schedule 10**

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
NURSING EDUCATION  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	\$ <u>15,000</u>	\$ <u>15,000</u>	\$ <u>15,000</u>
	<u>15,000</u>	<u>15,000</u>	<u>15,000</u>
<b>EXPENDITURES</b>			
Administration fee	1,500	1,015	1,046
Personnel	12,600	14,242	13,753
Program materials and supplies	<u>900</u>	<u>-</u>	<u>201</u>
	<u>15,000</u>	<u>15,257</u>	<u>15,000</u>
<b>SURPLUS (DEFICIT)</b>	\$ <u><u>-</u></u>	\$ <u><u>(257)</u></u>	\$ <u><u>-</u></u>



# Schedule 11

## NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC. TB INITIATIVE SCHEDULE OF REVENUE AND EXPENDITURES year ended March 31, 2016

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	\$ 456,550	\$ 560,000	\$ 497,550
Expense Recoveries	-	-	300
	<u>456,550</u>	<u>560,000</u>	<u>497,850</u>
<b>EXPENDITURES</b>			
Administration fee	45,655	56,000	49,755
Equipment lease and maintenance	362	454	413
Facility Costs	11,679	11,260	4,000
Personnel	459,103	395,103	366,682
Professional fees	-	-	8,832
Program costs	20,000	59,259	51,097
Incentives	6,000	5,569	6,640
Telephone and supplies	9,450	10,851	8,818
Travel and vehicle	28,000	29,274	23,600
	<u>580,249</u>	<u>567,770</u>	<u>519,837</u>
<b>DEFICIT</b>	\$ <u>(123,699)</u>	\$ <u>(7,770)</u>	\$ <u>(21,987)</u>



**Schedule 12**

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
ABORIGINAL HUMAN RESOURCE  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	<b>Budget 2016</b>	<b>2016</b>	<b>2015</b>
<b>REVENUE</b>			
Health Canada	\$ -	\$ -	\$ 148,791
Other Revenue	-	-	-
Transfer from deferred revenue	-	-	-
	<u>-</u>	<u>-</u>	<u>148,791</u>
<b>EXPENDITURES</b>			
Administration fee	-	-	13,887
Meetings and workshops	-	-	554
Program costs	-	-	133,936
Program materials and supplies	-	-	414
	<u>-</u>	<u>-</u>	<u>148,791</u>
<b>SURPLUS (DEFICIT)</b>	<u><u>\$ -</u></u>	<u><u>\$ -</u></u>	<u><u>\$ -</u></u>

# Schedule 13

## NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC. DENTAL THERAPY SCHEDULE OF REVENUE AND EXPENDITURES year ended March 31, 2016

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	\$ -	\$ -	\$ 67,608
Transfer from deferred revenue - NLCDC	33,197	38,138	93,666
Transfer to deferred revenue - NLCDC	-	(3,244)	(38,138)
	<u>33,197</u>	<u>34,894</u>	<u>123,136</u>
<b>EXPENDITURES</b>			
Administration fee	-	3,814	7,661
Facility Costs	28,413	31,028	58,852
Meetings and workshops	2,784	52	6,143
Personnel	-	-	36,047
Professional fees	-	-	14,433
Travel and vehicle	2,000	-	-
	<u>33,197</u>	<u>34,894</u>	<u>123,136</u>
<b>SURPLUS</b>	\$ -	\$ -	\$ -



Schedule 14

**NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.  
E-HEALTH SOLUTIONS  
SCHEDULE OF REVENUE AND EXPENDITURES  
year ended March 31, 2016**

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	\$ 545,962	\$ 756,944	\$ 669,313
Other Revenue	-	-	1,257
	<u>545,962</u>	<u>756,944</u>	<u>670,570</u>
<b>EXPENDITURES</b>			
Administration fee	49,840	72,609	66,891
Meetings and workshops	-	570	-
Equipment lease and maintenance	-	-	8,359
Personnel	-	243,128	92,107
Professional fees	-	6,786	1,749
Program costs	496,122	411,431	420,585
Materials and supplies	-	786	4,301
Travel and vehicle	-	1,644	3,741
	<u>545,962</u>	<u>736,954</u>	<u>597,733</u>
<b>SURPLUS</b>	-	19,990	72,837
<b>TRANSFER TO CAPITAL FUND</b>	-	(19,990)	(72,837)
	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

# Schedule 15

## NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC. TOBACCO CONTROL STRATEGY SCHEDULE OF REVENUE AND EXPENDITURES year ended March 31, 2016

	Budget 2016	2016	2015
<b>REVENUE</b>			
Health Canada	\$ 405,931	\$ 405,931	\$ 381,000
Transfer from deferred revenue	<u>125,957</u>	<u>97,349</u>	<u>(279,672)</u>
	<u>531,888</u>	<u>503,280</u>	<u>101,328</u>
<b>EXPENDITURES</b>			
Administration fee	17,590	11,236	9,212
Meetings and workshops	1,500	1,149	748
Personnel	73,640	78,484	12,096
Program costs	409,392	388,565	76,454
Telephone and supplies	28,266	21,582	305
Travel and vehicle	<u>1,500</u>	<u>2,264</u>	<u>2,513</u>
	<u>531,888</u>	<u>503,280</u>	<u>101,328</u>
<b>SURPLUS (DEFICIT)</b>	\$ <u>-</u>	\$ <u>-</u>	\$ <u>-</u>



Prince Albert, SK. S6V 5S4