Developing Health and Wellness Plans

A Guide for First Nations

First Nations Health Managers Association
Association des gestionnaires de santé des Premières Nations

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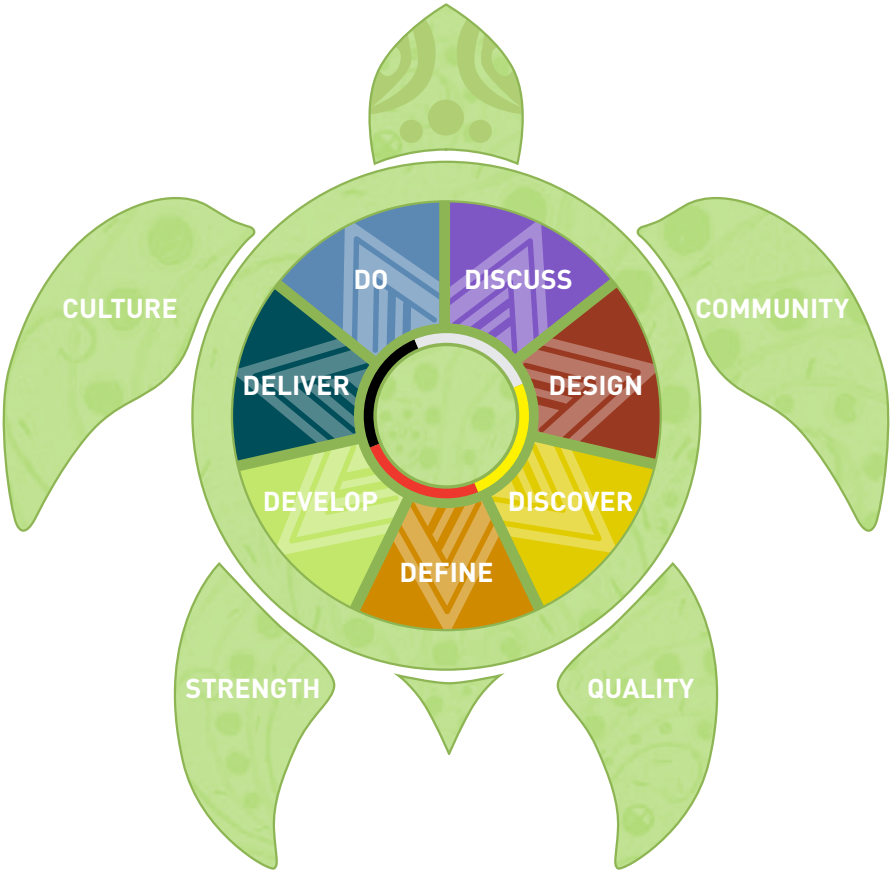

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Created in collaboration with First Nation health managers across Canada

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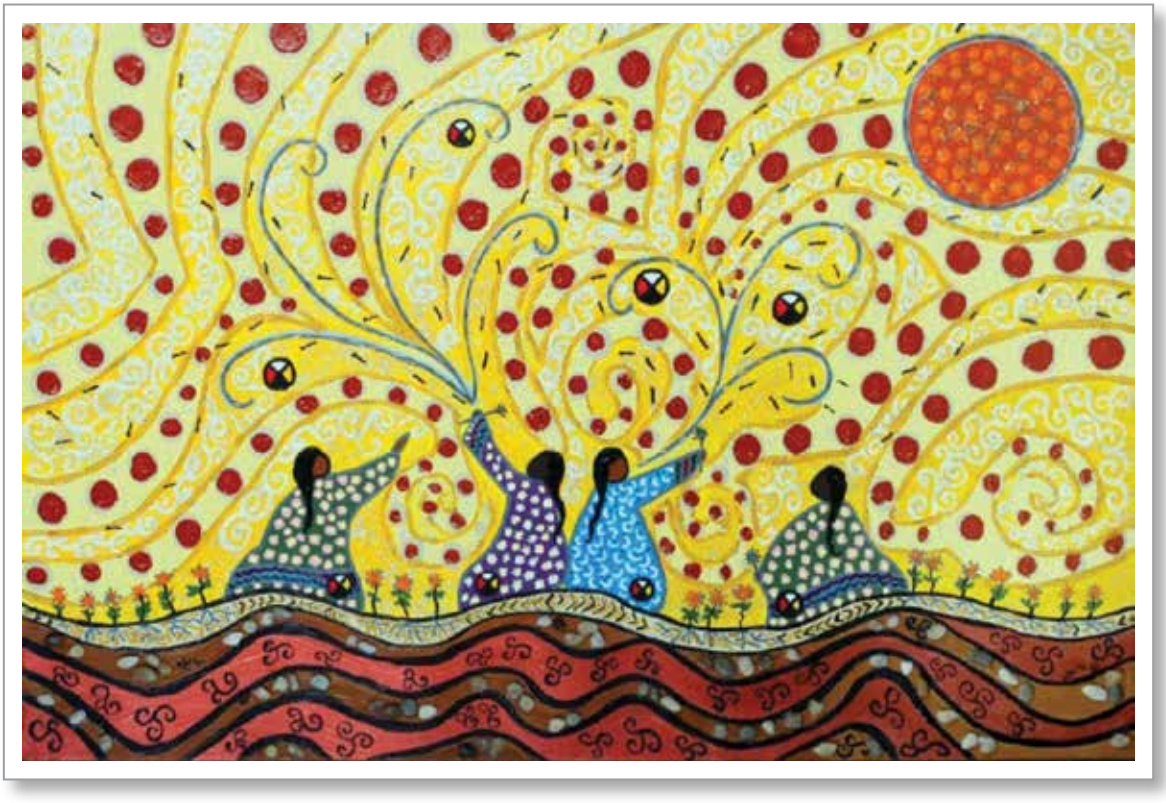
About the First Nations Health Managers Association

The First Nations Health Managers Association (FNHMA) is committed to excellence in expanding health management capacity for First Nations organizations. It is a national, professional organization serving the needs of individuals working for, or aspiring to positions with First Nations organizations. The mandate of the FNHMA is to provide training, certification, professional development opportunities, and support to those working in health management.

FNHMA provides leadership in health management activities by developing and promoting quality standards and practices, certification, and professional development for members and First Nation organizations. Health managers from across Canada can take advantage of the professional program leading to certification and the Certified First Nation Health Manager professional designation.

For information on membership, our national conference, our certification program through intensive or online courses, our customizable selection of workshops, our coaching program, or any other services, please contact us at: **613-599-6070, info@fnhma.ca** or **www.fnhma.ca**



DEDICATION

This Guide for Health and Wellness Planning is dedicated to *each* of the hard working and committed First Nations health managers, for whom this Guide was developed. Through our work supporting you, we have seen your dedication, heard your stories of strengths and challenges, and felt your commitment to help your communities. It is clear that it is love and a desire for change that guides you in your life's work.

You may be just one person, but you are part of a network of change-makers, and you are making a difference.

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ACKNOWLEDGEMENTS

It's never easy to acknowledge everyone that has been involved in a publication of this size, so we will respectfully offer our deepest thanks to the key groups that have contributed to this work.

To the hundreds of First Nation health managers who shared their ideas and perspectives on health and wellness planning; your insights created the vision and led the development of this Guide from beginning to end.

To the different committees that worked on the initial information gathering; your efforts got this project moving and contributed immensely to the Guide.

To the Thunderbird Partnership Foundation which generously shared their materials and content; this Guide is more culturally rich because of your wisdom.

To the Assembly of First Nations and Health Canada Joint Forum on Administrative and Operative Tools which shared their experiences and expertise; your input and feedback made the Guide stronger and more grounded.

To the First Nations Health Managers Association Board, which leads our organization in a good way; your thoughtful and consistent guidance sets an example of humble leadership and effective governance.

To the partners at Indigenous Services Canada, specifically the First Nations and Inuit Health Branch, who provided financial and logistical support for the development of this Guide; thank you for being willing to "let go" and continually supporting us in leading this work. The federal and regional contacts were always keen to help and encouraged us every step of the way.

To everyone who sees themselves in any of the above groups, or who participated in other ways, please know that your contributions are part of a strong and growing wave of change. A wave of change led by First Nations health managers and partners. We humbly acknowledge and thank you all.

INTRODUCTION

The First Nations Health Managers Association (FNHMA) is excited to offer ***Developing Health and Wellness Plans: A Guide for First Nations,*** developed for the first time by a national First Nation health organization. This new direction signals a change in approach, one that honours and respects the experiences and inherent wisdom of First Nation health managers.

Your Health and Wellness Plan is your "Big Plan". Quite simply, it is your organization's/community's primary document that defines your health priorities, outlines how the programs and services will help achieve your goals, and identifies how you will measure the progress and success of your efforts.

The Guide has been developed based on values – *culture-based, community-based, strength-based, and quality-based.* In the Guide, we call them "**Dynamic Values**" because they represent action and empowerment. The Dynamic Values are not activities but are "ways of working" that honour each community's traditions and strengths while inclusively planning for quality health services. The Guide will provide examples of how the Dynamic Values are demonstrated during each stage to help you integrate them into your planning process.

Rather than using a conceptual framework, this Guide is based on the key **stages** that an organization goes through as it develops their plan for wellness. This user-friendly approach is based on wise practices and incorporates the voices of hundreds of First Nation health managers. The benefits of this approach are three-fold:

- first, by focusing on wellness as well as health, the approach is holistic and can be rooted in a community's traditions;
- second, the "stages" approach supports customized planning, where communities can use their strengths and assets and plan for those areas that need to be improved;
- third, it helps newer organizations follow a step-by-step process that is clearly laid out and leads to robust planning.

In addition, this Guide is grounded in quality improvement, both as a Dynamic Value, and also as a lens through which programs and services are developed and delivered. Several sections explain how specific program elements support six quality dimensions.

This Guide to developing your Health and Wellness Plan is meant to be just that… a guide. Not "must do" or "have to", but "here are some wise practices", mainly based on input from First Nation health managers from across the country. Yes, there are some elements that have to be submitted to the funder; however, the key purpose of this Guide is to be a resource as you plan for your medium- and longer-term health services.

Whether this is the first time you are developing a Health and Wellness Plan or the tenth time, whether you are a single small community or a large multi-community group, and regardless of the type of funding agreement you are in, there will be content in this Guide that can help you plan.

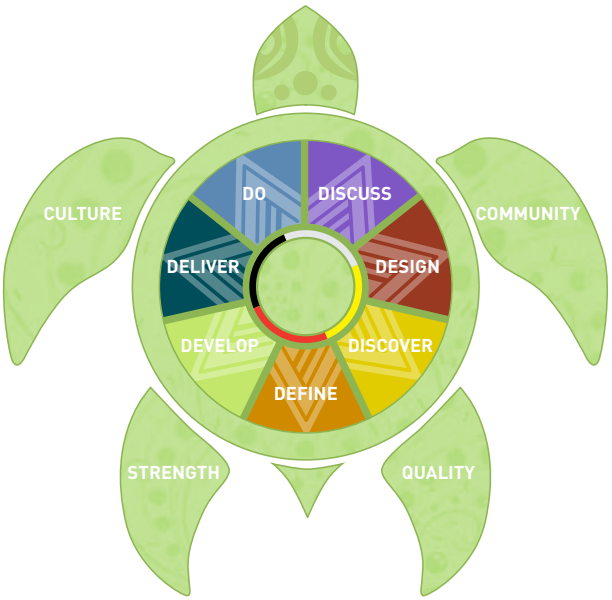
The FNHMA, as the only national organization that supports First Nation health managers, is proud to be involved in this exciting new direction in health and wellness planning. It has been a long time coming. As all the committed First Nation health managers continue their journey, helping their communities become stronger and healthier, we will be there every step of the way – providing resources, training, tools, and networks. Thank you for allowing us to work alongside you.

HOW TO USE THIS GUIDE

This Guide is intended to provide an easy-to-follow approach to health and wellness planning that supports a community-guided process. First and foremost, what sets this Guide apart is that it is grounded in Dynamic Values. These four values (Culture-based, Community-based, Strength-based, Quality-based) represent ways in which you work and will look different in every community. Each stage of the Guide includes some examples of how each of the Dynamic Values is being demonstrated. These examples have been shared by hundreds of First Nation health managers from across Canada. You will have your own ways of living the Dynamic Values.

The structure of this Guide incorporates seven action-focused stages – the Seven D's – that begin with establishing a planning group, and move through assets and needs assessments, establishing priorities, developing your Strategic Plan, and creating Annual Plans.

The purpose of using the Seven D's approach is to provide the structure that supports communities but doesn't prescribe exactly what to do or how to do it.



Briefly, the Seven D's cover the following:

1. **Discuss**... the process.
   This stage looks at the readiness elements of health planning, including preparing leadership, creating a planning group, and plenty of communication.

2. **Design**... the workplan.
   This stage helps you lay out your process to create your Health and Wellness Plan, essentially your plan to create a plan.

3. **Discover**... the current situation.
   This stage guides you through an assessment of your community – what your community ***has*** (i.e., assets) and what it ***needs*** related to health and wellness.

4. **Define**... the priorities.
   This stage builds on your Community Assessment and helps you identify priorities.

5. **Develop**... the draft.
   This stage is where you create your draft Health and Wellness Plan for the next five to ten years.

6. **Deliver**… the plan.
   This stage is where you take the completed draft Health and Wellness Plan and move it forward for review and approval, so it is ready for implementation.

7. **Do**… the work.
   This stage is where you create the Annual Plan that will bring your Strategic Plan to life!

The Seven D's offer a rigorous approach that is rooted in wise practices and can be adapted to your own organization and community.

You will notice that there are a few themes that are woven throughout the Guide.

- First, you are leading this process, and although this Guide offers suggested approaches, you can tailor the activities to work with your own situation.
- Second, this is an inclusive process. It is most effective when more people bring their voices and perspectives to the table.
- Third, communication is key. Share the plans – with many people, often, and in different ways. Make sure your community understands what the process is about, and why it is being undertaken.
- Fourth, the planning process is for ***your community***. In the past, the focus was mainly on responding to the needs of the funder. Now, strategic communities understand that planning, data-collection and analysis, and evaluation are all valuable tools that help ***them*** improve ***their*** programs and services for ***their*** members.

There are a few features throughout the Guide that are quick references to the following:

"***Communities in Action***" describe how a community has demonstrated success during this stage in their health and wellness planning.

"***Things to Consider***" during this stage of health and wellness planning.

We encourage you to read through the entire Guide before beginning your planning journey, so you can see all the stages as part of one entire process. And hopefully, you'll be excited and keen to get started!

Please note: If a difference in interpretation exists between wording used in this Guide and in a clause in a funding Agreement, the wording in the Agreement represents the legal requirement.

DYNAMIC VALUES

Effective health and wellness planning begins with recognizing the key values that guide your efforts. In this Guide, we are calling them "Dynamic Values" because they represent action and empowerment.

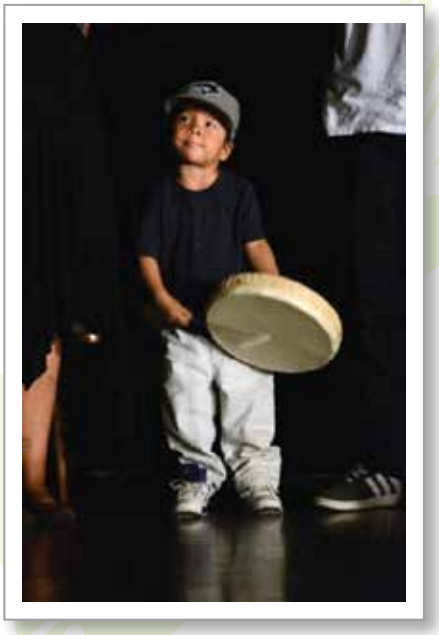
The Dynamic Values are not activities but are "ways of working" that inclusively respect your community traditions and integrate community strengths while planning for quality health services. The Dynamic Values are at the core of how your organization works.

This Guide will also provide examples of Dynamic Values during each of the seven stages to offer ideas to integrate activities at every step in your planning process. You may also have your own examples that best represent your community's values. Use what works best. ***This is your planning process.***

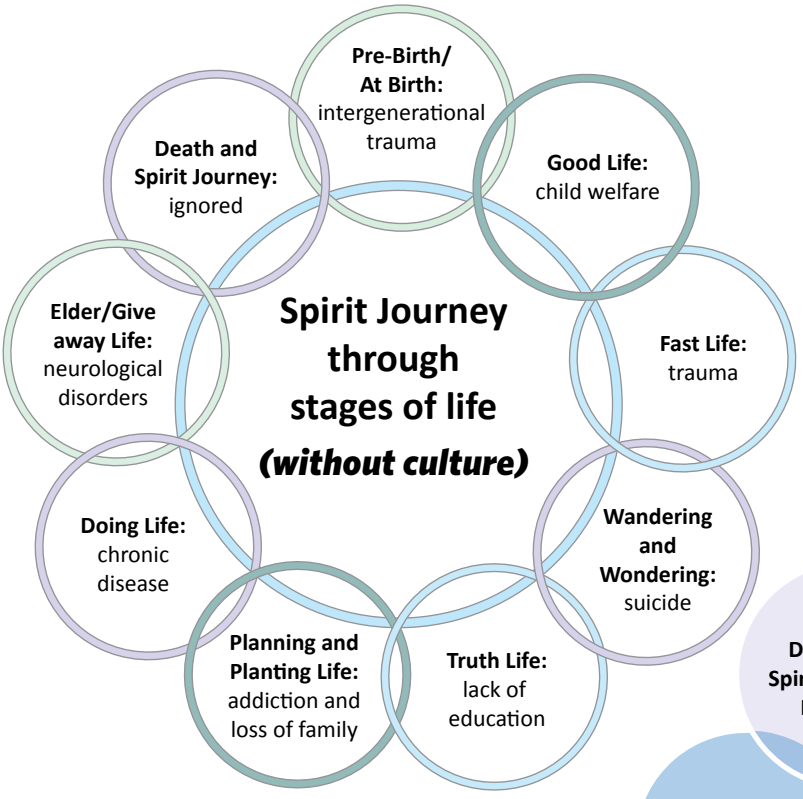
Culture-based

Culture can be the underlying foundation for your community health and wellness. This could represent values, knowledge, language, relationships, purpose, meaning, and practices and much more. Each community will represent culture in a way that is meaningful for them.

Every First Nation culture has specific practices that are necessary for supporting the journey of the spirit through life. Many of the cultural practices are similar; however, the diversity in cultural practices are necessarily defined from sacred societies, community knowledge, language, connection to Creation and land, and the teachings of the ancestors of the people.



Adapted from the Thunderbird Partnership Foundation *First Nations Mental Wellness Continuum Framework Implementation Guide* (2017), these diagrams share the developmental stages of life; without, and with culture.



As you develop your Health and Wellness Plan, consider the cultural practices that are valuable to your community for each stage of life. Identify where these practices still exist and determine how to support the revitalization of these practices within the community.

Consider these questions:
How does culture play a role in the health and wellness of our community?
How would we include culture in our health and wellness planning process?

Community-based (paced/led)

Health and wellness planning is most effective when guided by your community needs and priorities. That means that the planning process needs to include all who might be affected by health services. Because your community's wellness relies on more than health services, other services that contribute to supporting a healthy community would be included in the health and wellness planning process.

In addition, your community may have been engaged in health and wellness planning for many years and already has significant capacity and expertise. Or, this may be your first time developing a Health and Wellness Plan by and for your community. If this is the case, congratulations on taking this important step! Wherever your community is on the planning journey, your process will be respectful of the hard work and commitment that has brought you to this point.

The goal of this Guide is to help you, as health managers and leaders, lead the health and wellness planning process for, and with, your community. As such, these guidelines can be followed directly or tailored to accommodate your specific community's needs.

Consider these questions:

How would we include different community groups and the spectrum of services in our health and wellness planning process?

How can we ensure we move at a good pace that is respectful of our community?

What adaptations do we need to ensure a community-led process?

Strength-based

Each community brings a range of strengths to the "planning table". Some examples of community strengths are community members with skills and knowledge, a community history of resilience, effective leadership and good governance, along with many others.

A strength-based healthcare approach puts First Nation people and their communities at the centre to take charge of their health and healthcare decisions. It promotes a change in the relationship between First Nation families, communities and the healthcare team: all are partners working together to improve health and wellness for the community.

A strength-based healthcare model enhances service delivery by investing resources in the coordination of services, it infuses opportunity, hope and solutions rather than problems and hopelessness. Putting action into a strength-based approach requires a shift in focus from the current "problem-based model" (where the most important outcomes are client satisfaction and rates of mortality and morbidity) to strength-based outcomes that are concerned with resilience of human spirit, the whole person, healing, wellness, community health and quality of life.

Integrating a strength-based mindset when planning programs and services is moving from a focus on deficits to a discovery of strengths. The Thunderbird Partnership Foundation describes this process for mental wellness; below is a slightly modified version.

Focus on deficits	Discovery of strengths
Evidence that excludes Indigenous worldview, values, culture	Indigenous worldview, values, and culture that are the foundation to determine the relevance and acceptability of various sources of evidence for a community
Focus on inputs for individuals	Focus on outcomes for individuals, families, and communities; holistic collaborative approaches
Uncoordinated, fragmented programs and services	Comprehensive planning and integrated federal/provincial/territorial/sub-regional/First Nation models for funding and service delivery
Communities working within program silo restrictions	Communities adapt, optimize, and realign their programs and services based on their priorities
Program focus on health and illness	Approaches that strengthen multi-sectoral links, connecting health programs and social services, across provincial/territorial and federal systems to support integrated case management, integrating the First Nations social determinants of health

Adapted from the ***First Nations Mental Wellness Continuum Framework Implementation Guide***:

> Strength-based or asset-based approaches recognize and build on existing strengths and assets in an individual, group or community. This respects individual, group and community resilience. A strength-based approach sees potential, rather than need, and encourages a positive relationship based on hope for the future. Cultural continuity is a foundation of strengths. While culture may not be often recognizable within First Nation communities it is critical to recognize that culture is a way of life rather than a host of practices or way of doing things. Inherent in a culture-based strengths approach is the recognition of the natural ways First Nation communities continue to thrive as distinct people, despite the challenges they face. This is based on a fundamental belief across Indigenous cultures that the Creator or Great Spirit gave Indigenous people their identities and despite forces of colonization and assimilation, the inherent gift of identity remains.

A core Indigenous value is the belief in strengths over weaknesses and assets over deficits. This comes from Indigenous creation stories that teach about the "inherent" gifts given to Indigenous peoples by the Creator, commonly known as "kindness, caring, honesty, and strength". In a practical sense then, a strength-based approach facilitates shared learning and support between community services and across the social determinants of health sectors. Most essential to a strength-based approach is the belief that when engaged to do so, people are resourceful and can solve their own problems. The promotion of collaborative relationships with the client is also essential. Strength-based approaches typically facilitate a manner of doing things that starts from the belief that:

1. People (clients, communities, partners) have existing competencies;
2. First Nations have important cultural resources and with the right support can translate Indigenous knowledge for application within community services;
3. Clients are capable of learning new skills and knowledge to address their concerns;
4. Clients can be involved in the process of discovery and learning;
5. Clients are resilient, even at their weakest moments.

First Nation community health and wellness planning should convey principles and standards through an Indigenous lens while ensuring cultural protocols and integrity have the same importance as "evidence based" standards of practice. For example, a standard of practice might relate to rights, responsibilities and client safety. Through a western or mainstream lens on service delivery, "rights" may be defined by a license or other credentials that verify knowledge, skill and scope of practice. Through an Indigenous lens, "rights" of practice may be sanctioned by Elders, or Indigenous Knowledge Holders, sacred societies, or a First Nation government who also have formal systems of accountability and supervision on scope of practice.

Elders, kinship relationships, clan families, cultural societies, and community are the primary facilitators of strengths, inherent strengths and strength-based approaches to facilitate outcomes of Hope, Belonging, Meaning and Purpose.

Within your community, what are the strengths that help your health and wellness planning process?

Quality-based

Quality improvement consists of systematic and continuous actions that lead to measurable improvements in health services and improved health outcomes for clients. Collectively, they represent a purposeful approach to do things better, which results in progress and improvement.

Every community wants their health services to be of high quality; in other words, to ensure a "client-centred" experience that offers safe, culturally competent, timely, effective and efficient health care.

When exploring what those terms mean, it can be helpful to unpack the concepts, and define what each of those look like for your community. For example, "client-centred", have your clients been given the opportunity to describe what that means to them? Do all members of your team have a similar understanding of what "client-centred" represents in the context of their program or service?

How is "safe care" defined and determined in your organization?

How will you know if you don't ask? If you haven't already done so, check in with your clients, the community, and your staff to help your organization clarify what quality means to them.

Consider these questions:

What does quality care represent to your clients, your community, and your staff?

How can you ensure quality is embedded into all aspects of your health services?

DISCUSS …THE PROCESS

The "**Discuss**" stage looks at the readiness elements of health and wellness planning – those elements that need to be in place to help your process move forward in a good way. As the first stage, it incorporates recognizing the will of the community to begin a planning process, preparing leadership, and creating a Health and Wellness Planning Group. As the name suggests, "Discuss" includes communicating to ensure leadership and community are informed and ready to be involved. Follow the steps below to ensure that you've got the fundamentals in place.

It's important to clarify the terms for the various governing and management groups in this Guide. It is less important what each group is called, and more important to understand the role that each plays.

Leadership Group – this is the group to whom the health organization reports. In a small community, it could be directly to Chief and Council, or it could be a Health Committee or a Health Board. It refers to the group that is *accountable in a governance sense*. In the ISC-FNIHB requirements, this group is likely part of your "Management Structure". In this Guide, "Leadership Group" will refer to the ultimate decision-makers that your organization must report to or seek approval from.

Management Team – this refers to the Health Director (and Assistant Health Director, if the organization has one), and senior program managers. This group ensures the day-to-day smooth running of the organization.

Health and Wellness Planning Group – this refers to a group that is set up specifically for the development of the Health and Wellness Plan. It may be your Leadership Group, with some additional representation or expertise, or it may be a separate working group formed to develop your Health and Wellness Plan. Again, if your community is using your Leadership Group or your Management Team as the group to develop your Health and Wellness Plan, then refer to that when "Health and Wellness Planning Group" is noted.

Management Structure – this term is used in many of the ISC-FNIHB planning and funding documents and refers to the combination of both the governing structure (Health Board, Health Committee) and the Management Team. For several of the health and wellness planning elements in this Guide, the governing and managing roles are separated out.

Although the terms may be different, what is important is that all the roles are covered. Your organization needs a strong **governance** structure, an effective **management** structure, and a robust **planning** structure. They may be one, two or three separate groups. Adapt the terms to your own community situation.

ENGAGE WITH LEADERSHIP

Do this right up front. This is an important step for many reasons. Health and wellness planning is often part of a larger community effort and might be an intrinsic part of your Comprehensive Community Plan.

As such, it's essential that your leadership is aware of the good work that you're doing in helping to achieve the overall community goals. Do you need to have a Band Council Resolution (BCR)? What is your community protocol or practice?

By ensuring your leadership is aware of, supports, and is involved in your health and wellness planning process, you will help to create champions in your Leadership Group. And every planning process needs as many champions as it can get!

Consider the process that your community follows to inform and involve leadership. What would help you to get them on board? Do you need to prepare a briefing note? Do you have to present to the committee? What types of materials would you need to prepare in advance? Generally, a Leadership Group doesn't need all the specific details; they are often more focused on the big picture. Outline the benefits of an inclusive health and wellness planning process and show how it is important in achieving better community health. Whatever your Leadership Group needs, be prepared to follow due process.

- If you're unsure about the governance of the Health and Wellness Planning Group, ask your Leadership Group to clarify the role of the group and to whom they would report.
- Are there any other factors you need to consider or be aware of as you engage in health and wellness planning (e.g., timelines related to community planning, band elections, community audits, etc.)
- Ask them how often and in which format they would like to be kept informed as you move through the planning process. This can then be included as a component in your Communication and Engagement Plan.

To Consider…

Leadership support is considered the key success factor when planning and implementing any change processes.

DISCUSS
THE PROCESS

ESTABLISH A HEALTH AND WELLNESS PLANNING GROUP

The health and wellness planning process and the ongoing management of health programs and services are two related but different tasks. Your community may decide to have two separate bodies, such as a planning committee for your Health and Wellness Plan and a separate health management committee, or to have one body that does both. Having a single body may enhance the link between planning and implementation and facilitate ongoing review and adjustment of the Health and Wellness Plan as health services are delivered. Often smaller communities have the same person or group of people to both plan and manage the delivery of health programs and services.

If you set up a separate Health and Wellness Planning Group to help guide the development of your Health and Wellness Plan, it's important that you include several people that represent different sectors and areas of expertise within your community (e.g., nursing, education, employment, justice, housing, community member, etc.). This will help ensure strong guidance and a broad range of voices and will make your planning process richer.

If you have one committee, then consider adding a working group or a special task group for the health and wellness planning process, to bring the different voices and perspectives to the planning process. Your Health and Wellness Plan will be much richer because of this inclusive approach.

There are some simple and straightforward steps in establishing an effective Health and Wellness Planning Group.

1. Identify to whom this group reports, whether it's the Health Director or the Leadership Group or someone else. If you're not sure, ask your Leadership Group when you initially meet with them to get their support.

2. Create a draft Terms of Reference that outlines the following:
    a. The purpose or mandate of the Health and Wellness Planning Group – do they guide the health and wellness planning process, do they make recommendations, or do they make decisions? What is the objective or goal of the group? What are the expected outputs? This might seem overly simplistic, but it is surprising how often it isn't clearly stated or understood.

    b. Based on the mandate of the group, how many and what types of members would the group be seeking? For example, would the group include representatives of the following – Elders, youth, parents, health centre, education, social services, justice, etc.? You need a Health and Wellness Planning Group that has enough members to represent the different community perspectives, yet not so large that it is unable to make decisions.

How would the members of the Health and Wellness Planning Group be chosen? Through an invitation? Through a nomination process? Through a call for participation? It's also important to clarify the expectations of each member, such as who they represent and how they report back to them.

Your Health and Wellness Planning Group is a key element that will determine the success of your planning process. It's important that you have good representation of all segments of your community. Your community might have a protocol or process already in place that you can use.

To Consider…

Rather than a large Health and Wellness Planning Group, include more people through engagement activities such as focus groups and surveys, to ensure many perspectives are included.

c. Roles and responsibilities of the members of the Health and Wellness Planning Group:
    i. Who is the chair, or will you have co-chairs representing different segments of your community? Consider who has expertise in leading and motivating a group of people through a process that will take several months.
    ii. Who will be the secretariat? You will need someone who is organized and can keep the process on track.
    iii. Where will they meet?

d. Timelines for the Health and Wellness Planning Group:
    i. How long the group is anticipated to be functioning (plan for six to twelve months).
    ii. How often the group will meet.
    iii. When are the deadlines for reporting or specific deliverables such as the initial plan, the communications plan, etc.

e. Any specific or relevant protocols relating to:
    i. Conflict of interest;
    ii. Confidentiality;
    iii. How disagreements will be handled;
    iv. Expectations on coming prepared to meetings;
    v. Relationships with other committees;
    vi. Resource and budget considerations.

DISCUSS
THE PROCESS

LINK WITH YOUR COMPREHENSIVE COMMUNITY PLAN

Some communities will have done or be in the process of creating a Comprehensive Community Plan (CCP). From the CCP Handbook – ***Comprehensive Community Planning for First Nations in British Columbia***:

> "Comprehensive community planning is a holistic process undertaken with broad community participation. A comprehensive approach:
>
> - enables the community to establish a vision for its future and implement projects to achieve this vision
> - helps to ensure that community projects and programs are thought through, make sense and are the best use of resources
> - integrates and links all other plans the community has produced
>
> Processes that are driven by the community, for the community are most effective at achieving positive change. That's why the comprehensive community planning process is inclusive and represents the perspectives of all members, whether they reside within or outside the community. All members of the community, including Elders, youth, and family representatives, can offer unique and valuable perspectives on community needs, values and priorities.
>
> A comprehensive community plan addresses key planning areas, all of which are interrelated and interdependent: governance, land and resources, health, infrastructure development, culture, social issues, and the economy. Consideration of all key planning areas through one unified process defines community planning as a holistic and integrated exercise that can lead to sustainable development."

What does that mean for your health and wellness planning?

It means that your health and wellness planning will align with any overarching community plan. For example, if your Comprehensive Community Plan has a strategic goal relating to Elders, you can consider how you can include Elder wellness in your health and wellness planning discussions. When you are identifying the criteria for prioritizing your needs, an issue that is already listed in the Comprehensive Community Plan could have greater weight than one that isn't.

Another way of coordinating your health and wellness planning process with your Comprehensive Community Plan is to look at process factors such as timing of focus groups and surveys. This would help leverage more feedback through using a merged process. There might be a duplication of the people involved in both processes which could cause survey fatigue, which is another reason to combine some of the activities. Financially, it would cost less to blend both processes where relevant, as you could see economies of scale.

DETERMINANTS OF HEALTH

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment, and individual behaviour. These factors are referred to as determinants of health. They do not exist in isolation from each other; rather, their combined influence determines health status. The Assembly of First Nations recognizes the following First Nation-specific determinants of health that have an impact on wellness:

- community readiness;
- economic development;
- employment;
- environmental stewardship;
- gender;
- healthy child development;
- historical conditions and colonialism;
- housing;
- land and resources;
- language;
- heritage and strong cultural identity;
- legal and political equity;
- lifelong learning;
- on- and off-reserve;
- racism and discrimination;
- self-determination and non-dominance;
- social services and supports;
- urban and rural.

It makes sense to maximize the range of your community services, and your health and wellness planning process will be richer because of your efforts to be inclusive.

The health of a community depends on more than health services. As such, it's important when developing your Health and Wellness Plan, to ensure that the process and the content are aligned with the Comprehensive Community Plan if your community has one. If your community doesn't have a Comprehensive Community Plan, you can still use a determinants of health approach by including different sectors of your community in your planning process, to ensure a broader perspective.

Communities in Action

"We take a holistic approach to health that considers both determinants and outcomes of health. We do not focus solely on treatment; we include the whole continuum of health, from health promotion and prevention, to treatment and rehabilitation, to aftercare and ongoing health support. Our approach is different from standard health needs assessments because it was initiated and driven by the community and the central importance of community voices."

DISCUSS
THE PROCESS

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Include diversity in Health and Wellness Planning Groups
- Integrate with other groups
- Include youth, Elders, leaders, etc.
- Support cultural activities as part of your health and wellness planning framework
- Involve Elders and youth on the Health Board
- Include traditional food at meetings

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Find the leaders amongst youth, Elders, elected leaders, ISC-FNIHB representatives, etc.
- Link with Comprehensive Community Plans to show how both work within the same priorities

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Recognize the beliefs of the community (traditional, religious, etc.)
- Have community representation on the health committee
- Include participants from different sectors and ages on the Health Board
- Include an interagency focus on the Health Board
- Get leadership support
- Get a BCR
- Include key people in the community

QUALITY-BASED

Some examples that demonstrate **quality** as a guiding value:

- Have a strong Health Committee
- Ensure clear Terms of Reference for committees
- Maintain clarity in the chain of command

TRAINING THAT MAY BE HELPFUL

Some examples of training that could help in the "**Discuss**" stage:

- Leadership training (Chief, Council, etc.)
- Holding effective meetings
- Ensuring effective governance
- Effective communication
- Using a determinants of health approach

DESIGN
THE WORK PLAN

DESIGN …THE WORKPLAN

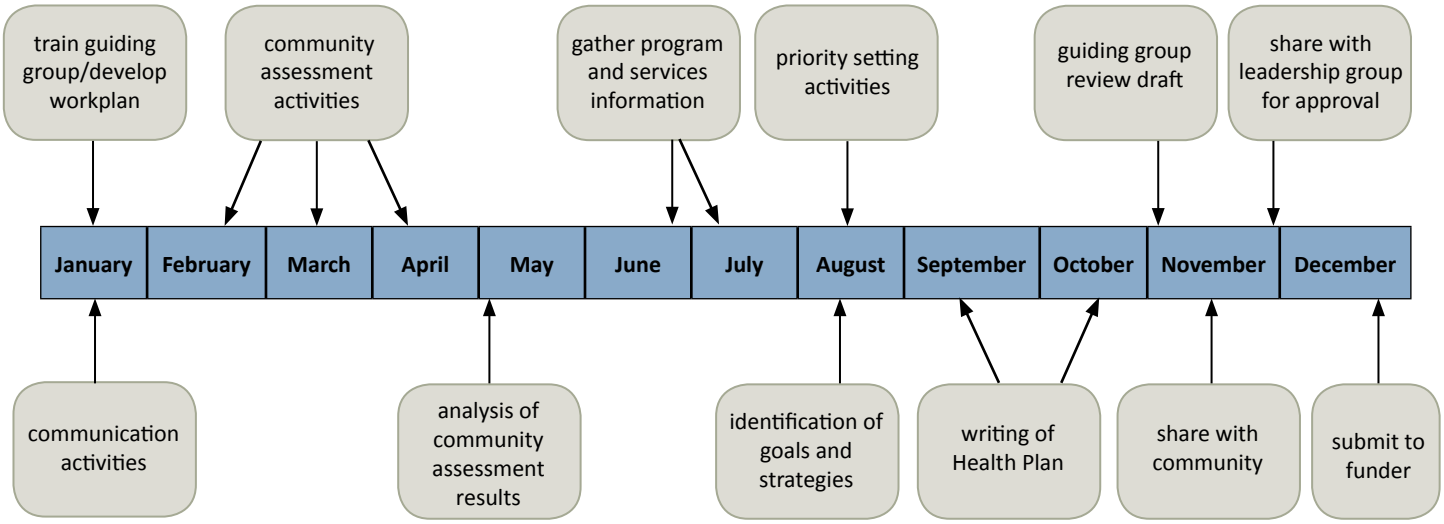
The "**Design**" stage helps you lay out your ***process*** to create your Health and Wellness Plan. It is not actually creating the Health and Wellness Plan but is the "plan to create the Plan". It's important to have steps to follow that you set out in advance, and that will guide you through the development of your Health and Wellness Plan. Make sure you allocate enough time to ensure you form a good foundation for the next steps.

CREATE THE WORKPLAN

When designing your "plan for the Plan", you need a critical path. To do this, it can be helpful to start at the end and work backwards, sometimes called "reverse calendaring". As an example, let's say you require your approved Health and Wellness Plan to be submitted to the funder at the end of December, in one year. That is where you start, and you work backward from there. Below is an example of reverse calendaring in the design of your workplan.

- Complete Health and Wellness Plan and submit for approval to funder (end December);
- Review and approval of Health and Wellness Plan by Leadership Group (end November);
- Share the draft Health and Wellness Plan with your community for feedback (if this is one of your community protocols, then you have to do that 2 weeks earlier (mid-November);
- Conduct final review of the Health and Wellness Plan draft by the Planning Group (early November);
- Finalize the draft Health and Wellness Plan with all content (early November);
- Write the Health and Wellness Plan (the writer will require 2 months to integrate all content, so will have to start writing early fall September-October);
- Identify goals and strategies based on priorities (mid-August);
- Review of community assessment data and priority-setting activity with Health and Wellness Planning Group (early August);
- Gather input from the programs and services (requires 2 months, June-July);
- Analyze and collate the community assessment data (requires 1 month, beginning May);
- Conduct community assessment activities including asset-mapping, needs assessment, surveys, focus groups, interviews, data review, reports review etc. (requires 3 months, February – April);
- Implement communication activities (mid-January);
- Train and prepare the Health and Wellness Planning Group, develop workplan (early January).

Your high level reverse calendar, (in this instance, one that takes place over one year), might look like this if done in a timeline format, with the finished Health and Wellness Plan submitted to the funder in December. (Your timeline may take more or less time; adapt to your specific needs.)



Look at your timeline or critical path and ensure that you've included all the important steps that you need to complete your Health and Wellness Plan. Your community might have special protocols or cultural practices related to some specific activities, such as surveys. Be sure you're aware of these in your planning.

By creating a timeline or critical path with the key activities listed, you can see and plan for how much time each activity takes to complete. Each of the key activities can be expanded to include sub-activities. For example, the "community assessment activities" step includes many sub-activities such as hosting focus groups, conducting a community survey, etc. Through the timeline, you see that all the "community assessment activities" have to be completed within three months (February – April in this example), to ensure there is enough time to collate and analyze the results. This gives an important timeframe in which to plan and conduct all the sub-activities.

The next step is to create a workplan that includes the sub-activities. This step may be done by the Health and Wellness Planning Group or by the Management Team, or whoever is leading the "on the ground" process of developing the Health and Wellness Plan. This step involves going through each of the key activities on the critical path and breaking it out into the sub-activities. You could create a mini workplan for each of the key activities, and then combine those into one comprehensive workplan.

The sections of a mini workplan should include the following:

- Activity – what is being done (for example, conduct two focus groups with Elders);
- Timeline – when it needs to be done - both beginning and ending - and be realistic on how much time it will take (for example, Elders' focus groups planned for March 5 and 6);
- Identify who needs to be involved in this activity (for example, all Elders in the community, Elders' helpers, facilitator) and explain how they are involved (for example, Elders attend focus groups, facilitator develops the outline and guides the focus group);

- Identify the one person who is responsible for ensuring the activity is done (for example, the Assistant Health Director);
- Specify the resources that will be required (for example, transportation for Elders, lunch, etc.).

An example of one section of a mini workplan for two activities under "Community Assessment Activities" could look like this example template:

Community Assessment Activities						
Activity	**Timeline**	**Who is involved?** **How are they involved?** **How often are they involved?**	**Expected outcomes**	**Who is responsible?**	**Resources required**	**Partners (if relevant)**
Host focus groups for Elders	March 5 March 6	Elders – attend focus groups Helpers – for those Elders that require help Transportation drivers – pick up and drop off Elders Facilitator – develop focus group questions, guide the day, create report	Elders' input on assets and needs is included	Assistant Health Director	$ for lunch Transportation drivers Facilitator	
Conduct community survey	February 1 – 28	Community members – fill out survey Health staff – hand out surveys Health Director or consultant – develop survey questionnaire	Community voices are heard Assets and needs are identified	Assistant Health Director	$ for prizes for participating	Band Office to distribute surveys IT to post surveys online

CREATE THE COMMUNICATION AND ENGAGEMENT PLAN

You know the importance of involving or engaging with your community members in planning your programs and services. In order to engage effectively, you need to have both good communication and opportunities for people to provide their input. The purpose of engaging with various groups is to hear a wide range of perspectives and experiences about their healthcare priorities and needs.

Communication can make the difference between a process that goes smoothly, and one that is rough and full of challenges. Consider that people need to receive information several times and often in a variety of ways to process it. For example, if you need to inform the community about a health and wellness questionnaire that is being distributed, you can do a radio spot, send out flyers, post a notice in the band office and health centre, and create a link on your organization's Facebook page and website. In this way, you are ensuring more people hear about it, and the importance of participating is being reinforced.

To Consider…

Communication is "information out". Engagement allows for "information back".

Social media (if done in a good way) is an excellent tool for two-way communication.

A key element of planning for effective engagement is to ensure you are clear about the reason for having people involved. Are you wanting to simply share information? Do you want to hear their opinions and perspectives? Will they have a role in decision-making? Understand how you will deal with contradictory opinions. Although it is more difficult to engage with community members (due to hearing and managing differing perspectives), if negotiated well, it leads to a much more effective planning process. Be transparent about the governance structure and the decision-making process.

Once you have your workplan created, you can add the communications and engagement elements, through your communications and engagement plan. This can be thought of as a mini-plan, which builds on your workplan and includes the types of communication and engagement you'll need to be successful in each activity of creating your Health and Wellness Plan. These will guide how you will share information (communication) and how you will get input and feedback from different groups (engagement).

The communication elements of your plan don't have to be long or detailed. They would clarify:

- The reason you are communicating (e.g., to inform the community about the survey, to encourage participation in the focus group);
- The message(s) that you are communicating (e.g., "We are creating a new Health and Wellness Plan – We need your voices");
- The people with whom you are communicating (e.g., parents, leadership, all community)

- The methods you will use to communicate (e.g., radio spots, posters in health centre, Facebook);
- The timing for different types of communications (e.g., briefing note to Chief and Council every month, flyers sent out three weeks before community meeting, Facebook reminder two days before community meeting).

Similarly, the engagement elements of your plan don't have to be complicated. They would include:

- The reasons you are engaging (e.g., gathering perspectives, getting input or feedback, making decisions);
- The topics or content with which you are working (e.g., identifying assets, identifying needs)
- The people with whom you are engaging (e.g., Chief and Council, Elders, youth, parents with young children);
- The ways you are engaging for each group (e.g., questionnaires, focus groups, interviews, community meetings, Facebook);
- How you will follow up (e.g., How will you thank participants? How will you post the results of the processes?).

Even the process of creating a Communication and Engagement Plan is helpful as it forces your Health and Wellness Planning Group to think broadly about good ways of sharing and gathering information.

If you like, you can add these elements to your workplan as a separate column, to align many of the communications and engagement activities with the workplan.

Communities in Action

"Having several types of communication and engaging with different groups in our community resulted in greater buy-in. We used this at several stages of the planning process."

Your workplan might look like this, with the addition of the communications and engagement activities:

Community Assessment Activities							
Activity	**Timeline**	**Who is involved?** **How are they involved?**	**Expected outcomes**	**Who is responsible?**	**Resources required**	**Partners (if relevant)**	**Communication/ Engagement activities**
Host focus groups for Elders	March 5 March 6	Elders – attend focus groups Escorts – help Elders Transportation drivers – for Elders Facilitator – develop focus group questions, guide the day, create report	Elders' input on assets and needs is included	Assistant Health Director	$ for lunch Transportation drivers Facilitator		Send invitations to Elders (1 month in advance) Send Facebook reminder (1 week in advance) Call to remind (2 days in advance)
Conduct community survey	February 1 – 28	Community members – fill out survey Health staff – hand out surveys Health Director or consultant – develop survey questionnaire	Community voices are heard Assets and needs are identified	Assistant Health Director	$ for prizes for participating		Post on Facebook page (3 weeks in advance) Post flyers (2 weeks in advance) Share info on community radio (2 days in advance and throughout survey period) Send Facebook reminders (every 3 days throughout survey period)

DESIGN
THE WORK PLAN

Remember that not everyone needs to be involved in the same way. Some people or groups just need to be kept informed, others need to be active participants. Your Communications and Engagement Plan will guide a lot of this; however, it is a good exercise when planning, to ask who needs to be involved at each stage of the process and how they will be involved.

Taking the time to create a workplan and a critical path helps ensure your key activities will be completed on time. Adding a communications and engagement plan means that you will have better community awareness, increased participation and a more inclusive process.

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Encourage diversity
- Include knowledge-keepers
- Hire cultural advisors/practitioners/Elders

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Honour past work
- Use community experience – don't reinvent the wheel

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Recognize the uniqueness of the community
- Commit to community engagement by the Health and Wellness Committee
- Get leadership endorsement
- Ensure a clear communication and engagement plan

QUALITY-BASED

Some examples that demonstrate **quality** as a guiding value:

- Have clear Terms of Reference
- Ensure strong policies and procedures
- Use a template for work planning

TRAINING THAT MAY BE HELPFUL

Some examples of training that could help in the "**Design**" stage:

- Project management
- Communication planning
- Writing briefing notes
- Creating workplans

DISCOVER
THE CURRENT SITUATION

DISCOVER …THE CURRENT SITUATION

The "**Discover**" stage is where you seek to understand the assets and needs of your community. In other words, in order to create and implement responsive, relevant and proactive health programs, you need to know what your community ***has*** (i.e., assets – people, knowledge, practices, competencies, experience, funding, infrastructure, traditions, etc.) and what it ***needs*** related to health and wellness.

The Community Assessment is one of the first activities you will do as you develop your Health and Wellness Plan. It provides valuable data that will help you establish priorities, which leads to your Strategic Goals and then guides the development of programs and services. As your Health and Wellness Plan guides your organization for several years, it's important that it is based on sound and relevant information. The Community Assessment provides this solid initial foundation for planning.

This section will guide you through conducting a Community Assessment.

CONDUCT A COMMUNITY ASSESSMENT

A Community Assessment is a process where you engage with your community and stakeholders to recognize and validate the assets of the community and identify the health and wellness needs of different groups such as children and parents, Elders, etc. It is a valuable and necessary activity in order to effectively identify your priorities.

Through this process you will be able to:

- get an overview of your community assets;
- clarify the most pressing health and wellness needs;
- understand how you can use your community assets in the best way to help address health and wellness needs;
- establish health and wellness priorities based on a structured process;
- engage the community so they are more involved in health and wellness planning.

Communities in Action

"Our approach to a community assessment emphasized capacity building, inclusion and empowerment as a path to healing. This process was initiated and driven by the community, including guidance and oversight by local leadership and a team of local planners."

If community members are fully engaged in your Community Assessment, you will have better participation in your health and wellness programs because you've involved the people who will be using the services. ***Community members are more likely to use and benefit from programs and services if they've been involved in the planning***.

A community asset is anything that improves the quality of community life. Assets can be concrete, such as facilities, the natural environment, community members who are involved in community issues, workers and other "experts," or they can be experiences and values that community members have, such as a solid track record in project management, a strong sense of "community," and initiatives to preserve cultural traditions.

This Guide uses a strength-based approach that recognizes and honours community assets. By using this approach, you will invest time in identifying those elements that sustain and enhance your community. These assets may be rooted in your cultural values and in how your community strives to live these values. ***Culture is a foundation and can inform your Community Assessment in a way that works best for your community.***

Conducting a Community Assessment and establishing priorities should be done regularly (at least once every five years) so you are able to stay on top of your community trends and adjust your programs and services to respond to community needs.

To Consider…

It's important to ensure you've included everyone that should participate and provided an opportunity for each group to engage in a way that works for them. For example, getting input from busy parents of young children might be most effective if done through a 5-minute discussion or survey at the daycare. Obtaining perspectives from Elders might be done through a dinner and focus group session.

Governance

As discussed earlier in this document, by now you will have set up a Health and Wellness Planning Group to help guide the process. They will need to be fully informed about the Community Assessment, as this is where the community is very engaged. For the Community Assessment, it should be clear to the Health and Wellness Planning Group:

- what types of activities will be conducted and why;
- who will be involved and why;
- what types of information will be gathered and why;
- what the next steps will be.

Your workplan will provide many of the key steps, and for more detail, each of the above will be explored in the step-by-step section below.

The Community Assessment depends on input and feedback from different groups who bring varied

perspectives and opinions. As part of the process, you need to clarify who you need to include and what their role will be. Some examples could be:

Participant	Potential Role
Community Leadership	Advise on the process Provide approvals Link to broader community planning
Community members (Elders, parents, adults, youth)	Provide perceptions Share lived experiences
Health Centre staff	Share experiences Offer perceptions Provide data
Other partners (e.g., Tribal Council, neighbouring communities, provincial services, ISC-FNIHB, etc.)	Clarify shared assets Explain shared services/Partnerships

The Community Assessment process will include a variety of activities to gather information on both assets and needs. You could use some or all of the following, or you may use other activities:

- Community questionnaires or surveys (paper and online);
- Face-to-face or telephone interviews;
- Focus groups;
- Community meetings;
- Community program reports (e.g., e-SDRT, CBRT, etc.);
- Program evaluation reports;
- Previous Community Assessments;
- Document reviews (e.g., facilities data, environmental public health reports, etc.);
- Community health and wellness data (e.g., charts review, Regional Health Surveys, etc.);
- Provincial and other external data sources.

Communities in Action

"Our process draws from a traditional philosophy that values the creative energy of the Creator, has Elders to guide the process, respects the past and land, and keeps a focus on the peoples' strength and unity."

Conducting a Community Assessment – Step-by-Step

1. Prepare.
   a. Review your previous Health Plan.
      i. Identify the community's previous priorities.
      ii. If you weren't involved in the development of your previous plan, try to find out how it went. Were enough people and were the relevant people involved? Were there gaps in the collection of peoples' perceptions? It's helpful to know so you can ensure a stronger and more inclusive process this time.

2. Collect your data.
   Depending on your engagement plan, this would include several different opportunities to identify both community assets and community needs. You might organize different activities for different purposes (i.e., some activities are more effective at discovering assets such as asset mapping) or you might combine the purposes as single activities for different groups (focus group for youth that discusses assets and needs from their perspectives). There may also be external sources of data that are available to use in planning, for example, provincial health data.

Communities in Action

"The quantitative and qualitative data available from existing sources gave us a baseline of information about community health status, including strengths and challenges. As we developed this baseline, our process was to ask community members and staff how well these data reflected their experiences as the process evolved."

Regardless of which data collection methods you use, the quality of information you receive will depend on what you ask and how you ask it. Ensure your data collection tools (e.g., surveys, interview scripts, etc.) and approaches (e.g., focus groups, interview protocols, etc.) are well-thought out, consistent, easy-to-understand, and will produce the information that you require.

Ensure that you have solid guidelines in place that ensure the confidentiality of information where relevant, and that all participants understand what will happen to the data.

DISCOVER
THE CURRENT SITUATION

Your activities could include the following:

To Consider…

Create guidelines to ensure confidentiality of information. You must be able to assure people that the information that they provide is going to be handled respectfully and that individual names or situations will not be used or reported. Respecting individual privacy is an important aspect of your community assessment.

a. **Focus groups** are a good way to gather the perspectives of small groups of people (six to twelve people works best). For example, you could hold a pizza party and focus group with youth to gather their insights on what has worked best for them and how this could help them address their needs. Focus groups are best if led by a facilitator to ensure the group stays on topic and you collect the information that you need. You also need a good recorder to capture the feedback. Activities in your focus groups could include the following:

i. Asset mapping to confirm and validate the community assets. Community assets include skills, knowledge, talents, experience, traditions, community groups, businesses, organizations, social services, structures, natural resources, etc.
ii. Strengths, Challenges, Opportunities and Threats (SCOT) activity which will help to guide the identification of priorities.
iii. Appreciative Inquiry is an activity that honours the positive elements of your organization and seeks to uncover what is working well, why it works, and identify how those successes can be transferred to other areas.
iv. Small group discussions guided by specific questions. Be sure you include a process, so the participants can rank their feedback; for example, the "most important" to the "least important". You need to have some weighting of the needs, as this ranking of feedback will be valuable when it's time to prioritize the activities.

b. **Community questionnaires** or surveys can be used to gather information from a broad base of people.
   i. Questionnaires should be manageable in length (10-20 questions) and easy to understand.
   ii. The questions should be clear and provide usable data. If you use multiple choice questions or rating scales, you will get data that is more easily organized for analysis. Asking for written comments gives more rich data however it is more time-consuming and complicated to analyze.
   iii. Offer questionnaires in hardcopy and online with reasonable timelines.
   iv. Provide incentives to participate.
   v. Ensure you survey enough people to get data that will be representative of your community.

c. **Face-to-face (such as home visits) or telephone interviews**, sometimes called "key informant interviews" are effective at gathering deeper insights from one person.
    i. Have a "script" or set of questions that will be used for all interviews.
    ii. Train interviewers in how to conduct effective and confidential interviews.
    iii. Key informant interviews are generally the most labour-intensive way to collect data. As such, it is suggested that you choose carefully who you want to interview. It may be key staff members, community leadership, partners, etc.

d. **Community forums** or meetings can gather small amounts of information from large groups of people. It is important to manage these very well, so they don't go off topic.
    i. Ensure you have a facilitator who is experienced in guiding these types of meetings.
    ii. Have 2-3 questions that you'd like to discuss. Don't overburden the group with too many questions.
    iii. Provide different options to gather their perspectives. For example, small group work, world café, etc.
    iv. Ensure that the feedback is recorded and collected.

e. Examine **program reports and evaluations**. These can be excellent sources of information which offer in-depth and evidence-based conclusions. Pull out the key priorities and recommendations.

f. Collect **data** from different sources to provide the quantitative base for your discussions. You will need to ensure that the data is non-identifiable to ensure confidentiality. Some examples of data sources are:
    i. Client charts
    ii. NIHB data (e.g., Prescription Drug Use)
    iii. CBRT
    iv. Regional Health Surveys
    v. Provincial databases
    vi. ISC-FNIHB

To Consider…

To avoid "survey fatigue", ensure you are not duplicating questions that have recently been asked through another source. If that is the case, consider whether you can arrange for information-sharing or adding a couple of questions to another survey to gather your data.

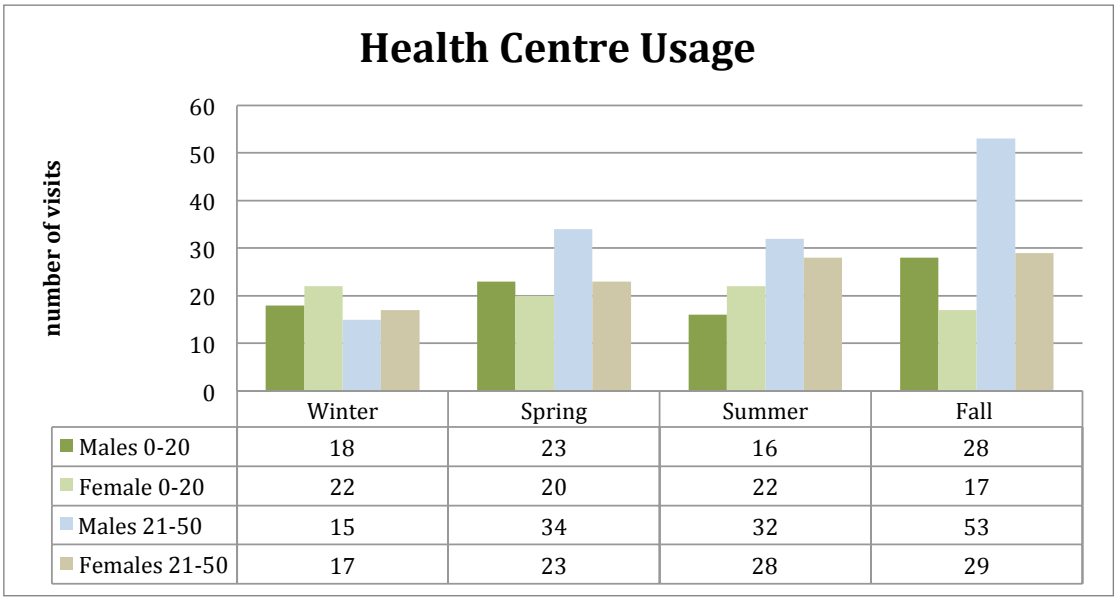
3. Confirm your resources.
   Be clear on all the resources that you have. There are three basic categories of resources – funding (your money), human resources (your people), and infrastructure (other elements that help you do your work).

a. Funding – clearly outline the funding you are receiving from all sources (e.g., ISC-FNIHB, provincial, not-for-profit organizations, academic institutions, corporations, etc.). This is what will pay for the programs and services you will provide.
b. Human Resources – these are your leaders, your staff, your volunteers, your partners, and others that contribute to the programs and services that you offer.
c. Infrastructure – this refers to your building(s), your machines, your supplies, your IT, your support networks, and any other structures that support your programs and services.

4. Analyze your data.
Analyzing all the information that you've collected is an important part of the assessment process. You likely have data from a variety of sources and in a variety of different formats. These data will relate to both community assets and community needs. The value of robust data and effective analysis is that they provide a solid base to identify priorities, which leads to a more relevant and realistic Health and Wellness Plan. You don't need to be an expert to translate your data into usable information – you just need to know a few basics. If you wish to go deeper, you can work with a researcher or epidemiologist.

In order to organize your data so it is useful, you will need to know a few of the basics.

a. Record and count the number of people who gave each response in multiple choice or rating questions. This is quantitative data (refers to what can be counted). It is important to first summarize the data in various ways to tell the story. This involves grouping the raw data into categories and potentially converting the categories into visuals such as tables, graphs or charts. See the basic example of health centre usage by males and females by calendar quarter.



	Winter	Spring	Summer	Fall
Males 0-20	18	23	16	28
Female 0-20	22	20	22	17
Males 21-50	15	34	32	53
Females 21-50	17	23	28	29

b. Write out the comments, identify the themes and then group similar comments under the themes. This is qualitative data (refers to information that is not numerical, that is more descriptive and reflects people's experiences).
c. Add a comment to interpret the data. For example, "It is clear that in the fall, male adults visit the centre at disproportionally higher rates than females". This can help you understand and add meaning to the data. It might also indicate that more research is necessary. For example, do these data represent more hunting accidents? This is helpful to know when planning your health promotion programming.

For your focus groups and interviews, you would organize the comments and responses by theme. (This underscores the importance of asking the right questions, to gather useful responses.) In this way, you can often see clear trends or common themes through the responses.

All this information is required for the "Define" stage, where you will establish your priorities.

Communities in Action

"We sought to increase the skills of community members through providing opportunities to participate, and also to learn about community planning and the health needs of our community by engaging with a wide variety of worksheets, surveys and tools."

5. Prepare a draft document.
Once the Community Assessment is complete with both assets and needs analyzed, you can develop a draft document with the results that will be shared with the Health and Wellness Planning Group, community leadership (and maybe community members) for validation. This draft report will guide the next step in the planning process. The draft report could include the following components:

    a. A description of the Community Assessment process:
        i. The purpose of the assessment of assets and needs.
        ii. The methods and activities used in the process and who participated – not names, just age and gender – as long as this information doesn't identify anyone (e.g., there is only one male over 80 in your community).
        iii. The instruments used (e.g., surveys, focus group questions, interview questions, etc.).
        iv. Any limitations in the process or with the instruments (e.g., difficulty recruiting for particular groups, explanations in response rates, etc.).

b. Describe the community and its health assets.
    i. Provide a brief community profile (e.g., location, closest centres, recent economic development in the community), demographics (e.g., population size with breakdowns by age, gender, education levels, employment rates, numbers of on- and off-reserve populations served).
    ii. Summarize the community assets including knowledge, skills, competencies, traditions, experiences, funding (from all sources), health resources, facilities, staff and visiting health professionals, partnerships, community groups, etc.

c. Summarize the health needs.
    i. Based on the information collected from all activities and instruments, outline the health needs. At this point, you don't have to identify any priorities, just the results related to the needs.
    ii. Include quantitative data (charts and graphs).
    iii. Include qualitative data (group the information by themes and objectives).

The report needs to be easy to read and understand, as it will be used to help your Health and Wellness Planning Group to prioritize the needs and lead to the development of your Health and Wellness Plan. This information can also be included as content in your Health and Wellness Plan.

Communities in Action

"A summary of the Community Assessment report, and priorities was presented to the community at a community dinner and Health Plan update. The question was asked "Do the health priorities reflect the community?" Valuable feedback was received from community members."

Below is an example of how it could be organized:

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Work with others – practice integration
- Seek input from diverse groups
- Include Elders and knowledge keepers
- Recognize cultural knowledge

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Review previous or existing plans
- Evaluate the Health and Wellness Plan – what does it tell us?
- Seek examples from other communities
- Discover what the data and stats are "saying"

- Look at Human Resource needs
- Recognize strengths across the social determinants of health
- Identify and use assets
- Use strengths to address gaps

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Use community data sources
- Involve as many community members as possible
- Follow community protocols
- Link with other community data collection processes where relevant
- Know what is happening in the community – all the programs and services that are offered
- Understand the skill sets in your own community
- Use your own people to lead the process

QUALITY-BASED

Some examples that demonstrate **quality** as a guiding value:

- Use accreditation data
- Ensure data quality – how it's gathered and interpreted
- Use data from ISC-FNIHB, Tribal Council, RHA, province/territory, etc.
- Use your Human Resources
- Map and honour your assets
- Recognize your professional skills and knowledge

TRAINING THAT COULD BE HELPFUL

Some examples of training that could help in the "**Discover**" stage:

- Conducting interviews
- Conducting focus groups
- Data Analysis
- Asset mapping
- Survey design

DEFINE
THE PRIORITIES

DEFINE …THE PRIORITIES

The "**Define**" stage is where you determine what your community's priorities would be. The process of developing your Community Assessment draft document has provided you with significant data as well as information on your community's perceptions about health and wellness, both the strengths and the needs. However, few communities are able to tackle all the needs all at once. The Health and Wellness Planning Group can use the Community Assessment document to decide which health and wellness needs can be addressed and which should be responded to first. This is done through a series of steps that will help identify priorities.

Identifying these priorities in a thoughtful and structured way can guide you in planning programs and services that are most relevant for your community. It can also avoid the potential problem of using too many of the resources to treat high-profile or short-term health needs which may not be in the best long-term interest of your community. As you develop programs and services based on clearly identified needs, you will use your resources most effectively and strengthen your accountability to your community and the funder(s).

This section will guide you through the process of establishing health priorities.

PREPARE

Your Leadership Group or Health and Wellness Planning Group will probably be involved in the priority-setting process. Providing ***enough*** information and the ***right*** information will ensure the prioritization exercise will be more effective.

Your Community Assessment document contains a great deal of information on assets in your community, or in other words, the strengths, resources and capacity. Essentially, your assets tell a story of all that your community HAS.

Your Community Assessment document also details the needs in your community, based on peoples' perceptions and other data sources. In other words, what your community NEEDS to be addressing.

Communities in Action

"We used our assessment in different ways; as a decision-making tool (identify priorities), as a communications tool (increase understanding of the process, data for proposals and reports), and as an evaluation tool (a baseline to measure progress)."

Establishing priorities is a process of balancing several different considerations, with many of the needs requiring necessary or urgent attention.

In order for priorities to be addressed most effectively in your Health and Wellness Plan, you will need to find the intersection between assets and needs.

If there is a health or wellness need, but no capacity or resources to address the need, then it would be futile to identify it as a key priority (although there should be efforts to secure resources and build capacity, and it would be a priority in future plans). Similarly, if you have the capacity but it isn't a need in your community, then don't identify it as a priority as you would waste valuable resources.

Quite simply, the priority-setting activity is where you consider what you HAVE and what you NEED to determine what you CAN do. By using the approach as shown in the diagram, you are effectively and strategically leveraging your **assets** – your strengths – in addressing your health and wellness **needs**.

A good priority-setting process includes:

- the chosen criteria;
- processes to vote/score/rank the options;
- roles and decision-making to finalize the priorities.

Prepare for the process by ensuring your Health and Wellness Planning Group is aware of the prioritization process and has received a copy of the Community Assessment document in advance so they can come prepared for the prioritization session. It is helpful if you prepare a presentation that clearly outlines the process you are following to establish priorities.

DEFINE
THE PRIORITIES

CHOOSE THE CRITERIA

Criteria are the considerations you use to assess the needs and assets and help you determine priority. The criteria can be considered as lenses through which you assess the needs and assets, in a consistent and structured manner. ***The criteria should be in harmony with the values of your community***.

The Health and Wellness Planning Group can choose and use the criteria as a starting point and modify them or add others that are important for the community. It might also be necessary to adjust the criteria over time, once you are a few years into your plan. It is important that the Health and Wellness Planning Group agree on the criteria before the prioritization process begins. Choose your criteria; examples of criteria that may be used include:

1. Community importance – this can be measured by considering:
    a. the number of people affected;
    b. the number of community members indicating this is a serious concern;
    c. whether the health need is very serious or has been worsening over time;
    d. the ability of community members to access alternate local programs or programs in another community.

2. Impact (current and potential) – this can be measured by considering if:
    a. it is a significant burden to individuals, families and the community;
    b. there is a high cost to the community in terms of death, disease, lost days of work, rehabilitation, disability, damage, etc.;
    c. the costs of an intervention are worth the benefits;
    d. there is potential that a program could significantly improve the health situation.

3. Feasibility – this can be measured by considering if:
    a. community assets are available to address the needs (strengths, capacity, culture, resources, knowledge, experience, training, etc.);
    b. funding is available (ISC-FNIHB, province, other organizations, etc.);
    c. opportunities are available to create or enhance a program by integrating resources from other funders;
    d. there are opportunities to link and coordinate with health programs of other communities;
    e. there is special expertise or partnerships available and accessible to the community.

APPLY THE CRITERIA

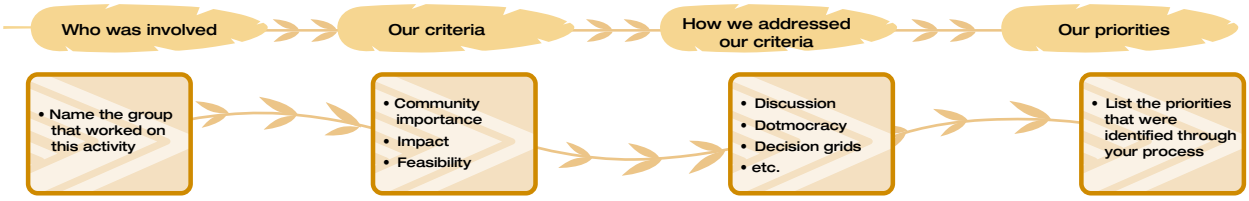
Once you've identified the criteria you'll be using, then clearly outline the roles of the participants – are people making recommendations or are the "votes" binding? Is there someone who will make a final judgement or can veto group decisions? Is there a neutral facilitator who can guide the process and navigate any differences of opinions?

Consider how the needs will be assessed against the criteria. A good facilitator can help guide this process. Some examples of priority-setting activities that can involve the entire group are:

- Discussion, Dialogue, Debate;
- Dotmocracy;
- Quadrant Analysis/Decision Box;
- Grid Analysis.

Or you may have a process that you use in your community. What's important is that by examining all your data and applying a structured process, you can reach consensus on the key priorities that you will address in your Health and Wellness Plan. By using a process that consistently applies your criteria to all the community needs, you have used a transparent approach that can be explained if any of your program plans are questioned.

Create a summary report which builds on the earlier Community Assessment document. Adding visuals or diagrams can help describe the key points. Below is an example of how your prioritizing process could be explained in one visual.



This could also be presented in a table or text format. Follow your own community's protocols. For example, you can:

- present the summary to community leadership first to ensure they understand and support the conclusions or;
- provide community members an opportunity to first review and determine whether the identified priority health needs accurately reflect their concerns. They may have additional insights or questions about the priorities.

DEFINE
THE PRIORITIES

Share the summary through your community communication channels; some examples that communities have used are a newsletter (with contact information for comments) or through a community dinner and meeting.

Once you've had your draft reviewed through your community processes, you can finalize the document and prepare to use the valuable information in the creation of your Health and Wellness Plan.

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Understand what is important to community members
- Be sensitive to the needs of specific groups such as youth, Elders, knowledge keepers, etc.
- Recognize the differences between community groups
- Understand your cultural practices

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Foster strong partnerships
- Honour past work
- Build on earlier processes

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Be flexible (adapt to the changing needs of the community)
- Use community information
- Recognize community history that may influence current practices

QUALITY-BASED

Some examples that demonstrate **quality** as a guiding value:

- Use high quality data
- Use relevant criteria
- Make decisions using a consistent approach
- Record the process and decisions to ensure transparency

TRAINING THAT COULD BE HELPFUL

Some examples of training that could help in the "**Define**" stage:

- Priority setting
- How to facilitate (e.g., World Café, group decision-making, etc.)
- Writing reports
- How to do effective presentations
- Population health
- Working with teams
- Communication

DEVELOP …THE DRAFT

The "**Develop**" stage is where you get to create the actual Health and Wellness Plan. Every effective health organization needs a Health and Wellness Plan – a strategic roadmap that is based on achievable goals – otherwise priorities can get sidetracked, delayed or lost along the way. Because you have been diligent with your process, by following a workplan, by including as many of your community members and partners as possible, and by using criteria to establish priorities, you will be prepared to generate your Strategic Goals based on solid information. This means your Health and Wellness Plan will use your community assets to address the greatest needs of your community.

This stage will guide you through the development of the Strategic Plan sections of your Health and Wellness Plan. There are several common elements of planning that will be covered in the first section. These elements, such as quality, human resources, and risk management, to name a few, can be applied to your planning as a whole, or in some instances, may need to be specifically described.

Some activities of the mandatory programs and services have clearly outlined approaches to implementation and reporting. Other programs offer flexibility in how your community meets its needs. ***What is important is that your Health and Wellness Plan describes the work as a whole and that each activity of each program and service is shown to be helping achieve the organization's goals.***

Let's get started.

DESCRIBE YOUR ORGANIZATION AND THE HEALTH AND WELLNESS PLANNING PROCESS

1. Begin by offering an overview of your organization:

    - Your organization's vision (where you see your organization in 20 years);
    - Your organization's mission (the purpose of your organization, why it exists);
    - Your organization's values (the values or principles upon which your organization operates);
    - Any other guiding documents you use in your organization (traditional or cultural beliefs or practices, etc.).

    Explain how the organization is governed, whether through a Board of Directors or a Health Committee, or however your leadership structure is set up. An organization chart that includes both the governance and management team structures is an effective way to show how the leadership and management work together.

What is the role of your organization in your community? How does your organization relate to and work with other community departments? Provide an overview, rather than an in-depth examination. Community linkages will be explored later in your document.

Communities in Action

"We held a diversity of community engagement sessions to collect ideas on community strengths, issues and needs. We did interviews and focus groups (Youth, Elders, Teachers, Women, Staff). We analyzed this information and presented summaries back to the community for feedback."

2. Describe the funding model that governs the agreement your organization has with ISC-FNIHB. The funding model often determines the amount of flexibility you have in directing the funds to your community priorities. It is also important that your community understand the level of flexibility you have in developing and implementing programs; this helps to manage expectations about what you can accomplish with your funding.
3. As this Guide demonstrates, the process of creating your Health and Wellness Plan is as important as the plan itself. In this section, outline the process that you used so far. Describe the different steps you followed (your workplan from the "Design" stage provides this information). Include the activities you held, who was involved, the number of people that participated, and the outcome of each activity.
4. Provide an overview of your Community Assessment document (this is where you will appreciate the time spent reporting on your Community Assessment process, as it provides clarity on what activities were done and what information was collected). If you have it, provide the baseline data on key areas, so the Strategic Plan has a 'starting point', and you are able to assess progress over time.
5. One area that is very important to document is the process used to identify the Health and Wellness Plan priorities. Based on the assets and needs, describe the criteria and the process that the Health and Wellness Planning Group used to decide on the priorities. Having this clearly outlined will make it easier for you to explain the decisions if necessary.

This will bring you to the section where you identify your Strategic Plan.

DEVELOP
THE DRAFT

For the purposes of this Guide, the entire planning and development process leads you to your *Health and Wellness Plan*. The term "Strategic Plan" will refer to the part of the Health and Wellness Plan that describes your medium/longer term goals and strategies (a sample template is provided in the next section). Therefore, if ISC-FNIHB asks for your Strategic Plan, they are seeking that particular document, the part of your Health and Wellness Plan that outlines the goals and key strategies that you will use to achieve your goals. The annual objectives and tactics will be formulated as part of your annual planning; your Annual Plan can be submitted to ISC-FNIHB if required.

ISC-FNIHB has reduced the number of requirements to be submitted. In addition, the requirements may change over time and according to the type of funding agreement you have. Confirm with your contact at ISC-FNIHB which elements you are required to submit.

SET YOUR STRATEGIC GOALS AND KEY STRATEGIES

Setting Strategic Goals is often where organizations will start when creating a plan. However, that approach is missing one of the most important elements of the process. The priority areas that you've identified by using your criteria will guide you in choosing your Strategic Goals. In fact, that's the reason for all the process so far, to use a structured and robust approach that will ensure your Strategic Goals are relevant and realistic and will make a difference in your community.

There are many ways of choosing Strategic Goals and there are also many different terms or vocabulary used for goals, objectives, strategies, tactics, etc. The words you use in your organization are not as important as the concepts when creating your Strategic Plan. What's critical is that your organization:

- Identifies four to eight medium/long term goals that your organization will aim to achieve within the lifespan of the Health and Wellness Plan (five to ten years):
    - the goals need to be connected to addressing the priorities;
    - the goals are the "what" you'd like to accomplish to address the priorities;
    - the goals are building on the baseline data that you've identified;
    - the goals need to be fairly high level (save the detail for the annual plans);
    - each goal needs to have a performance metric associated with it, so you will know whether you have achieved the goal, or see how far you've come in achieving the goal;
    - an example of a long-term goal would be "rates of new cases of STIs are reduced by 50% within five years (or by …)".

- Chooses key strategies that will be used to achieve the goals:
    - the strategies are the "how" you will put the goals in to action;
    - the strategies should be high level, leaving the detailed tactics for the annual plans;

- use information that has been already gathered through your community assessment, to identify types of strategies that have been successful in the past;
- some examples of strategies related to the above goal could be "create public awareness campaigns" or "develop school-based learning programs". These strategies can then be expanded upon with more detailed objectives and tactics in the annual workplan.

It is easy to get "stuck in the weeds" when creating the Strategic Plan of your Health and Wellness Plan, as we naturally jump to tactics and activities. However, ***it is important to keep your Strategic Plan at a higher level and only identify the medium to longer term goals and key strategies***. The reason is that it is very difficult to plan for details that will happen years down the road, and the aim right now is to set out the big picture goals. The health landscape is always changing, so if you have too much detail in your Strategic Plan, it may make your entire Health and Wellness Plan outdated or obsolete before its time. The place for the details on tactics and activities is the annual plan that your organization will develop and implement each year. This will be discussed in the "Do" stage.

Most successful organizations use a template to develop the Strategic Plan in their Health and Wellness Plan. Here is an example of a template for showing your Strategic Goals and strategies. Note – this template shows six goals and two examples of strategies, you may have more or less, depending on your community priorities.

Strategic Plan (5-10 years)				
Vision				
Mission				
Values				
Priorities				
Goals *(**what** you want to accomplish over the next five-ten years)*	1. Goal – Reduce the rate of teenage pregnancies by 75% 2. Goal – Increase the rate of community members participating in physical activities by 50% 3. Goal 4. Goal 5. Goal 6. Goal			
Strategies *(**how** you will accomplish the goals)*	1. Strategy – Conduct awareness campaigns 2. Strategy – Teach traditional practices 3. Strategy – Create physical activity programming for all ages 4. Strategy 5. Strategy			

DEVELOP
THE DRAFT

This format provides the medium-longer term goals in one place, and demonstrates linkages to the vision, mission, and priorities, all at-a-glance. It will also help keep the organization focused on the big picture as it guides the annual planning.

The next sections will guide you as you plan your programs and services. The first section describes elements that are common to all programming, both mandatory and community-guided, then the mandatory programs and services will be described. Some programs and services have specific requirements for professional credentials, implementation, and reporting that must be considered in your planning, while others have more flexibility. Whether or not there are any specific considerations for programs and services, they are all part of your health and wellness approach and should be planned holistically. As such, ***all programs and services should clearly demonstrate how they help achieve your organization's health and wellness Strategic Goals***.

COMMON PLANNING ELEMENTS

As you plan for your health programs and services, it's clear that several elements are relevant to all areas. These common elements would be considered across all programs and services included in your Health and Wellness Plan.

CONTINUOUS QUALITY IMPROVEMENT

Quality care is safe and effective care that is delivered in a respectful, client-centred, and culturally sensitive manner. All organizations want to provide high quality services to their community and most are striving to be the best they can be. When you have ongoing planning for high quality services, this represents quality improvement. ***Continuous quality improvement*** is the systematic, collaborative, and continuous efforts of the entire organization to make changes that will lead to better health and wellness outcomes for your community and better workplace health for your employees.

As an organization that focuses on continuous quality improvement, your health and wellness planning process will include clients and families, community leaders, and other services inside and outside of the community. Everyone shares the responsibility for building a "culture of quality", where programs and services are based on evidence and wise practices, and where quality indicators, including those defined through Indigenous knowledge, are used.

QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The terms 'quality assurance' and 'quality improvement' are sometimes used interchangeably, but they are not the same thing.

Quality assurance indicators seek compliance with certain necessary or minimum standards. ***Quality improvement*** is a continuous improvement process. Quality assurance may be a requirement for some aspects, and normally focuses on individuals or single elements, while quality improvement is a proactive approach to improve processes and systems. However, standards and indicators developed for quality assurance can inform the quality improvement process. The chart below provides some distinctions between the two terms.

	Quality Assurance	**Quality Improvement**
Motivation	Measuring compliance with minimum standards	Continuously improving through standards of excellence
Attitude	Required, possible reluctance	Chosen, proactive
Focus	Improving things going wrong	Improving processes
Scope	Individuals or elements	Overall client care outcomes, system-focused
Responsibility	Held by a few people	Everyone takes responsibility

DEVELOP
THE DRAFT

QUALITY DIMENSIONS

Quality improvement approaches frequently differ by jurisdiction, organization, context, and populations served. However, the common goal is to create a better healthcare system where the client experience and their health and wellbeing are the central focus and provide the greatest value for the investments made. As such, many quality considerations and service planning elements are common to all community-based healthcare programs and services. These are addressed below under the six ISC-FNIHB quality dimensions. Additional quality considerations and service planning elements specific to various programs are addressed in the relevant sections in this Guide.

Accessibility: "Accessibility" means providing equitable, timely, and appropriate health programs and services based on assessed needs, and, at the right place and right time, considering geographic location and cultural background. Accessibility is characterized by improved coordination across programs and services, decreased health disparities, and increased awareness of clients' needs when designing programs and services. Enhance the accessibility of your health services by developing and implementing standardized processes that are supported by culture and evidence-informed policies, guidelines, and procedures to:

a) Identify community health and wellness needs as a basis for developing health services.
b) Develop your Strategic Plan including your Strategic Goals. Build your Annual Plan around measurable objectives that will help achieve your Strategic Plan.
c) Identify what can and cannot be provided based on your community assets and needs.
d) Determine resource availability and requirements, such as:
    i. Funding sources;
    ii. Community and broader health system supports to assist clients including partners (both current and future), networks (children, youth, Elders, LGBTQ2, etc.) and cultural supports (traditional practices, ceremonies, etc.);
    iii. Medical supplies, diagnostic tools, and equipment that meet operating and safety standards, as well as processes or protocols for accessing these services;
    iv. A Human Resources Plan that identifies current and future human resource needs for your organization to achieve your Strategic Goals.
e) Ensure mechanisms are in place to communicate information about your programs and services.
f) Facilitate access to services available both within and outside of the community. This would include elements such as:
    i. Screening and prioritization of clients according to assessed need;
    ii. After-hours care and emergency services;
    iii. Established criteria for wait times and waitlist monitoring;

iv. Medical transportation, as required based on documented criteria;
v. Access to consulting staff, specialty services (e.g., mental health services, women's health practitioners, cultural practitioners, etc.), and regional or provincial service networks;
vi. Telehealth consultations;
vii. Documented service agreements that outline service and quality expectations.

g) Make health services information available in your Indigenous language. Your health services information would include items such as:
i. Contact information for health services;
ii. Hours of operation;
iii. Emergency numbers;
iv. Services provided for band and non-band members;
v. How to access provincial health cards;
vi. Available community care resources.

Communities in Action

"Our community wanted to make sure all populations were represented, so we hosted a youth, post-secondary, and high school student event, and also went door-to-door to gather information."

Client-Centredness: "Client-centredness" means involving individuals, families and the community in healthcare planning and delivery and respecting their needs and preferences where possible. As such, client-centredness is characterized by compassion, empathy, and responsiveness. It refers to programs and services that establish a partnership between providers, clients, and their families to ensure that decisions respect clients' needs and preferences. It also means that clients have the information and support they need to make decisions and participate in their own care. Enhance the client-centredness of your health services by developing and implementing standardized processes supported by culture and evidence-informed policies, guidelines, and procedures to:

a) Integrate harm reduction and cultural approaches in your services;
b) Reduce stigma and discrimination against populations with specific needs (e.g., LGBTQ2, mental health and addictions, etc.);
c) Engage community members in primary care services design and delivery;
d) Conduct comprehensive and standardized assessments of clients' health and wellness needs;
e) Develop comprehensive care plans based upon assessed needs and clients' goals;
f) Support clients with comorbid conditions, chronic disease, and complex health needs using case management;

g) Support clients with end-of-life and palliative care needs;
h) Ensure smooth transitions of care;
i) Assist with pain management;
j) Provide advance care planning;
k) Include processes that provide clients the opportunity to provide feedback on their care;
l) Make ethical decisions that do the most good with the least harm.

Culturally Competent and Culturally Safe Care: "Culturally competent" care means that service providers are aware of their own worldviews and attitudes towards cultural differences. Cultural competence includes both knowledge of, and openness to, the cultural realities and environments of the individuals, families and communities they serve.

More powerful is the concept of "cultural humility", which extends beyond cultural competency and includes reflecting upon cultural, historical, and structural differences, and power relationships within the care that is provided. Cultural humility involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to clients, families, and communities.

"Culturally safe" care is different because it is the ***client*** that defines whether they have received safe care. The client describes what culturally safe services mean to them, rather than the health system determining whether the care has been culturally safe. As such, cultural safety is an outcome, defined and experienced by those who receive the services.

Enhance the cultural competency of your health services by developing and implementing standardized processes supported by culture and evidence-informed policies, guidelines, and procedures to:

a) Recruit healthcare personnel with the knowledge, competence, training, and experience to work effectively in Indigenous health services and communities, with attention to cultural practitioners and cultural resources;
b) Support cultural competency among service providers (e.g., offering cultural sensitivity training, community orientation, etc.);
c) Provide services in the language of the client, where possible;
d) Provide services to help clients feel culturally safe, including resources such as patient navigators, translators, etc.;
e) Integrate cultural practitioners, Elders, and ceremonialists, where available;
f) Provide professional development for cultural practitioners and Elders, as members of the care team;
g) Provide services in alternate settings, where possible and feasible, such as school, community hall, cultural camps, etc.;
h) Have the décor of the facility reflect cultural meaning and symbolism, and provide a designated space to hold cultural healing practices, as required;
i) Be inspired by wise practices.

Effectiveness: "Effectiveness" means applying current evidence, Indigenous knowledge, including best practices, to achieve the best possible health outcome. It requires continuous monitoring and analysis of evidence to evaluate which processes, programs, and services are likely to be effective and to use this information to improve programs, and services. Health outcomes need to be defined from within the culture and knowledge of the community.

Enhance the effectiveness of your health services by developing and implementing standardized processes supported by culture and evidence-informed policies, guidelines, and procedures to:

a) Develop and implement Annual Plans that are linked to and operationalize your Strategic Plan;
b) Develop and sustain leadership skills to sustain good management practices;
c) Ensure an interdisciplinary team approach to client care, that includes Indigenous knowledge;
d) Optimize teamwork and minimize duplication;
e) Ensure that teams regularly evaluate their processes and results and make improvements;
f) Ensure a seamless continuum of care and services for clients, both within community services, and between community and external services;
g) Implement continuous quality improvement based on a Quality Improvement Plan that is reviewed and renewed annually. Your Quality Improvement Plan should include:

i. Activities that address identified areas for improvement across the organization (e.g., leadership, managerial, professional, administrative, etc.);
ii. A designated employee, with quality improvement training, to coordinate the quality improvement activities (may also be the Safety Officer, in smaller organizations);
iii. Training and support for personnel who wish to be involved in quality improvement activities;
iv. Timely access to information on "wise", "best", and "leading" practices, and practice guidelines;
v. A process to develop, adapt, and update policies, procedures, and guidelines, based on current evidence and leading practices;
vi. Quarterly quality improvement reports to leadership and key stakeholders.

h) Formally monitor and evaluate your service performance and quality improvement trends at all levels within the organization (e.g., teams, services, programs, full organization) against goals and objectives. Select indicators that are meaningful to your organization and defined from within the Indigenous knowledge of your community, and that are linked to your Strategic Plan. Use the results to guide decision-making and future planning.

Indicators of effectiveness include (among others):

i. Administrative decision-making (e.g., allocation of resources);
ii. Cleaning, disinfection, and sterilizing processes (e.g., audits of disinfection practices);
iii. Clinical decision-making (e.g., health screening tools);
iv. Communication planning (e.g., community newsletters);
v. Community engagement (e.g., community focus groups);
vi. Community, client, and staff feedback on services (e.g., surveys);
vii. Emergency planning (e.g., evacuation times during drills);
viii. Human resources management (e.g., performance appraisals);
ix. Infection prevention and control (e.g., handwashing audits);
x. Information management (e.g., security breaches);
xi. Medication management (e.g., vaccine storage protocols);
xii. Preventive maintenance processes (e.g., equipment calibration);
xiii. Safety incident management (e.g., falls, medication errors);
xiv. Service delivery (e.g., client outcomes);
xv. Strength-based indicators (e.g., how services contribute to cultural continuity through outcomes of hope, belonging, meaning, and purpose);
xvi. Team performance (e.g., collaborations between teams);
xvii. Training of healthcare personnel (e.g., types of training);
xviii. Transition planning (e.g., undue delays between accessing services).

i) Manage information effectively, including:

   i. Signage that includes after-hours and emergency contact information;
   ii. An up-to-date community partners list, including contact information;
   iii. Regular Board, community, staff, and team meetings to share pertinent health service information (e.g., new services available, feedback from clients, actions taken, etc.);
   iv. Standardized assessment and communication tools (e.g., referral forms, screening tools, etc.) to effectively share key client information;
   v. Personnel records storage that protects privacy and meets applicable regulations;
   vi. Use of cellphones;
   vii. Use of computers and information systems, including timely technical supports;
   viii. An organizational communication plan to ensure ongoing exchanges with internal and external stakeholders;
   ix. Health records management (electronic and paper versions) based on current privacy legislation;
   x. A comprehensive eHealth infostructure and related processes.

Efficiency: "Efficiency" means using resources wisely. It is demonstrated by better practices and processes, improved operations, and the identification and elimination of systematic waste and inefficiency. Concern for efficiency addresses short- and long-term value for resources – both money and time. Often people think that efficiency is about cutting costs or services. But efficiency may also mean different ways of doing things. For example, adding new services such as cultural practitioners, traditional Indigenous medicines, or Indigenous knowledge, all of which may increase efficiency in client care.

Enhance the efficiency and reduce waste for your health services by developing and implementing standardized processes supported by culture and evidence-informed policies, guidelines, and procedures to allocate and evaluate the use of resources:

a) Prioritize resource needs according to assessed clients' needs;
b) Assure that all personnel work within their scope pf practice;
c) Develop and implement a succession plan to ensure continuity of services;
d) Cross-train personnel, where possible;
e) Move resources to where they are needed;
f) Use reusable medical devices where possible;
g) Avoid sending unnecessary supplies to clients' homes;
h) Avoid overstocking supplies.

DEVELOP
THE DRAFT

Safety: "Safety" means minimizing risk and avoiding harm. This dimension ensures that healthcare programs and services are designed and delivered to promote safe practices and reduce adverse outcomes. It means keeping the people, and the environment in which programs and services are delivered, safe.

Enhance the safety of your health services by developing and implementing standardized processes supported by culture and evidence-informed policies, guidelines, and procedures to:

a) Develop and implement a Patient Safety Plan (may be integrated with your Quality Improvement Plan).

b) Provide safe care and services to clients and families, including:
   i. Comprehensive, culturally relevant assessments which may include culturally adapted assessments, as required;
   ii. Activities, materials, and tools to support safe self-management by clients in easy-to-understand language;
   iii. Comprehensive patient safety guidelines, policies, and procedures.

c) Ensure standardized procedures are in place for:
   i. Transferring clients and personnel to and from alternative healthcare delivery sites;
   ii. Insuring and maintaining transport vehicles.

d) Provide safe and healthy workplaces for healthcare personnel, including:
   i. Liability and malpractice coverage;
   ii. An orientation program;
   iii. Onboarding and continuing education regarding patient safety for all personnel, including training on quality improvement, risk management, strengths-based approaches, cultural competency, and trauma-informed care;
   iv. Supports to staff who experience an incident;
   v. Participation of staff in annual performance appraisals that include learning objectives for the coming year;
   vi. Ethical decision-making processes;
   vii. Developing and implementing an employee wellness program;

viii. Confidential Employee Assistance Program, preferably by an outside agency;
ix. Oversight of the quality of work done by contracted personnel;
x. A comprehensive Occupational Health and Safety Program.

e) Safely manage the equipment (handling and storage) and the physical environment, including:
   i. A plan to ensure utilities are provided to the premises;
   ii. Enough space to provide safe, effective, and confidential services;
   iii. Medical equipment and supplies that meet operating and safety standards;
   iv. Comprehensive infection prevention and control guidelines, policies, and procedures;
   v. Comprehensive communicable disease control and management guidelines, polices, and procedures;
   vi. A Health Emergency Plan (linked to the community Emergency All Hazards Plan) for providing essential services in cases of dangerous situation or major service disruptions.

Quality is also one of the four Dynamic Values upon which your programs and services are delivered. How this is represented will depend on how your community defines quality and quality improvement. Each stage of this Guide includes some examples of how quality improvement would be demonstrated; consider which examples work for you and add others that resonate for your community.

PLAN-DO-STUDY-ACT (PDSA)

The PDSA cycle is a commonly used and effective approach to quality improvement. It guides you through planning the change (Plan), testing the change (Do), observing and learning from the results (Study), and determining what adjustments need to be made (Act). The PDSA cycle is often applied when organizations are seeking to improve specific elements of their programs or services, an example would be making the client intake process more efficient. The proposed improvement would be tried out for a short amount of time, or on a few clients first, to see how well it works, and then review and adjust, if necessary.

The PDSA cycle provides a useful, controlled process for:

- Quality improvement approaches, when the cycle is repeated as new areas for improvement are identified;
- Exploring possible new solutions to problems, trying them out, and improving them in a controlled way before selecting one for full implementation;
- Avoiding the large-scale waste of resources that comes with full scale implementation of a mediocre or poor solution.

This approach enables organizations to make changes and assess the effectiveness of the change before adapting, adopting, or abandoning the change. It is a nimble approach to change on a smaller scale.

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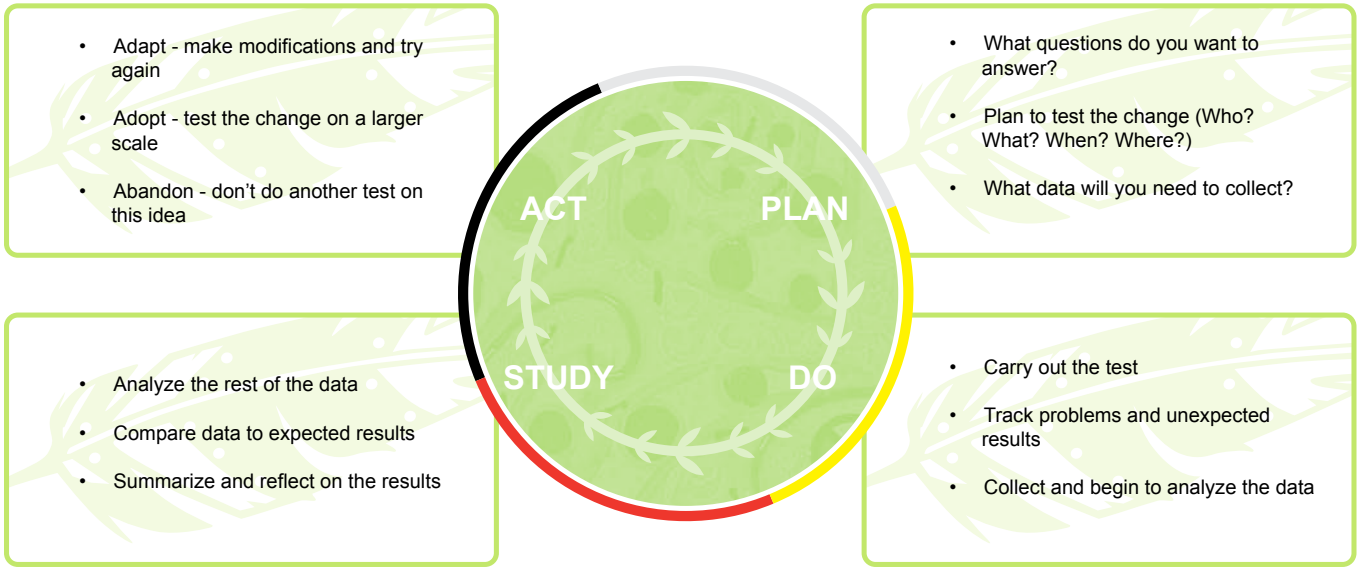
Consider what changes you'd like to incorporate as part of your quality improvement. On which ones could you use the PDSA approach?



QUALITY IMPROVEMENT AND CULTURE

How does the concept of continuous quality improvement mesh with your community culture? First Nation communities traditionally promoted wellness through Elders, traditional healers, and knowledge keepers, whose work was based on sacred teachings. Their approach also encompassed a connection to the earth and a constant quest for balance.

Community health leaders often face challenges in blending traditional health practices with western approaches. Recently, because of community empowerment and purposeful health and wellness planning, it has become more common for health managers to incorporate their traditional practices into their healthcare system.

The following conditions are necessary to understand and embed cultural competencies in a quality-driven health system:

- Community assessments that are community-driven;
- Feedback mechanisms that matter to the community;
- Information systems that are relevant (e.g., in language and context);
- Indicators of community health that are reviewed and adjusted;
- Resources and approaches that are culturally relevant.

These elements are fully represented in health services accreditation programs in which several First Nation health centres are engaged. These health organizations are continuously improving while reinforcing their culture in their healthcare system.

ACCREDITATION

What is Accreditation?

Accreditation is an ongoing, comprehensive quality improvement process used by healthcare organizations in Canada and around the world to improve the quality and safety of their programs and services. Participating in accreditation involves comparing all key organizational processes against standards of excellence to identify what is being done well and what needs to be improved. As such, accreditation helps organizations to build a culture of quality, safety, and excellence which benefits the clients, the community, as well as the healthcare personnel.

Benefits of Accreditation

The first and most important benefit of accreditation is that it helps organizations improve the quality and safety of health care services. This can lead to better health for clients and communities.

Secondly, accreditation publicly demonstrates to clients, the community and partners-in-care that the healthcare organization is committed to quality improvement. This enhances the credibility of an organization and is reassuring for community members and clients. Also, accreditation can be a meaningful motivator that leads to better recruitment and retention, as well as improved relationships within and outside of the workplace.

Thirdly, accreditation can help organizations make more efficient use of healthcare resources. Since it enables health organizations to measure their performance against standards of excellence, accreditation helps to provide a clear picture of organizational strengths and areas for improvement, thus contributing to the development of a quality Health and Wellness Plan. Furthermore, standardized processes developed through accreditation can be used to address several health and wellness planning requirements.

Who Accredits First Nation Health Services?

Accreditation is granted by a recognized accrediting body. ISC-FNIHB does not accredit health services, but rather, provides support to organizations wishing to engage in the process with an accrediting body of their choice and offers ongoing support to First Nation organizations already engaged in accreditation. The stages involved in preparing for and participating in accreditation are shown in the following diagram.

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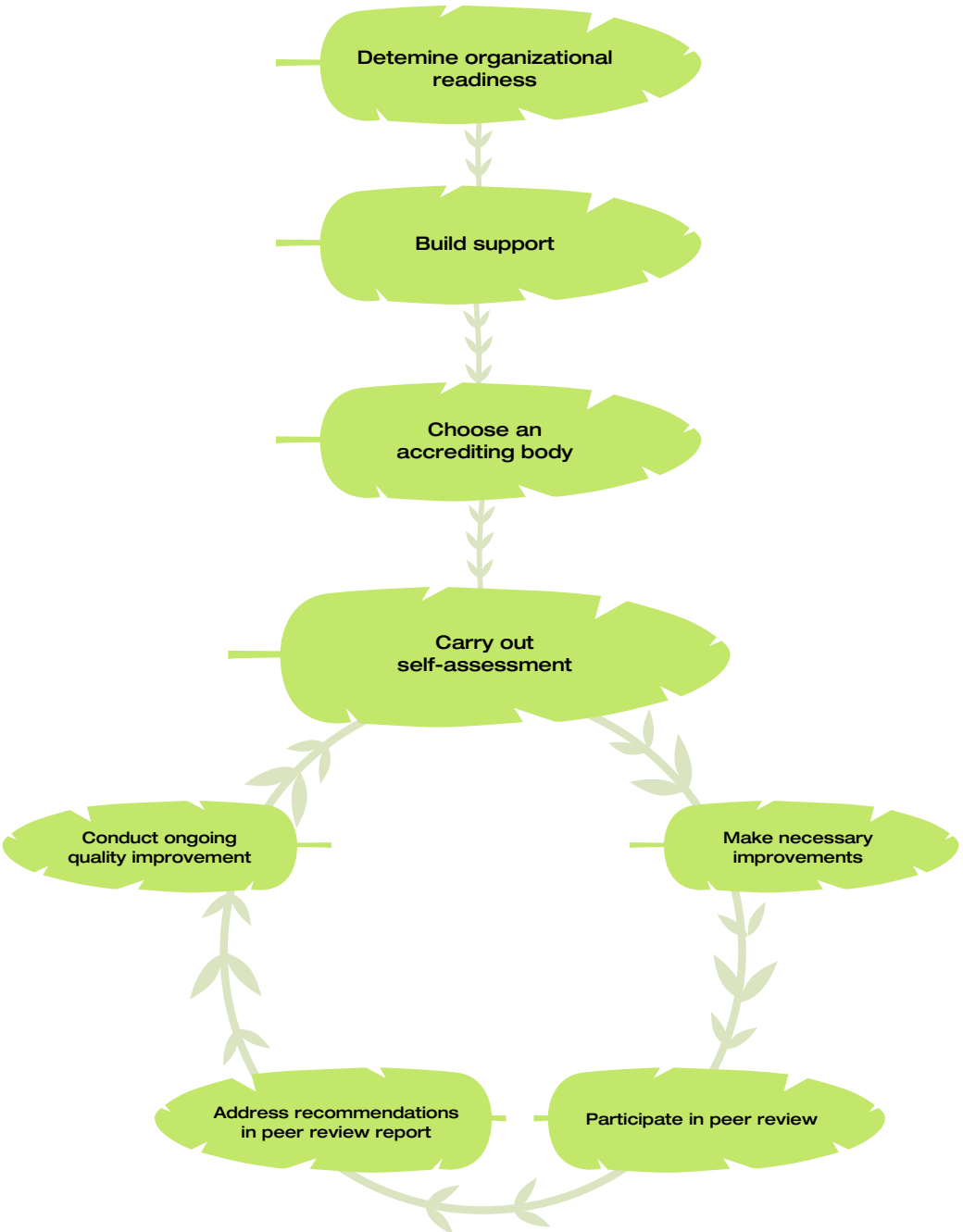
How does an organization participate in accreditation?



Participating in accreditation is a cyclical and ongoing process of continuous self-evaluation and quality improvement as shown in the figure. This involves:

- Determining if your organization is ready to undertake the accreditation process;
- Building and sustaining organizational support for accreditation;
- Choosing an accrediting body, using the standards provided by this body to systematically identify what needs to be improved;
- Conducting a self-assessment and carrying out the necessary improvements to achieve compliance with the standards of excellence;
- Participating in peer reviews/onsite surveys to determine if these improvements demonstrate compliance with the standards;
- Making any further improvements recommended in the peer review/onsite survey report;
- Continuing with ongoing quality improvement until the next accreditation cycle begins again with the same accrediting body.

Any healthcare organization that wishes to participate in accreditation is encouraged to:

1. Contact the ISC-FNIHB Regional Accreditation Lead to request a meeting or an overview presentation on accreditation and discuss readiness for accreditation and funding eligibility.
2. Contact other communities already in the accreditation process and learn from their experiences. This information will be available from your ISC-FNIHB Regional Accreditation Lead.
3. Discuss accreditation requirements with your Board/Council and healthcare personnel to confirm their support before engaging in the process.
4. Contact and research various accrediting bodies for further information and/or to receive an application package. This information can also be provided by the ISC-FNIHB Regional Accreditation Lead.
5. Choose an accrediting body that best fits the needs of your organization and apply to begin the process.

PATIENT SAFETY

Patient safety means to reduce and mitigate unsafe acts in the healthcare system, and to use best practices to improve client outcomes. There are many aspects of patient safety, and it's important that everyone involved in patient safety, including clients, their families, and healthcare professionals, be aware of the issues, mitigation strategies, and best practices for ensuring patient safety.

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Effective teamwork and effective communication are critical for ensuring the safe delivery of care, and can decrease client harm, promote cross-professional collaboration, decrease workload issues, and improve staff and patient satisfaction.

The Canadian Patient Safety Institute identifies six key competency domains that support patient safety. Consider how your organization and your teams would incorporate these competencies. If you are in accreditation, you would be addressing these through the standards and practices.

1. **Contribute to a culture of patient safety** – A commitment to apply core patient safety knowledge, skills, and attitudes to daily work.
2. **Work in teams for patient safety** – work within inter-professional teams to improve patient safety and quality of care.
3. **Communicate effectively for patient safety** – promote patient safety through effective communication.
4. **Manage safety risks** – anticipate, recognize, and manage situations that place clients at risk.
5. **Optimize human and environmental factors** – manage the relationship between individual and environmental characteristics to improve patient safety.
6. **Recognize, respond to, and disclose adverse events** – recognize a patient safety incident and respond effectively to reduce harm to the client, ensure disclosure, and prevent recurrence.

A patient safety incident is an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. There are three types of patient safety incidents:

- Harmful incident/adverse event – A patient safety incident that resulted in harm to the patient.
- No-harm incident – A patient safety incident that reached the patient, but no discernible harm resulted.
- Near miss – A patient safety incident that did not reach the patient and therefore no harm resulted.

Examples of Patient Safety Incidents:

- Clients – care provided to wrong client, mislabeled charts, falls, etc.
- Medications – missed dose, wrong medications, severe reactions, etc.
- Equipment – faulty equipment, inappropriate use, lack of maintenance, etc.
- Vehicles – poor maintenance, inappropriate driving for road/weather conditions, etc.
- Clients and families – intimidation, verbal/physical abuse, incorrect information provided, etc.
- Staff and colleagues – bullying, harassment, etc.

Every healthcare organization needs to consider how to improve patient safety. Your policies and procedures manual should include the following topics related to patient safety:

- Client identification
- Client self-management
- Clients' rights and responsibilities
- Confidentiality
- Disclosure of harm due to safety incidents
- Falls prevention
- Filing complaints
- Follow-ups for abnormal critical diagnostic tests
- Home safety risk assessments
- Informed consent for services and the transmission of client information
- Suicide assessment and intervention
- Patient safety teaching (e.g., falls prevention, self-care, wound care, medication storage, self-harm, etc.)
- Pain assessment and management
- Preventing client abuse
- Research activities involving clients
- Safe medication management
- Screening for risks (e.g., disease, abuse, etc.)
- Screening of clients at risk for readmission
- Substance abuse assessment and intervention
- Wound care

Develop a Patient Safety Plan which includes the following elements:

- A designated Safety Officer with safety training, to coordinate patient safety activities;
- Annual (or more frequent) risk assessments carried out in all key areas;
- Identification of vulnerable clients and client populations;
- Activities that address identified safety risks across the organization;
- A formal process to identify and report safety risks, near misses, and safety incidents to leadership, for analysis, follow-up, and reporting;
- A formal process to disclose harm to clients due to safety incidents;
- Quarterly safety reports to leadership and key stakeholders;
- Training and support for healthcare personnel wishing to be involved in patient safety and risk management activities.

Understanding patient safety and where your organization could improve, can also be included in your risk management plan.

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DELIVERY MODELS

Delivery models refers to the different ways that you'll be offering programs and services. Essentially, your models of program and service delivery will be a mix of approaches, such as community-based activities, land-based services, shared programs and services with partners, and several others.

The ***First Nations Mental Wellness Continuum Framework*** (2015) refers to Indigenous approaches to programs and services:

> "First Nations seek to achieve whole health—physical, mental, emotional, spiritual, social, and economic well-being—through a coordinated, comprehensive approach that respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing."

What is an Indigenous Service Delivery Model?

Increasingly, First Nations are searching for ways to gain more control over the delivery of health care in their communities. Developing their own Indigenous service delivery approaches can be a way for communities to progress toward control of community healthcare services, developing and implementing culturally relevant services, and achieving better health outcomes. While there is not one clear definition of an Indigenous service delivery model, there are some characteristics and important considerations for communities that are interested in developing and implementing this in the context of health and wellness planning.

An Indigenous service delivery model is rooted in knowing that individual communities who want to plan in a different way can provide accessible, effective and efficient health services, actively involve and respect the needs of individuals and families, integrate cultural knowledge from their community into health programs and services, and build capacity by collaborating with other communities. It is about building autonomy and control over the health service delivery in your community.

It is very important to encourage active participation of families and the community as allies, to plan "with them" rather than "for them". This is essential to ensure that your culture and knowledge are represented within your model of care. Cultural practitioners, Elders, community workers, and ceremonialists can serve a community-defined role within your care team as one more way to empower your community in taking charge of complex health needs.

Your community may integrate land-based programs, traditional practices and ceremonies, or collaborate with other organizations. This approach, a collaborative Indigenous service delivery model, involves your community choosing to collaborate with another community, external stakeholder, Friendship Centre, or Tribal Council (as examples), to build capacity and develop resources to deliver your healthcare services. Your community can draw upon its strengths, rooted in your culture, language, knowledge, land base, and values to enter an arrangement with another community. Collaboration can be based on geographical area, cultural alignment, or the common need for specific health services (or a mix of all three, or others).

Communities in Action

"A foundational piece for our community was asking what 'health' means to them. This informed what we were assessing. Community members shared their ideas at various community engagement sessions."

Benefits and Challenges

Within the context of your health and wellness planning, there are several considerations when implementing a collaborative Indigenous service delivery model.

Some potential benefits of a collaborative Indigenous service delivery model:

- Provides a framework to collaborate with partners and clarify decision-making processes about issues affecting your community. Collaboration offers a stronger voice for negotiating and the ability to better integrate health programs and services with provinces and territories;
- When grounded in culture, it enables a community to plan and deliver their health services in a way that works for them;
- Increases ownership and influence over health programs and services and builds capacity to address local issues;
- Supports better health outcomes by increasing access to culturally appropriate services and advocating for higher quality services.

Some potential challenges of a collaborative Indigenous service delivery model:

- Winning the trust of all collaborating partners and keeping all informed of decisions;
- Ensuring that the visions and goals of each community are preserved;
- Addressing the perception that individual communities will lose resources if they partner up or join a collective;
- Knowing what infrastructure needs to be in place to support communities;
- Ensuring the real costs of delivering services are included in calculations (e.g., transportation, competitive salaries, etc.) especially in remote and isolated communities.

When planning for a strength-based Indigenous service delivery model, consider the following themes and guiding questions as you do your planning.

1. Culture (as the foundation)
   Guiding questions:
   a. What defines culture in our community?
   b. How do we define cultural competency and what are some possible indicators?
   c. How can we work with partners to improve cultural competency in our health services?
   d. What role does language play in our community?

2. Community Development, Ownership, and Capacity-building
   Guiding questions:
   a. As a community, what are our health and wellness priorities?
   b. How can we develop and build capacity within our community?
   c. With whom do we need to partner to gain more control over our health services?

3. Quality Care, Competency-based Workforce
   Guiding questions:
   a. What are our strengths related to delivering high quality health services to our community?
   b. How do we define a culturally competent workforce?
   c. How can we support, promote, and strengthen a culturally competent workforce?
   d. What kind of training and professional development would benefit our community health service delivery?
   e. How do we ensure support systems for worker wellness?

4. Collaboration with Partners
   Guiding questions:
   a. How do we define the roles and responsibilities for partners in our community?
   b. Who will be the leaders in our community when establishing an Indigenous service delivery model?
   c. How will we create more partnerships and networks to create more access to services for our community?

5. Enhanced Flexible Funding
   Guiding questions:
   a. What are some ways we can enhance funding options in our community?
   b. Which channels exist to increase the flexibility of funding in our community?
   c. With whom could we partner to leverage different funding sources?
   d. What other funding options are available to us (e.g., not-for-profit organizations)?

When choosing to move forward with a collaborative Indigenous service delivery model, begin by understanding the strengths and needs of your community, then you can choose to collaborate with other communities and organizations based on shared or complementary characteristics and goals.

Your health programs and services will likely be a blend of many types of delivery models; integrate as many different approaches as you need to help achieve your health and wellness goals.

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CULTURE-BASED STANDARDS OF CARE ACROSS THE LIFE SPAN

In the "Culture" section of the Dynamic Values, an adaption of a model shared by the ***First Nations Mental Wellness Continuum Framework Implementation Guide*** (2017) was used to illustrate the stages of life, with and without culture. When planning your programs and services, Indigenous knowledge-based standards can provide an excellent framework that ensures your culture and knowledge are integrated with all health services. Below is more information related to culture-based standards of care, also adapted from the ***First Nations Mental Wellness Continuum Framework Implementation Guide*** (2017).

1. Pre-birth

Primary Focus: Connection with family, lineage and clan/kinship family through visiting the fetus and providing cultural care for mother.

Critical Elements of Care: Before birth, cultural practices include important activities to ensure a good and safe journey of the baby into the world.

Performance Indicators:
Outcome – Hope, creates a sense of spiritual balance
Indicators – cultural identity, belief/worldview, values

2. At Birth

Primary Focus: Connection to the earth, family, and community.

Critical Element of Care: Securing attachment to land, lineage, and language are necessary for ensuring a good life path.

Performance Indicators:
Outcome – Hope, creates a sense of spiritual balance
Indicators – cultural identity, belief/worldview, values

3. Childhood - "Good Life"

Primary Focus: Spiritual development that is focused on developing a sense of self in relation to others.

Critical Elements of Care: The use of Indigenous language is important for supporting a connection to the Indigenous world view.

Performance Indicators:
Outcome – Belonging
Indicators – family, community, relationship (people and Creation), attitude towards living life

4. **Adolescents: "Fast Life"**

Primary Focus: Teaching skills for delayed gratification while developing a sense of social belonging and a connection to physical sense of self.

Critical Elements of Care: Every nation has cultural practices specific to the rites of passage at puberty.

Performance Indicators:
Outcome – Belonging
Indicators – family, community, relationship (people and Creation), attitude towards living life

5. **Young Adult: "Wandering/Wondering Life"**

Primary Focus: Cultural practices grounded in family and community, identity, worldview, and beliefs support exploration of how to exercise and live with Indigenous identity and purpose within a world that may or may not be reflective of such.

Critical Elements of Care: Continuation of a focus on the expression of one's cultural identity and worldview through translation into life.

Performance Indicators:

Outcome – Purpose, creates balance between rational and intuitive thought to develop a more holistic understanding of life

Indicators – rational/cognitive development, intuitive thought and spiritual knowing, learning to integrate rational and intuitive thought to create understanding and meaning for life

6. **Adult: "Truth Life"**

Primary Focus: Cultural practices to apply meaning in an environment that celebrates cultural identity, promotes cultural safety, and ensures Indigenous knowledge is translated into everyday life.

Critical Elements of Care: It is said that truth is anchored in both the physical world and spirit world – identity, worldview, values, beliefs, family, community, relationships, and an attitude towards living – knowing that answers are always possible even in the most difficult times.

Performance Indicators:

Outcome – Meaning, creates balance between rational and intuitive thought to develop a more holistic understanding of life

Indicators – rational/cognitive development, intuitive thought and spiritual knowing, learning to integrate rational and intuitive thought to create understanding and meaning for life

7. Continuity: "Planting Life"

Primary Focus: Ensuring continuity of culture and identity.

Critical Elements of Care: Essential in programs and services support activities for "cultural ways of doing" and "cultural ways of being".

Performance Indicators:
Outcome – Purpose
Indicators – ways of doing, way of being, wholeness

8. Fulfilling Purpose: "Doing Life"

Primary Focus: Support the use of the developed gifts, potential, capacity and purpose.

Critical Elements of Care: First Nation communities have capacity for applying cultural knowledge and skills across programs and services promoting wellness.

Performance Indicators:
Outcome – Purpose
Indicators – ways of doing, way of being, wholeness

9. Elder: "Give away Life"

Primary Focus: Cultural practices ensure that culture-based knowledge and skills continue to the next generations, teaching, and giving to all those coming behind.

Critical Elements of Care: This requires that Elders, cultural practitioners, and cultural teachers are a critical part of the workforce addressing health issues.

Performance Indicators:
Outcome – Purpose
Indicators – ways of doing, way of being, wholeness

10. Death and the Journey of the Spirit

Primary Focus: Cultural practices focus on care for the spirit journey and care for the family that is left behind.

Critical Elements of Care: Respect for cultural protocols regarding burial.

Performance Indicators:
Outcome – Purpose
Indicators – ways of doing, way of being, wholeness

TRAUMA-INFORMED CARE

The ***First Nations Mental Wellness Continuum Framework*** (2015) provides an excellent explanation on trauma-informed care.

> "Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma experienced as individuals early in life (e.g., a result of child abuse, neglect, witnessing violence, or disrupted attachment) or later in life (e.g., due to violence, accidents, sudden and unexpected loss, or other life events that are out of one's control) and understands trauma beyond individual impact to be long-lasting, transcending generations of whole families and communities. Traumatic experiences like these can interfere with a person's sense of safety, decision-making ability, sense of self and self-efficacy, and ability to regulate emotions and navigate relationships, as well as for whole families and whole communities. Given the number of adverse experiences and the history of trauma in First Nation communities, a trauma-informed approach to care is highly recommended.
>
> Integrating a trauma-informed approach to care for individuals, families and the community, helps to rebuild a sense of control and empowerment. With trauma-informed care, communities, service providers, and frontline workers are equipped with a better understanding of the needs and vulnerabilities of clients affected by trauma. An important shift in thinking moves to considering trauma as an 'injury' rather than a 'sickness'. ''

Trauma-informed care is based on compassion and genuine relationships between service providers and clients. This underscores the importance of cultural competency for service providers, as it's essential to understand the individual, family, and community history of trauma.

GUIDES AND RESOURCES

The following resource can assist in the development of this approach.
First Nations Mental Wellness Continuum Framework (2015) (Thunderbird Partnership Foundation)

RISK MANAGEMENT

Risk is inherent in health care. As such, all health organizations should be aware of the potential for risks and take the appropriate steps to manage the range of risks they face.

Risk can be defined as an actual or potential danger. It doesn't necessarily mean that harm ***will*** happen, but that it ***can*** happen. That is what makes risk harder to deal with; if you knew it would happen, you would plan for it… but it's the "***maybe***" factor that means that sometimes organizations aren't prepared. It's also why every health organization needs to develop a process for risk management.

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Risk management is the process of thinking systematically about the possible risks and problems ***before*** they happen and setting up procedures to:

- avoid the risk;
- minimize the impact;
- cope with the impact.

Essentially, you are asking three questions:

1. What could go wrong?
2. What can we do to prevent it?
3. What will we do if it happens?

The National Native Addictions Partnership Foundation (now the Thunderbird Partnership Foundation) effectively outlined and defined key risks in three main categories. These and others are included below and can provide a good starting point when you are assessing your risks and developing your risk management strategy.

Operational Risk **Risks that relate to the delivery of services, including all factors that can impact the operations of your health organization.**	**Resource Risk** **Risks that relate to resources used by the organization to accomplish its objectives.**	**Compliance Risk** **Risks that relate to compliance with regulations, policies, legal agreements, or legislation.**
Quality Services Risk that the delivery of services is compromised due to inappropriate planning that may result in an adverse outcome.	**Human Resources** Risk of a lack of skilled, qualified, motivated, and committed staff to ensure good management and quality services.	**Health and Safety** Risk that the organization does not provide a safe working environment for its staff.
Board Governance Risk that the organizational structure, decision-making, governance, internal culture, and communication do not support the strategic direction of the organization.	**Financial** Risk that the organization lacks sufficient capital and operating funds to provide appropriate services. Also includes the risk of financial mismanagement.	**Environment** Risk that the organization is negatively affected by environmental factors or is not environmentally friendly.
Operations and Client Support Risk that the operations do not efficiently and effectively support the needs of the organization and its clients.	**Resource Availability** Risk that resources may be reduced due to changes in political priorities or to budget reallocation.	**Legal and Regulatory** Risk that the organization is exposed to legal liability because of non-compliance to legislation, regulatory standards, and contractual agreements.

Operational Risk **Risks that relate to the delivery of services, including all factors that can impact the operations of your health organization.**	Resource Risk **Risks that relate to resources used by the organization to accomplish its objectives.**	Compliance Risk **Risks that relate to compliance with regulations, policies, legal agreements, or legislation.**
Reputation and Public Image Risk that the organization's public image is negatively affected by issues related to effectiveness, efficiency, attention to client needs, media coverage, and relationships with governments.	**Data, Information Systems, and Technology** Risk that the use of data and technology are not supporting current and future needs of the organization; are not operating as intended; or are compromising the integrity and reliability of data.	**Policies** Risk of non-compliance with established direction and guidance as provided in policies, guidelines, and directives – both internal and external to the organization.
Politics Risk that changes in the political leadership and community administration may negatively impact the effective operations of the organization.	**Physical Assets** Risk that relates to the acquisition, maintenance, and disposal of physical assets including buildings, equipment, and program materials.	**Standards** Risk of non-compliance with establish relevant standards and the requirements of the applicable professional regulatory bodies.
Community Dynamics Risk that community discord or family allegiances will negatively affect the effective operations of the organization.	**Natural** Risk that natural disasters or situations can compromise the ability of the organization to provide quality services.	

There are three key steps in risk management.

1. Risk identification – what are all the possible risks your organization faces?
2. Risk analysis – what is the probability of an event happening, and the impact it will have if it does happen?
3. Risk mitigation – develop a plan for (1) avoiding the potential risk, (2) reducing the impact of the risk, and (3) coping with the impact of the risk if necessary.

A useful approach to assessing risks in your organization and developing a risk management plan is to host sessions with your management group and your staff. This will provide several benefits:

- You will include people who are seeing risks from different perspectives;
- Your leadership and staff will feel included and involved;
- You are more likely to develop a robust risk management plan.

Ensure that your organization understands how important this is. Communicate what you are doing and why – that your organization is doing this to better ensure everyone's safety. Build a supportive culture of "***Good catch***!" when risks are identified, rather than a "blame" culture.

HUMAN RESOURCES

Human resources (HR) encompasses many key aspects of your health services. HR focuses both on the people who provide your health services (personnel) as well as the policies and procedures that underpin the services. It's difficult to have a strong well-functioning health service without effective HR policies and procedures that support the personnel. This section will look at both the people side of HR – the types of health providers that your organization requires and has resources to support, and the process side of HR – the policies and procedures that provide structure for your organization.

HUMAN RESOURCE PLAN

To plan for the personnel requirements of your health services, you need to know what types of programs and services you will be providing. Your priority-setting and planning process so far has given you a clearer idea of the human resources you require to achieve your goals. Review current staffing arrangements to consider both current and emerging community health needs, present and planned health programs, and existing and future service partnerships. Your HR plan can directly link to the priorities in your Health and Wellness Plan, as these will directly affect your staffing options. You may already have the personnel employed in your centre or you may need to initiative some staffing activities.

Some questions to ask might be:

- What services do our clients need?
- Which services can we provide?
- What are the high-priority services?
- What service partnerships with other organizations do we need to establish to provide access to services that we cannot provide?
- What healthcare providers will provide the services?
- What hours will services be available on-site and off-site?
- What after-hours services will be provided, by whom, and for what clients?
- How many nurses or other healthcare providers will be on duty at any given time?
- How will we manage the need for extra personnel for peak periods, replacements for sickness, vacation, etc.?

This gives you the information you need to create a Human Resource Plan. This plan will ensure that you have the right staff to meet your community's current and future healthcare needs.

Your Human Resources Plan should contain the following items, among others:

- A determination of how many staff of what category you need to hire to meet clients' needs using clear criteria (i.e., competencies required, etc.);
- Cultural competency requirements and training that includes community history and current profile;
- Competency-based recruitment and selection of personnel with the right skill mix to safely and effectively provide services;
- Regularly updated job descriptions with clear roles and responsibilities;
- Services provided by qualified professionals (e.g., nurse practitioners, nurses, physiotherapists, etc.) and non-regulated healthcare providers (e.g., Diabetes Educators, mental health and addictions resources, etc.);
- Qualified support staff (e.g., clerical, housekeeping staff, etc.);
- Guidelines to ensure that personnel work within their respective scopes of practice;
- Standardized employee files;
- Employee development and training;
- Coaching, mentoring, and annual performance appraisals;
- Succession planning for key positions;
- Collaborative practices and interdisciplinary protocols;
- Ongoing professional and cultural support and supervision.

A few examples of personnel changes to meet current or future human resource needs might include:

- Hiring a part-time assistant Health Director;
- Changing a full-time position to part-time or vice-versa;
- Changing a contract position to a salaried employee position or vice-versa;
- Reorganizing the duties of positions with similar responsibilities;
- Modifying existing positions or job descriptions to meet identified needs;
- Creating a new position with a completely new job description to meet identified needs (e.g., Nurse Practitioner, nurse-liaison, quality-risk manager, etc.);
- Creating shared positions with personnel from local hospitals or health centres, etc.;
- Developing service agreements with other care providers (e.g., for after-hours services).

Be aware of your flexibility to reallocate or change staffing categories to fit your community needs, found in your Contribution Funding Agreement. Certain government funding programs have specific requirements for program activities, as well as for related financial and program reporting, while others allow for community-determined allocations. For example, if a community receives funding from the Building Healthy Communities program for a half-time coordinator for a mental health initiative, a full-time community health employee might coordinate this mental health initiative and also work on a part-time initiative funded by Brighter Futures, as long as the accountability requirements of both programs are met.

THE PERSONNEL

This section outlines the roles and responsibilities of two of the regulated community-based health professionals (nurses and dental personnel) that work in many communities.

Nursing

Nurses work closely with the members of the health team to support health service delivery. A nurse may provide clinical care, education, management, policy and program development, evaluation, and research. The ability of a nurse to provide specific services depends on the permitted scope of practice, personal competency, education, training, and experience.

This section will assist you in understanding the services that community-based nurses may provide, the conditions under which they work, and how they can help meet your community's needs.

There are three separate groups of regulated nurses, registered nurses (two types, registered nurses and nurse practitioners), registered psychiatric nurses, and licensed practical nurses. The following is a brief description of each group. Refer to the regulatory body in your province/territory to clarify the scope of practice, as these may differ across jurisdictions.

Registered Nurses (RN) – An RN provides health services to all types of people, including those who are very ill, unstable or have complex health problems. In addition to direct client care, an RN may be involved

in community development, management, education, public health programs, health promotion initiatives, design and evaluation of health services, strategic planning, and policy.

Nurse Practitioners (NP) – An NP is an experienced RN who has taken additional education and training to prepare them to make a diagnosis, order and interpret tests, and prescribe treatment, including medications. These nurses provide direct health services in primary care and community health, serve as clinical practice experts, consult and advise other nurses, and provide education and leadership in evidence-based practice.

Registered Psychiatric Nurses (RPN) – An RPN may provide therapy for mental health concerns, grief counselling, and crisis intervention. They develop mental health programs for specific health issues and as mental health experts, RPNs provide consultation support to other healthcare providers.

Licensed Practical Nurses (LPN) – An LPN completes a training program of 12-18 months. They provide nursing services to people who have stable health problems and need routine care, working closely with registered nurses to ensure high quality and safe client care. The LPN participates in activities such as education, health promotion, and supports community development programs.

(Note: in Ontario, this designation is called Registered Practical Nurse [RPN]. The term LPN is used here to reflect the national scope of this Guide and to reduce confusion with the term Registered Psychiatric Nurse [RPN].)

When reviewing nursing roles within a health service delivery model, consider the following when making a decision about the types of services you require:

- Availability and accessibility of health services outside the community;
- The level of funding your community receives for nursing positions including the resources available to support nurses' practice;
- The scope of practice, legislation, and regulations under which the nurses practice;
- The opportunities for partnerships (e.g., with other health service providers);
- The opportunity to ensure safe and complete health care, in consideration of the needs of the community to match the services that nurses can provide.

Nurses need ongoing education and training to maintain professional competencies as well as special education to meet the specific care needs of a community.

Dental Providers

Dental services can be provided by five different oral healthcare providers. They work together to deliver dental services to communities. Refer to the regulatory body in your province/territory to clarify the scope of practice, as these may differ across jurisdictions.

Children's Oral Health Initiative (COHI) Aide – A COHI Aide is a community member who has been trained by a professional dental provider to provide certain dental services in their community (e.g., application of fluoride, oral health sessions, etc.).

Dental Assistant – The dental assistant's role includes clinical chair-side care, client intra-oral care, radiography, oral health education and promotion, laboratory skills, business administration, and equipment maintenance.

Dental Hygienist – Dental hygienists are registered oral health professionals who perform a variety of roles including clinical therapy, health promotion, education, administration, and research in a variety of practice environments.

Dental Therapist – Dental therapists are primary dental healthcare providers who work in community nursing stations, health centres, and school-based dental clinics. They are trained to perform basic clinical dental treatment and preventative services.

Dentist – Dentists diagnose and treat problems with patients' teeth, gums, and related parts of the mouth. They provide advice and instruction on taking care of the teeth and gums and on diet choices that affect oral health.

When reviewing oral healthcare provider roles, consider:

- The availability and accessibility of dental services outside your community;
- The level of funding your community receives for dental positions including the resources available to support dental practice;
- The scope of practice, legislation, and regulations under which oral healthcare providers practice;
- The opportunities for partnerships (e.g., with other health service providers);
- The opportunity to ensure safe and complete dental care, in consideration of the needs of your community to match the services that different oral healthcare providers can provide;
- The need for oral healthcare providers to have ongoing education and training to maintain competence as well as special education to meet the specific care needs of a community.

Supervision and the Special Interchange Arrangement

The Special Interchange Arrangement (SIA) was implemented to give First Nations the ability to include health professionals who are not recognized under some provincial/territorial health acts due to lack of applicable legislation. These include dental therapists and nurses working in an expanded role.

Under the SIA, participants are appointed to ISC-FNIHB positions (term or indeterminate) through an Interchange Canada Letter of Agreement for dental therapists and for nurses working in an expanded role. These health professionals function as members of the community health team under the day-to-day direction of a health committee. Professional supervision is provided by ISC-FNIHB staff. The ISC-FNIHB Regional office can provide you with details about supervision and the SIA.

Professional Supervision and Consultation

Your Health and Wellness Plan (and your Personnel Policies and Procedures) should include detailed information on how professional supervision and consultation will be provided for health professional employees including nurses and dental therapists/hygienists. The Health and Wellness Plan should indicate:

- Where, when, and how often this supervision/consultation will be provided;
- Who will provide this service;
- The kind of professional supervision/consultation they will provide;
- Which healthcare staff they will be supervising;
- The estimated cost of each service.

Communities may access these services from the following sources:

- A local or provincial/territorial health unit;
- A provincial/territorial association;
- ISC-FNIHB health professional staff;
- The community's own professional staff (employed or contracted);
- Other sources that may be available (e.g., voluntary, charitable, and private providers).

The process for accessing these services and the rules and regulations surrounding them may vary between provinces. Contact your ISC-FNIHB Regional office for information on the process applicable to your community.

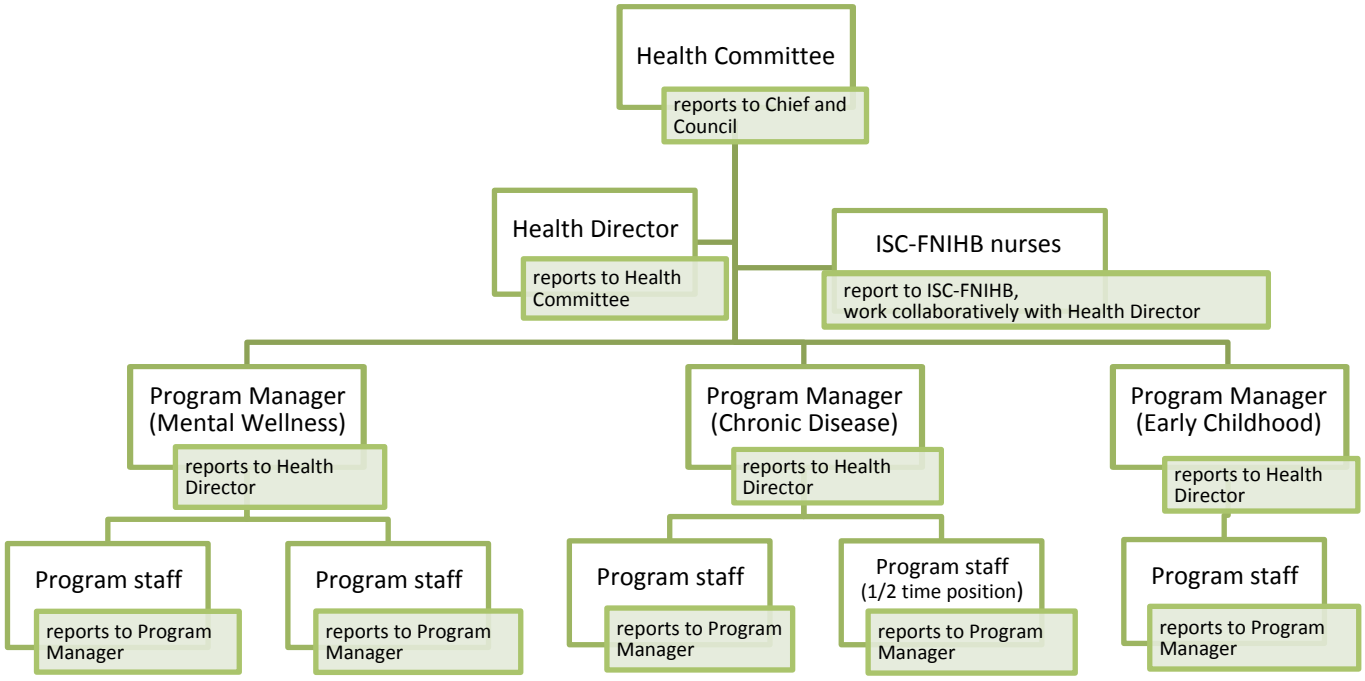
Professional supervision is required as follows:

Community Health Nurse	Senior Qualified Nurse
Personal Care Worker Licensed Practical Nurse	Registered Nurse
Dental Therapist/Hygienist	Licensed Dentist

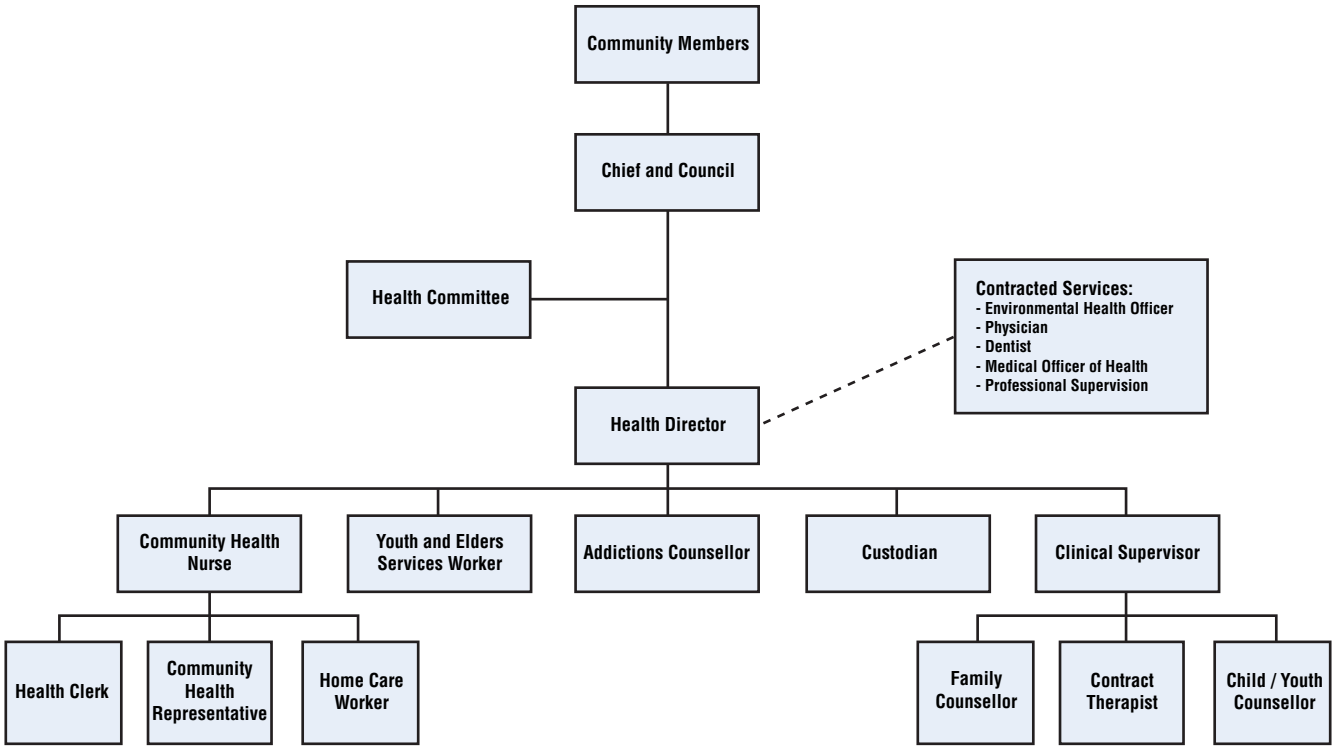
Refer to the regulatory body in your province/territory to clarify the supervision requirements, as these may differ across jurisdictions.

THE ORGANIZATIONAL CHART

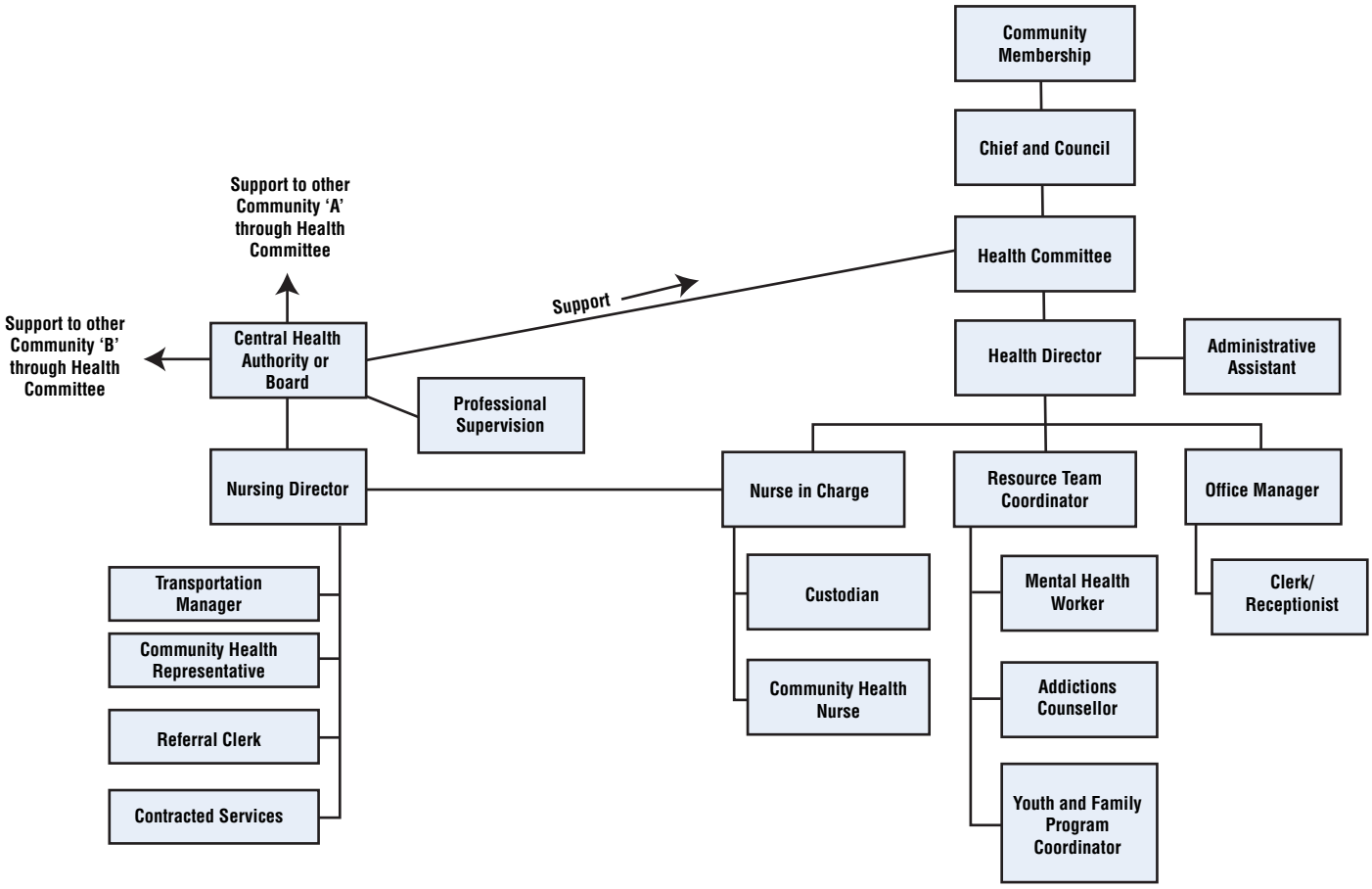
Once you've clarified your organization's health personnel positions, it's important to lay out the organizational structure, most often done through an organizational chart. This is a graphic representation of your organization, the positions and how they relate to each other, and the governance and management team structures under which the organization functions. This can be created easily in Word, using the SmartArt function. The simple example below is for a small organization, with nurses provided through an agreement with ISC-FNIHB.



The example below shows an organization with several outside contractors.



Another example shows a multi-community health structure.



The descriptive text accompanying the organizational chart should briefly clarify the following:

- Lines of authority, supervision, and reporting relationships;
- Services that are provided to the community by ISC-FNIHB and services provided "out-of-community," such as hospitals and other treatment centres;
- The relationship between the Health Committee and the community leadership.

The organizational chart is a helpful tool to illustrate your structure and accountabilities and should be available to all staff.

HR POLICIES AND PROCEDURES

Your organization's human resource policies are extremely important documents and can make the difference between a well-run and effective organization and one that is constantly dealing with internal issues. Your human resource policies clarify the practices that ensure fair and consistent treatment of all employees (including professional, para-professional, and contracted staff) and help make employees (including supervisors) aware and accountable for their responsibilities.

Here are some things to consider when creating human resource policies:

- Check with other organizations to see if they'll share their policies that you can use as templates, rather than reinventing the wheel. Modify them to suit your organization.
- Keep your policy manual to a manageable size. Instead of writing a policy to deal with one particular incident, consider ways of broadening an existing policy so that the incident is covered. It's most effective if you can keep each policy down to one or two pages.
- Have a lawyer who understands labour law review your policy manual. A lawyer can help you to write policies that minimize risk (and reduce the possibility of legal problems) or let you know what could happen if you don't follow the policies you set. Ensure that the policy isn't written in 'legalese' but in simple language that everyone can understand.
- Get staff involved in reviewing and inputting to the policies to ensure they remain current. All employees should have access to the policy manual; include the policies in employee handbooks and your orientation package.
- Have all employees read the human resource policies. For certain policies, such as the Conflict of Interest policy, it's best practice to have each employee sign a form stating that they have read it.
- The policy manual should state that:
    - The purpose of policies is to provide guidelines regarding the relationships between employees and the organization.
    - The Board/Health Committee has authorized the policy.
    - Policies are subject to change as per official decisions of the Board/Health Committee.

The types of human resource policies that most organizations have can be clustered into the following key themes (depending on the size and services of your organization, you may not require all of them):

1. Employment Policy, Roles, and Responsibilities

    a. Purpose of the policies
    b. Definition of terms
    c. Employer's responsibilities
    d. Personnel responsibilities
    e. Employment principles
    f. Employment equity
    g. Record-keeping for human resource documents

2. Health and Safety
    a. Health and safety requirements
    b. Reporting of safety incidents (including adverse events and near-misses)
    c. Security for home visits
    d. Prevention of workplace violence

3. Recruitment and Selection
    a. Job descriptions
    b. Recruitment advertising
    c. Recruitment and selection of employees
    d. Recruitment and selection of Executive Director
    e. Pre-employment reference checks
    f. Criminal reference checks

4. Orientation
    a. Orientation program

5. Salary and Benefit Administration
    a. Salary administration
    b. Employee benefits
    c. Personnel/Payroll records
    d. Employee Assistance Program

6. Terms of Employment
    a. Attendance and absenteeism
    b. Code of conduct
    c. Conflict of interest
    d. Confidentiality
    e. Dress code
    f. Expense reimbursement
    g. Hours of work
    h. Layoff
    i. Leaves of absence
    j. Letters of reference
    k. Media relations
    l. Overtime/lieu time
    m. Paid holidays
    n. Retirement
    o. Safe handling of medications
    p. Sexual harassment
    q. Sick leave
    r. Social media use
    s. Staff meetings
    t. Travel expenses
    u. Vacation
    v. Copy of draft letter of offer
    w. How to submit grievances

7. Performance Appraisals
    a. Performance appraisals
    b. Exit interviews

8. Career Development
    a. Professional development and training
    b. Secondments
    c. Student placements

9. Discipline
    a. Progressive disciplinary procedures
    b. Conflict resolution and appeal procedures

10. Termination of Employment
    a. Employee resignation
    b. Termination of employment
    c. Severance

Job Descriptions

The job description is a key element of the hiring process and sets up the orientation, supervision, and training of employees. A job description is a written, official record for a particular job. The job description includes:

- Title and Classification – the name of the position, its classification (e.g., full-time, part-time, etc.) and to whom the position reports;
- Summary – a brief overview of the position;
- Responsibilities – a more detailed description of what's involved;
- Job Competencies – the knowledge, skills, abilities, education, and experience needed for the job;
- Basic Terms of Employment (optional) – salary range, benefits;
- Performance Standards (optional) – minimum expectations of performance for the position.

Documentation and Record Keeping

Your organization needs to have a policy for managing human resource documents. The policy should be straightforward and clear and outline which types of documents need to be kept, where they are to be kept and for how long. It is critical that human resource records be kept securely locked up and only authorized people be allowed access to the files.

When you hire a new employee, the following documents should be put in their employee file:

- Completed application form;
- Resumé, cover letter, and reference letters;

- Interview notes;
- Signed letter of offer;
- Job description;
- Other signed agreements (e.g., Confidentiality, Conflict of Interest, etc.);
- Criminal records check and child abuse registry check documents (where applicable);
- An employee information form, which must include;
    - Full name
    - Salary and pay schedule
    - Social Insurance Number (SIN)
    - Employee address
    - Date of birth
    - Employer address
    - Date of hire

The following items aren't required on an employee information form, but you may want to include them:

- Emergency contact information;
- Benefits information.

For an employee with driving responsibilities, you will also want to include copies of:

- Their driver's license;
- Any additional required certification;
- Their vehicle registration and insurance (if they are using their own vehicle).

In addition, over time you will add other documents to the employee record, such as all completed performance appraisals, letters of promotion, and any records of disciplinary action.

Confidentiality and Privacy

Your personnel policies and procedures should describe how you plan to ensure confidentiality of clients' medical information, healthcare personnel records as well as any other sensitive organizational information; whether in verbal, paper, or electronic format. Confidentiality procedures must show who has authority to authorize access to client records, HR records, and other sensitive organizational information, how security will be maintained, who the organization will delegate to be responsible for this (e.g., designated Security Officer) as well as who will have access to confidential information and under what conditions (e.g., accompanied by the Security Officer etc.).

Include the procedures to ensure protection of confidential information while the facility is open and during off-hours. Confidentiality procedures should consider confidential information kept in filing cabinets, in computers, on employees' desks, and in other work areas.

When dealing with client records, clear policies are also needed related to sharing client information (e.g., only with the client's written consent, on a "need to know" basis, never in a public setting, only with people part of the circle-of-care, etc.). Court-ordered release of information should also be addressed. Your funding agreement includes a provision on respect for the confidentiality of information of a personal medical nature in accordance with the federal ***Privacy Act*** and applicable provincial and territorial laws. In addition, the Agreement includes clauses that ensure community respect for confidential information relating to the affairs of the federal government, and government respect for confidential information relating to the affairs of the community, both in accordance with the ***Privacy Act*** and the ***Access to Information Act***.

Both ISC-FNIHB and your community have obligations with respect to medical records. Your community has responsibility for maintaining and securing medical records in your possession and must have procedures for the safe, practical management of those records. Legislation on the management of medical records varies from province to province and your community should develop procedures in accordance with the relevant provincial/territorial legislation. Check with the ISC-FNIHB Regional office to learn more about the provincial/territorial legislation on medical records.

Additionally, communities should also develop a protocol for dealing with inappropriate or accidental release of confidential information. With this in mind, communities are encouraged to require all employees and Board Members to sign an Oath of Confidentiality annually. The Health Committee should ensure that the Oath of Confidentiality form complies with the most up-to-date federal and provincial/territorial privacy legislation. Before signing such an oath, however, employees and Board Members should receive training about their obligations and responsibilities concerning privacy and confidentiality and about best practices for maintaining confidentiality procedures.

LIABILITY AND MALPRACTICE INSURANCE

When a First Nation Health Committee is mandated to plan and direct community health programs, it requires liability insurance. Your Health Committee must have liability insurance that covers Health Committee members, employees, and contractors for actions in the performance of their duties and for accidents on the premises where health programs are provided. As an employer, a community is legally responsible for any harm or damage resulting from its own activities and those of its employees including professionals, para-professionals, and support staff.

Coverage for members of employee groups, for example Community Health Representatives (CHRs), Environmental Health Officers (EHOs), addictions counsellors, and health support staff (e.g., clerks, receptionists, janitors) is usually provided through the community. For professional healthcare staff (e.g., nurses, physicians, dentists, dental therapists/hygienist), personal liability and malpractice insurance coverage is usually available through their professional associations. In any case, the community must ensure that all professional contractors and staff are registered or licensed with provincial/territorial professional regulating authorities and that they have up-to-date liability and malpractice insurance with the appropriate coverage.

To obtain liability insurance coverage, a First Nation community may wish to join a provincial/territorial hospital or healthcare association and secure coverage through this organization. This type of membership will also provide a community with a valuable network of healthcare organizations.

If this type of membership is not available, the community should review coverage options directly with insurance brokers and companies.

Regardless of the source of the insurance coverage, it is recommended that each year, you review your situation and ensure adequate levels of liability and malpractice coverage for an appropriate range of protection.

Your Health and Wellness Plan document should include:

- Information on the coverage for each type of insurance (e.g., malpractice, liability, and property insurance) to be purchased for the health program;
- Cost of all insurance types (listed in the annual budget expenditures);
- The name of the company that will provide the insurance;
- Proof of types of coverage and liability amounts for staff and contract professionals whose professional membership includes liability insurance coverage;
- Procedures for annual confirmation by professionals that their liability coverage is adequate.

TRAINING

In a Health and Wellness Plan, each community is required to include a plan for training all their employees. Your Training Plan will apply to both community-based workers and trained professionals. All your employees

need ongoing training, professional development, and refresher courses throughout their careers to stay up-to-date and to improve their skills and expertise to continue to provide safe care. Regular training ensures that qualified personnel will be able to manage and deliver high quality, safe health services.

All professional staff require regular training to provide specialized care and to remain certified/licensed in their respective fields. For example:

- Nurses providing primary healthcare in remote and isolated communities must have the competencies and be qualified to provide advanced care. For planning purposes, your organization will need to ensure all nurses have the required mandatory courses (e.g., Advanced Cardiac Life Support, Immunization, Controlled Substances, etc.) and any other courses that your organization either requires or suggests.
- They must be registered in their province of work to practice. This registration requires proof of ongoing continuing education as one demonstration of competency.
- Community Health Nurses should have appropriate training in health promotion, disease prevention, and public health (i.e., nurses who immunize must meet provincial/territorial regulations).
- All Environmental Health Officers must have a Certificate in Public Health Inspection issued by the Canadian Institute of Public Health Inspectors (CIPHI). (Any community staff working in your Environmental Public Health Program must be supervised by an Environmental Health Officer with a Certificate in Public Health Inspection.)

Measure the training outcomes using indicators set during the performance discussions you hold with your teams.

Depending on the job responsibilities, additional training, certifications, and cross-training to facilitate collaboration and succession planning should be considered for all health team members (e.g., LPNs, housekeeping personnel, drivers, home health aides, diabetes educators, cultural practitioners, support workers, etc.) Some examples are:

- Cardiopulmonary Resuscitation (CPR)
- Case Management
- Client and Family Centred Care
- Collaborative Practice
- Coughing Etiquette
- Cultural Competency
- Disclosure
- Emergency and Disaster Response
- Ethical Decision-Making
- Falls Prevention
- First Aid
- Immunization Protocols
- Infection Prevention and Control
- Hand-Hygiene training to staff (annually)
- eHealth Tools (e.g., Telehealth, digital health records, and public health surveillance)
- Informed Consent
- Interdisciplinary Teamwork (Skills and Tools)
- Leadership Skills
- Management and Prevention of Violence (e.g., de-escalation)
- Medication Management
- Nurse Safety Awareness Training (NSAT)
- Palliative Care and End-of-Life needs
- Patient Safety
- Quality Improvement
- Risk Management
- Pandemic Response
- PDSA Methodology
- Privacy
- Reprocessing (for appropriate staff)
- Road Safety (for appropriate staff)

- Safe Use of Equipment
- Safety Event Reporting
- Safe Use of Infusion Pumps
- Self-Care Management for Clients
- Smoking Cessation
- Strength-Based Approaches and Practices
- Suicide Assessment
- Transportation of Dangerous Goods
- Trauma-Informed Care
- Workplace Hazardous Materials Information System (WHMIS)
- Wound Care

Communities are encouraged to develop a policy on professional development as part of their personnel policies. The policy would let employees know what kinds of training will be supported, how much the employer will contribute toward the cost, and how to apply for financial assistance.

The Training Plan should:

- Identify the critical competencies required by all health team members in the context of their work;
- Describe the immediate and long-term training requirements of all health team members, the Health Committee, and the Board;
- Identify training priorities, related funding, and low-cost training opportunities (e.g., webinars);
- Identify the number of employees by job categories, their training needs (based on the health priorities and the services to be delivered), how and where the training will be provided, and the approximate cost;
- Include the list of certifications required by job categories and a plan for re-certification;
- Consider the financial support for training from ISC-FNIHB, as well as other sources. If multiple sources of funding are obtained, it should be reflected in the budget for the Training Plan;
- Monitor training activities (e.g., types of training offered, training hours, participation rates, etc.) to ensure that the objectives of the Training Plan have been met and to help guide decisions for future training;
- Focus on areas that have been or could improve the safety of clients and healthcare personnel (e.g., de-escalation techniques, safe driving, falls prevention, managing medications safety, etc.).

A Training Plan may be required to be submitted to ISC-FNIHB. However, a community developing a first Health and Wellness Plan can submit a preliminary Training Plan, if necessary and submit the final version to the ISC-FNIHB Regional office within six months of implementation of the Health and Wellness Plan.

A template and example for a one-page overview of your Training Plan that could be used is shown below.

Target Group/ Individual	Training/ Learning Area	Relates to/ requirement for	Training Plan Action	Timeframe	Notes
clerks	Client records	confidentiality	Attend course Confidential Record-keeping	Sept-Dec	1 clerk attend per session

CHANGE MANAGEMENT

Managing change is essential when working in organizations, and in health organizations especially. Managing change involves people and systems and finding a way to move from where you are now to where you want to be. Your Health and Wellness planning is one area that can be greatly affected, as you make a plan to improve wellness.

Successful change isn't only based on project management, or vision, or strong personalities. The path to successful change leads beyond those elements and activities; it recognizes that organizational change happens when individuals change. Therefore, to effectively manage change in an organization or community, the focus needs to be on understanding the impacts at an individual level.

Although it seems intuitive that everyone will be on board for change if it means improvements, the reality is that people are often resistant to change. They may feel that they have always done things this way and don't see the need to change; they may be personally invested in how it works now, especially if they've been involved in the development; they may be afraid that they won't have the skills or training to do the work in a new way; or they may just not understand what it all means.

In order to help individuals move through change, there are five key elements to be considered.

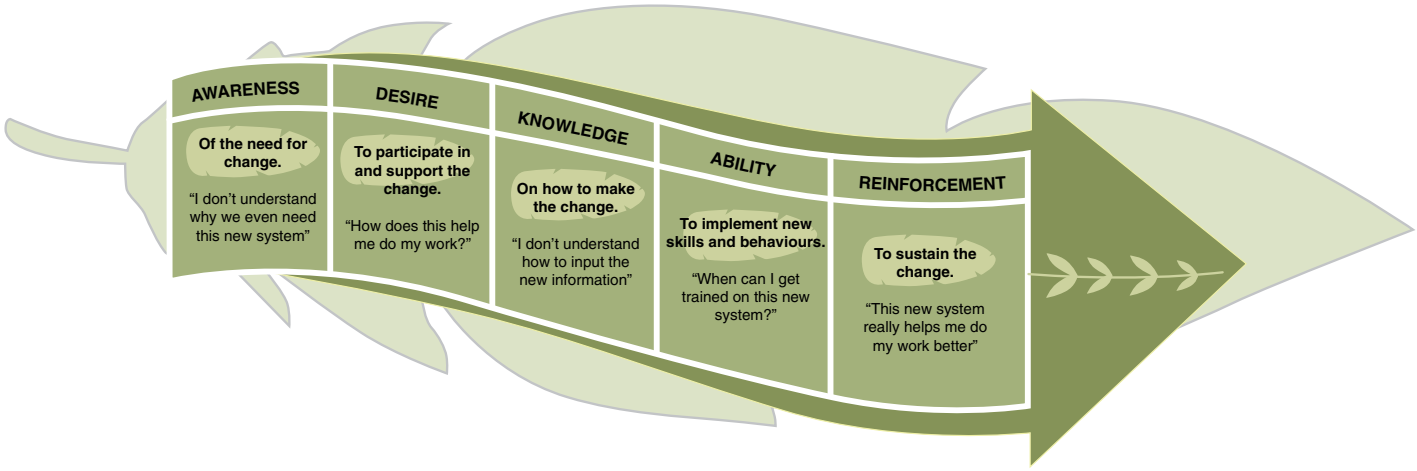
1. Awareness – this represents a person's understanding of the nature and the need for the change. Individuals need information about the need for the change, as well as understanding "***what's in it for me***".

2. Desire – this represents the willingness to support and engage in the change. Individuals need to feel that they're able to make a choice and want to move forward.

3. Knowledge – this represents the information, training, and education that is necessary to know ***how*** to change. Individuals need to have access to processes, tools, systems, skills, roles, and techniques they will need to implement the change.

4. Ability – this represents the accomplishment of the change, by turning knowledge into action. Individuals need to have the capacity to implement the change in a good way.

5. Reinforcement – this represents the factors (internal and external) that sustain the change. Individuals need to feel reinforced, both internally (though feeling personal satisfaction) and externally (through being recognized, rewarded and celebrated).



Each of these must be in place in order to move to the next stage.

- ***Desire*** cannot come before ***awareness*** because it is the awareness of the need for change that triggers the acceptance or resistance to that change.
- ***Knowledge*** cannot come before ***desire*** because people do not seek to know how to do something that they do not want to do.
- ***Ability*** cannot come before ***knowledge*** because it's not possible to implement what is not known.
- ***Reinforcement*** cannot come before ***ability*** because one can only recognize and appreciate what has been achieved.

Once the changes have been identified, following this approach provides a framework and a sequence for managing the individual side of change. It provides a solid foundation for change management activities including assessments, communications, coaching, training, and recognition.

A few considerations:

- The stages can pertain to all levels within your organization – governance, leadership, management, employees, and stakeholders.
- At any given time, your organization will likely have people at all stages, so ensure there are supports for each stage.
- Ensure there are activities in place to help individuals as they move through each stage. (i.e., don't leave someone in the ***desire*** stage, without providing supports to move to the ***knowledge*** stage).
- Ensure a welcoming and non-judgemental environment to help individuals as they progress through the stages.

Consider what changes will be required because of your Health and Wellness Plan. Now, assess how you will provide support and guidance for your teams and your community, along each stage of this approach. This will help you reduce the resistance that naturally comes with change and will create a more engaged organization.

LINKAGES

First Nations concepts of health incorporate mental, physical, spiritual, emotional, and social aspects. All elements of health, work, family, culture, and community are connected, with the health and well-being of individuals and communities interdependent and equally important.

Community health and wellness planning cannot be done in isolation by the health department. One of the goals of this Guide is to promote a shift from working in silos to working collaboratively across the social determinants of health, an inclusive process. Ensuring that you have strong and relevant linkages throughout the process is key.

The social determinants of health approach explains that being healthy isn't only about lifestyle choices or the healthcare system, although both are vitally important. In fact, the health of each community member is based more on a variety of determinants related to health, social, education, employment, economic development, and other factors.

The ***First Nations Mental Wellness Continuum Framework*** (2015) identifies the Indigenous social determinant of health as environmental stewardship, social services, justice, education, lifelong learning, language, heritage and culture, urban and rural, land and resources, economic development, employment, health care, and housing. Expressed simply, social determinants of health are the social and economic conditions which determine the health of your people.

It may be challenging to apply a 'social determinants of health' approach in a community setting which may receive funding based on specific project definitions and outcomes. However, this underscores the need for a collaborative community approach to health and wellness planning, one that ensures involvement from all relevant community sectors and outside partners.

DEVELOP
THE DRAFT

So, what could this look like? Your Health and Wellness Planning Group should include representatives from the other service sectors in your community, as they have valuable insight that could be beneficial for planning. If you've conducted a robust community assessment, then you've likely already included several community partners in your surveys, focus groups, or interviews. With whom can you partner up to achieve better health and wellness? In listing your assets, did you include your linkages and partnerships? They are considerable assets and can make a significant contribution to a more effective continuum of care.

Make note of your external partners, such as other communities, Tribal Councils, Regional Health Authorities, acute care centres in a neighbouring city, your ISC-FNIHB Regional office, not-for-profit associations such as the Canadian Diabetes Association, corporations, and others. What role do/could they play in helping to maintain and strengthen your community health and wellness? For many linkages and partnerships, it's effective to have a Memorandum of Understanding (MOU) or some other agreement that outlines the reason you are partnering, the governance or authority of the agreement, the roles each partner will play, as well as any other expectations or protocols.

Identify all your organization's linkages and partnerships, both internal and external. Then note what role they play, or how they are involved. How would you like them to be involved? List some ways you could strengthen the linkages and partnerships, (or maybe it is good the way it is). This is a good idea to incorporate during a planning session with your team; having more people involved would provide a more complete list. If it helps, use a template like the one below (***some examples are in italics,*** add as many lines as you need for each category of linkage/partner).

Linkage/Partner	How they are involved now	How they could be involved more	Ideas to make it happen
Other community sectors/departments			
Education	*Support immunizations*	*Incorporate "safe sexuality" training in middle school curriculum*	*Who else has done this?* *Develop presentation* *Meet with principal*
Other Communities			
Name of neighbouring community	*Occasionally plan combined events for Elders*	*Many opportunities to share and collaborate*	*Discuss with our team first* *Reach out to their Health Director*
Regional Health Authority			
Public Health	*Provides information brochures*	*Help train on new public health surveillance system*	*Set up meeting with our contact*

Linkage/Partner	How they are involved now	How they could be involved more	Ideas to make it happen
Other Health Providers			
Physiotherapist	*Provides services once a month*	*Help train an assistant for routine practices*	*Discuss with PT* *Identify potential role*
Tribal Council, PTO, etc.			
Diabetes Nurse	*Provides diabetes education 2x/month*	*Offer video sessions through e-Health*	*Speak with Tribal Council*
Not-for-Profit Associations			
Accreditation Canada	*Provides accreditation support*	*No suggestions*	
Industry			
Nike	*Provides training supplies for the school*	*Support the new community walking path*	*Reach out to community liaison representative*
Academic Institutions			
Saskatchewan Polytechnic	*Provides training*	*No suggestions*	
Governments			
ISC-FNIHB	*Provides Community Liaison Officer (CLO)*	*Participate in the planning focus groups*	*Discuss with CLO*

CAPITAL

It is important to consider how health programming will be delivered and understand the associated space requirements. It is possible that a major capital project, including a building expansion or a new construction, will be identified as a means of upgrading an existing site to safely and efficiently meet health services delivery needs. It is also possible that minor capital projects, which generally relate to building serviceability issues, including renovations and repairs, will be identified. If you believe there is a need for a major or minor project at your health facility, contact your ISC-FNIHB Regional office to ensure the proper process is followed.

Major projects

ISC-FNIHB has some funding available for major capital projects and considers funding such projects on a case-by-case basis. Due to the increased risk associated with funding major capital projects, all are subject to a rigorous review process and need to be supported by documentation that outlines a sound analysis and justification for the project before being submitted for consideration.

DEVELOP
THE DRAFT

You can expect to work with the ISC-FNIHB Regional office to undertake a formal assessment of the healthcare service needs that the project is intended to address. This assessment will serve to determine your community healthcare needs, confirm eligibility of health program funding for your community, and update your community health program planning documentation. The outcome of this work is documented in a formal report (***Community Needs Assessment***[1]), that provides a comprehensive description of each healthcare service provided/proposed to be provided, including major operating parameters, associated workload, staffing, equipment, and space requirements.

The ***Community Needs Assessment*** forms the basis for establishing an estimate of the operating and capital funding requirements necessary to carry out the project. Once this is complete and based on the information contained in the ***Community Needs Assessment***, additional documents are prepared, including a functional plan, which defines the design and spatial requirements associated with a specific health program or service, and a business case. At this point, the region will prioritize the project for funding and it will be included on the regional Long Term Capital Plan (r-LTCP) for consideration and approval.

Minor projects

Serviceability risks to First Nation health facilities are identified through a coordinated approach to inspections and reporting that involves both the First Nation and ISC-FNIHB. There are two main processes by which capital projects relating to existing First Nation health facilities are identified to ISC-FNIHB.

[1] This is a specific document for capital planning and is different from the Community Assessment referred to in this Guide as part of health and wellness planning.

The first process is initiated by you. While undertaking routine maintenance and inspections of your health facility, you may identify capital-related issues that cannot be addressed with available Operations and Management (O&M) funds. In such instances, you would submit a funding request outlining details of the capital need to your ISC-FNIHB Regional office for validation, prioritization and inclusion on the r-LTCP.

The second process is initiated by ISC-FNIHB. As part of the Department's audit and assurance framework, ISC-FNIHB undertakes facility audits/inspections to assess compliance with the terms and conditions of its funding arrangements. These audits/inspections focus on the condition and performance of a facility's infrastructure and buildings, and the performance of the facility's operations and maintenance practices. Audit/inspection results are shared with the First Nation building owner and where findings indicate that immediate action is required to reduce a health and safety risk to staff and/or a disruption in health services, ISC-FNIHB works with the centre to find a resolution. When less critical issues are identified, ISC-FNIHB coordinates with the centre to ensure that they submit capital funding requests outlining details of the capital need to their ISC-FNIHB Regional office for validation, prioritization, and inclusion on the r-LTCP.

GUIDES AND RESOURCES

The following resources provided by ISC-FNIHB can assist in developing the capital program and related services.

Community Needs Assessment template

E-HEALTH

First Nation health organizations and communities are enabling front-line healthcare providers to use electronic health information management and communication system technologies to support the delivery of healthcare services and programs in their communities.

The ISC-FNIHB eHealth Infostructure Program (eHIP) is available to First Nation communities to support their work to continue to modernize, transform, improve, and sustain their healthcare services using eHealth technologies. One of the main priorities eHIP undertakes with communities is to assess needs and implement health system technologies that will provide First Nation community healthcare providers with access to patient information or to other off-reserve healthcare providers in a secure and timely manner. The main priority is to support implementation of health system technologies that work to enhance and improve healthcare service delivery in First Nation communities.

To carry out its mandate, eHIP also acts in partnership with First Nation communities, other federal government departments, provincial governments, regional organizations, and private industry to achieve progress. First Nations are also forming their own linkages and partnerships with other health service providers (e.g., telehealth service providers, Regional Health Authorities, etc.) to provide safe and effective healthcare services.

It should be noted that eHealth refers to specialized digital health information tools and applications. It does not refer to core facility infrastructure needs such as broadband connectivity, computer networks, servers, switch devices, network security, or general IT support for desktop operating systems. While eHealth is dependent on such infrastructure being in place, it is not within the area of eHealth to address these core requirements for all programs and services being delivered out of the community health centre. These considerations would be covered under Capital (for new builds) or under maintenance and utilities for current facilities.

Key eHIP activities include:

- Assisting communities to access some of the following eHealth tools:
    - Telehealth services and/or equipment;
    - Mobile digital health solutions and/or equipment;
    - Public health surveillance systems and/or equipment;
    - Electronic Medical Records (EMR), Community Electronic Medical Records (cEMR), Electronic Health Records (EHR) and other Health Information Management and Communication Technologies (HICT) and/or equipment;
    - Remote presence technologies.
- Community eHealth capacity-building in partnership with First Nation communities and organizations;
- eHealth governance and partnership development.

Meeting the Needs of Communities

First Nations are establishing eHealth services to meet specific needs of their community health services and programs. Communities are encouraged to contact their ISC-FNIHB Regional office to help assist you in identifying your requirements and the best options for eHealth solutions to meet your needs.

Regional Variation and Leveraging Existing eHealth Resources

One of the primary objectives of eHealth is to connect patients, health care providers and patient information across multiple jurisdictions. It is important to be aware of which eHealth resources are already in use in other nearby First Nation communities, regional health authorities (or equivalent), and at the provincial level. There may be opportunities to connect to, learn from, or utilize existing eHealth resources, rather than develop those from scratch. Provincial eHealth programs are an important information resource to explore, and the regional ISC-FNIHB eHealth program can help provide information on what is available. Note that the regional eHealth infrastructure may vary with the availability of providers, services, and the provincial context.

Engaging Prepared and Proactive Staff

First Nation communities will need to have adequate internet access plus a managed service (quality of service, or QOS) to be able to sustain eHealth tools. Working with assistance from the eHIP program in the ISC-FNIHB Regional office, communities can work with their staff to implement and provide on-going management of an eHealth system.

As a first step, communities should assess their health care delivery needs and services, the partners with whom they work to deliver those services, the comfort level of community leadership and staff in taking on new ways of delivery services using eHealth tools, and the technical environment needed to support reliable use of such tools. Readiness assessment tools are available through the eHIP program in the ISC-FNIHB Regional office to help communities with this self-assessment.

It is important for communities to ensure that staff are appropriately trained on all relevant eHealth tools before healthcare providers use them for their patients. eHIP regional staff can assist communities to access training programs and offer on-going capacity building support when required and where possible.

Furthermore, all healthcare professionals using eHealth tools will require training on the privacy and security considerations regarding health information. Associated with each eHealth system is the need to protect a patient's health information, which may be stored in a cloud environment. All professionals need to be aware of and comply with existing policies/protocols, as well as provincial and/or federal privacy legislation and/or policies and professional regulatory body policies before accessing and using an eHealth system. Clinical privacy training is of vital importance and should be considered when selecting eHealth tools.

Purchasing and Maintaining eHealth Applications, Equipment, and Networks

Standards and guidelines need to be followed to keep eHealth equipment and telecommunication networks reliable. They may relate to purchasing appropriate equipment, carrying out preventive maintenance activities, testing equipment after installation, training users, and developing contingency plans. Responsibility for the reliability of eHealth equipment and telecommunication networks may be shared between the community and vendors, and/or between the community and telecommunication providers. In the community, usually a staff person is assigned the responsibility to monitor and maintain the eHealth system, but some communities share this responsibility among several employees so when considering an eHealth system, it is important to evaluate the monitoring and maintenance needs.

Adopting Comprehensive Written Agreements

When two or more organizations are involved in delivering eHealth services (e.g., First Nation community and provincial eHealth agency), communities should have a comprehensive written agreement with each organization (e.g., Information Sharing Agreement, Terms of Use, etc.). The agreement outlines items like reimbursing providers, securing and protecting health information, obtaining informed consent, documenting and storing client health records, and protecting client rights to privacy, confidentiality, and quality care.

Written agreements also address liabilities; the responsibilities of each organization; how to prepare, transmit, and receive data; and how to resolve disputes. Certain guidelines for written agreements may be based on relevant provincial legislation, regulations and/or policies.

eHealth Considerations during the First Nation Community Health and Wellness Planning Process

Broadband Connectivity

- Acquire broadband connectivity management services with quality of service implemented to enable consistency of connectivity.

Telehealth

- Procure appropriate solutions to suit the identified needs of the community and install and certify the equipment (Technical and Site Certification Process), either directly or through a telehealth service provider (varies from region to region).
- Ensure collaboration of external partners (such as the province) and negotiate written service agreement before purchasing the telehealth equipment.
- Design and initiate the workflow process that will facilitate integration of telehealth services into regular service delivery.
- Ensure staff are trained in the use of the video conferencing equipment and the scheduling system and understand the standards and procedures related to usage.
- Develop a change management approach to prepare and support staff and the facility when making organizational changes in eHealth.

Mobile Health

- Incorporate mobile health technologies such as tablets and hand-held devices in the facility for information sharing between healthcare providers and/or to access to a patient's health information.
- Provide tablets to be used with mobile telehealth services.

Public Health Surveillance

- Work with partners to implement a provincially approved system.
- Develop and implement formal eHealth agreements with partner(s).
- Adapt existing information technology infrastructure and acquire staff training (e.g., access to network, hardware, user training, technical support, various software tools as required, etc.).
- Work with partners throughout to ensure sound project management and support organizational change.

EMR, cEMR, EHR and other HICT

- Adapt existing information technology infrastructure and support staff training (e.g., access to network, hardware, user training, technical support, various software tools as required, etc.).
- Work with partners throughout to ensure sound project management and support organizational change.
- Identify and support innovative approaches/best practices that enhance broader eHealth system alignment/interoperability and functioning, such as encouraging knowledge transfer and knowledge exchange, creating community knowledge networks, and community mentoring to support capacity building.
- Ensure appropriate information sharing and terms of use policies are in place.
- Develop a sustainability plan for costs associated with ongoing licenses and support.

Community Capacity Building

- Ensure service delivery is governed in compliance with existing information/data agreements, policies, and/or legislation that clearly identify scope of services, roles, and responsibilities of each partner (community and provincial or federal or private service provider), and provide employee training and plan for any specific conditions that may be required.
- Conduct eHealth readiness assessments and develop organizational and individual training plans.
- Train health professionals, community-based health workers, and community administrative and support staff on eHealth tool use and maintenance.
- Plan for human resources that will manage and maintain eHealth services – these activities could include project management, technical supports, privacy and data security compliance, performance monitoring, and evaluation.

Governance and Partnerships

- Develop and implement integrated and comprehensive plans around eHealth infostructure and public health surveillance activities in collaboration with provincial health departments and First Nations.
- Discuss improving linkages between on and off-reserve health information systems, where applicable, for effective health and wellness planning and programming, and for providing a broader geographical range for a patient's continuity of care.

Additional Supports that may be Required

- Computer hardware like desktops, laptops, and peripherals;
- Medical peripherals for telehealth services;
- Evergreening (replacing at end of operational life) of eHealth equipment;
- Individual and/or organizational licenses;
- On-going eHealth system maintenance;
- Negotiation and development of Service Level Agreements;
- Negotiation and development of data/information sharing agreements;
- IT training plans;
- The sharing or development of best practices, policies, and process documentation.

GUIDES AND RESOURCES

The following resources provided by ISC-FNIHB can assist in planning eHealth services.

Health Infostructure Strategic Action Plan

DATA COLLECTION AND INFORMATION MANAGEMENT

Data collection for your programs and services is a key element of assessing how well your organization is performing or achieving its goals. In the past, data collection was mainly focused on reporting to the funder, as a condition of funding. Organizations now realize the value of collecting data, for their ***own purposes,*** for their ***own assessments***, for their ***own planning***. Some data do need to be submitted to the funder(s), however, the true value of ***your*** data is to help ***your*** organization.

In your planning process, you will identify the types of data that will be collected. Some programs have specific data requirements, while others will be based on your organization's needs. Your annual plans will include the details on what types of data you'll be collecting, which indicators will be assessed, where you'll gather the data, and how.

Information Management

Information management refers to the management of personal health information in healthcare organizations. Specifically, it refers to the collection, usage, storage, preservation, and disposal of client health and employee data. It is especially important in First Nation health systems, as patients often have to cross jurisdictions to access care. When creating your Health and Wellness Plan, you will need to describe how your organization is managing information including the type of software system you use to collect, enter, store, retrieve, and analyze your data.

Principles are the foundation of your organization's approach to information management. They underpin the policies which are created, the protocols that are drafted, and the practices that are implemented.

The table below lists several principles that can help organization build a robust approach to information management. It also offers examples of policies that support the principles, protocols, and practices that operationalize the policies. These are the day-to-day activities that ensure standardized practices and consistent and secure management of health information. If you are accredited, you will be required to put in place rigorous practices that safeguard your information.

Principle – Openness and Transparency
Overarching principle referring to policies, procedures, practices and technology

Why is this important?

Individuals understand what information exists about them and how that information is used. Helps promote privacy practices and instills confidence in the privacy of their data.

Principle – Specific Purpose for Data Collection

Personal health data are obtained only by fair and lawful means, and, if applicable, with the knowledge or consent of the individual. Explains why data are collected and why it is to be used. Data use must be limited to what is necessary to accomplish specified purposes.

Why is this important?

Important for individuals to understand how information about them is collected. Helps to reduce privacy violations which can occur when data are collected for one legitimate reason and then reused for different or unauthorized purposes.

Policies/Protocols/Practices

- Policies on uses and disclosures of health information
- Organizational practices implemented to control access to personal health information
- Master data sharing agreement includes obligations for data use and data provision
- All system users have received training in data security and understand policies and procedures

Principle – Individual Participation and Control

Every individual has the right to request and receive information regarding who has their health data, to know any reason for a denial of such request, and to challenge or amend any personal information.

Why is this important?

Enable individuals to be participants in the collection and use of their data.

Policies/Protocols/Practices

- Notification and Consent Policy
- Patient Access to Information Policy

Principle – Data Integrity and Quality

Health data should be accurate, complete, relevant, and up-to-date to ensure it is useful.

Why is this important?

The quality of health care can depend on the existence of accurate health information; individuals can be adversely affected by inaccurate health information.

Policies/Protocols/Practices

- Ensure a process to match patients with their records at key points in their care journey
- Assign a person to ensure compliance with legislation and respond to requests, inquiries and complaints

Principle – Safeguards and Controls

Security safeguards are essential because they help prevent data loss, corruption, unauthorized use, modification, and disclosure.

Why is this important?

Design and implementation of technical security precautions strengthen information privacy.

Policies/Protocols/Practices

- Organizational policies designed to control access to personal health information
- Authentication of those seeking access; user identification and authorization such as unique user IDs, passwords, or hardware devices such as card keys or security tokens
- Access based on job; level of access to personal health information is outlined in job descriptions
- Secure transmission of data
- Transmission of data on media or portable devices is secured before leaving a secure environment
- Minimum data necessary are collected
- Physical security devices are used, such as key card access locks to security file rooms containing personal health information
- Appropriate practices are adopted to secure fax transmission
- Secure methods are established for transporting paper files
- Retain all data modified until purged, deleted, archived, or otherwise deliberately removed from the system by security administrators
- Data backups are securely transported and stored off site
- Recovery of data from backups is tested regularly
- Movement of records within the organization is tracked via a manual or computer-based log application
- Storage areas for patient records are located to protect against floods and fires and natural disasters

Principle – Accountability and Oversight

Processes are in place to ensure that protection is not violated.
Violators are held accountable for compliance failures.

Why is this important?

Hold those who violate privacy requirements accountable and correct system weaknesses to rebuild an individual's trust in the system.

Policies/Protocols/Practices

- Audit Policy
- Privacy audits that help to identify and address privacy violations and security breaches
- Response to security incidents including reporting, sanctions, and mitigation

NON-INSURED HEALTH BENEFITS

Non-Insured Health Benefits (NIHB) Program

The *Canada Health Act* requires that provinces and territories provide coverage for "insured services" (medically necessary hospital and physician services) to all eligible residents including First Nations. Individuals may also have access to other health-related goods and services through other publicly-funded programs or through private insurance plans. The ISC-FNIHB NIHB Program is a national program that provides registered First Nations people in Canada with coverage for a range of medically necessary health-related goods and services which are not otherwise available to them through other private plans or provincial/territorial health or social programs.

The benefits under the NIHB Program include: pharmacy (prescription drugs and some over-the-counter medication), medical supplies and equipment, dental care, vision care, mental health counselling, and medical transportation to access medically required health services not available on reserve or in the community of residence.

Objectives

The objectives of the NIHB Program are to provide non-insured health benefits to First Nations people in a manner that:

- is appropriate to their unique health needs;
- contributes to the achievement of an overall health status for First Nations people that is comparable to that of the Canadian population as a whole;
- is sustainable from a fiscal and benefit management perspective;
- facilitates First Nations control at a time and pace of their choosing.

Planning

As with other ISC-FNIHB programs, NIHB can be managed by a community or a group of communities through a Contribution Agreement. However, as per the NIHB Program mandate, benefits provided under the NIHB Program are 'nationally consistent and portable' to ensure equitable access. This means all benefits must be delivered according to national benefit policies and frameworks as outlined in the NIHB Program plan.

While identifying your needs and resources in preparation for your Health and Wellness Plan you may consider managing and delivering some of the non-insured health benefits. After carefully assessing the challenges and advantages, your ISC-FNIHB Regional office can assist you identifying the best approach available according to your needs and strengths.

While funding for NIHB cannot be used for purposes outside of NIHB, you may consider organizing the delivery of these services in an integrated manner with all your other services to ensure a continuum of services and care for your population.

Linkages should be examined between the non-insured health benefits you wish to manage and the programs and services you are planning to offer to address health priorities for your population. Benefits such as mental health counselling and the various mental wellness programs are typically integrated to ensure a continuum of care. Medical transportation is also another common benefit that is delivered through contribution agreements. Linkages between this benefit and areas such as traditional healing, addictions, mental health services, and primary health care are usually established.

The NIHB information in the Health and Wellness Plan should:

- Explain the following NIHB elements;
    - management and governance structure
    - accountability framework
    - budget
- Define the eligible population to be served;
- Demonstrate how the applicable benefit area is being managed consistent with the applicable NIHB Benefit Policy Framework;
- Provide the scope of benefits to be provided and managed under the agreement;
- Offer a plan and process for how expenditures will be monitored and how the need for budget changes (increase or decrease) will be communicated with the ISC-FNIHB Regional office;
- Describe how the benefits will be delivered and what the appeals process will be (specific to the benefit areas);
- Demonstrate how any applicable licensing and insurance will be maintained.

GUIDES AND RESOURCES

The following resources provided by ISC-FNIHB can assist in planning NIHB services.

- NIHB Program information can be found at www.canada.ca/nihb. Under 'Benefits and Services', you will find a page for each benefit area that provides links to benefit policy guides and frameworks.
- The ***ISC Program Plan Part 2 (First Nations and Inuit Health) 2018-2019*** provides the terms and conditions for delivery of ***ISC-FNIHB*** programs through contribution agreements, including NIHB benefits (under "Supplementary Health Benefits"). It is available at the following link: https://www.aadnc-aandc.gc.ca/eng/1513089555917/1513089649764

BUDGET

You are developing your Health and Wellness Plan, with significant flexibility and autonomy over your plans, programs, and services. You are creating your Strategic Plan, which outlines your priority areas and Strategic Goals for the next five to ten years. At this point, you know what your budget is and, in broad strokes, where you will be allocating the resources over the next five to ten years. However, it is difficult to do concise budgeting five to ten years in advance.

This is where the Annual Plan plays another important role, as this is when you will allocate your financial resources for the upcoming year. Each year, as you review your progress toward your Strategic Goals and determine your annual objectives, you will be able to target your financial resources to those activities.

The first step is to be very clear on your financial resources – how much you receive from all sources for all your health programs and services. Projected resources could come from ISC-FNIHB programs, other federal departments, province/territory, Regional Health Authority, Tribal Council, corporation, etc. The total of your expected income is what you'll begin with as you plan your allocations.

Now you can determine what your expected expenditures will be (i.e., your best estimate of all the expenses) for delivering the programs and services according to your Annual Plan.

In addition to resources required to deliver your programs and services this year, include the following financial estimates:

- Cost of salaries and benefits (including budgeting for overtime and replacement workers if necessary);
- General operating expenses for your health facilities and equipment, including maintenance costs where applicable;
- Expenses related to training and professional development (your training plan will help guide these estimates);
- Costs of medication and medical supplies.

In addition, you will need to account for expenses related to:

- Costs of depreciation on moveable assets such as computers;
- Costs of conducting audits and evaluations;
- Insurance coverage;
    - Liability and malpractice insurance coverage is mandatory for professional healthcare staff,
    - Property insurance (if applicable),
- Contingency funds for unexpected health needs or variability in demand for services.

Develop your Annual Plan with an attached budget that outlines the financial resources you will receive and what you will expend.

Depending on the funding model your organization is in with ISC-FNIHB, you will also have flexibility in what you report on your funding, as the requirements for most reporting have been reduced. It's important to understand what the reporting requirements are for your contribution agreement and incorporate the requirements into your annual planning. Speak with your ISC-FNIHB contacts to clarify if you are unsure, or if your funding agreement has changed.

MANDATORY PROGRAMS AND SERVICES

Certain programs and services have been identified as mandatory by ISC-FNIHB to ensure compliance with relevant standards, to ensure safety, and to support public health. Mandatory programs and services are those that have a direct impact on the health and safety of community members. They generally have a strong clinical component and require that health staff have certain credentials/certification/licensing and meet practice standards to ensure quality client care is provided. As of the writing of this Guide, the mandatory programs and services are the following:

- Nursing/primary care/treatment
    - Nursing in nursing stations
    - Primary care including specialist referrals
- Home and Community Care
- Communicable Disease Control and Management
    - Vaccine Preventable Diseases – Immunization Program
    - Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) – HIV/AIDS Program
    - Respiratory Infections – Tuberculosis (TB) Program
    - Communicable Diseases Emergencies – Pandemic Influenza
    - Communicable Diseases Emergencies – planning and response
- Environmental Public Health Services
    - Environmental Public Health
    - Drinking Water Safety Program

To ensure delivery of these mandatory programs, certain minimum requirements for professional services have been identified as essential to meet mandatory program requirements. They are:

- services of a Medical Officer of Health (MOH) or Regional Medical Officer (RMO);
- services of an Environmental Health Officer (EHO), who holds a Certificate in Public Health Inspection issued by the Board of Certification, Canadian Institute of Public Health Inspectors (CIPHI).

When planning for these programs and services, you need to ensure that your Health and Wellness Plan explains how all the necessary requirements will be met. This includes, situations where ISC-FNIHB or another organization is responsible for the mandatory program; who is responsible, and the role that your community will play in the delivery of the program. If your community is taking on responsibility for these programs, then your Health and Wellness Plan must provide details of the elements listed below for treatment services such as Primary Care, Communicable Disease Control, Environmental Public Health, and Home and Community Care.

The sections below will provide the requirements for each of the mandatory programs.

Once you have identified the mandatory programs for your community, consider the following factors as you plan further. They will have an impact on what type of service delivery structures and processes you set up:

- Remoteness and/or isolation factors;
- Population numbers for sub-groups (e.g., children, youth, adults, Elders, etc.), vulnerable groups (e.g., clients with chronic disease, clients with mobility issues, clients needing home support, etc.) and other identified health needs;
- Availability of appropriate infrastructure (e.g., office space, equipment and supplies, information technology such as telehealth or broadband connectivity, policies and procedures, etc.);
- Number and types of anticipated client visits for different categories of clients;
- Number and types of clients requiring emergency and/or rapid intervention as well as related medical transport;
- Availability of qualified healthcare providers and community-based workers;
- Availability of, and access to specialty services in and outside of the community;
- Availability of community resources (e.g., ambulance, pharmacy services, etc.).

NURSING SERVICES/PRIMARY CARE/TREATMENT SERVICES

Primary care focuses on the direct delivery of healthcare services. Its purpose is to provide access to a range of urgent and non-urgent health services where provincial services are not readily available. While the focus of this section is to provide useful information for planning the delivery of primary care, it is essential that those services link across the continuum of care including public health, home care, and planning for other health priorities. As such, planning your primary care services may require that you work directly with your ISC-FNIHB regional nursing contacts. This is especially critical if there are services provided through ISC-FNIHB that operate out of your community facility, where there needs to be clear and ongoing communication related to lines of reporting, standards, etc.

In First Nation communities, primary care services are usually the first point of contact to the healthcare system. Often, these primary care services are provided by a nurse-led team which is responsible for coordinating and integrating this care with the broader health system by enabling access to other healthcare providers and services. Ongoing consultation (often at a distance) between primary care providers and services is necessary to provide a broad range of essential services, including assessments, diagnostics, and treatment for emergent, urgent, and non-urgent care. This often entails coordinating care and referrals with provincial secondary or tertiary care facilities outside the community.

It is important to encourage active participation of your community in primary care service planning, so services are planned “with you” rather than “for you”. This is essential to ensure your culture and knowledge are represented within the primary care team. Cultural practitioners, Elders, community workers, and ceremonialists can serve a community-defined role within your primary care team as one more way to empower your community in taking charge of your health needs.

Think about the variety and type of primary care services that will be offered in or accessible to your community. How will these be decided? ISC-FNIHB is developing a primary care “Standard Essential Services” document which identifies essential treatment services required in ISC-FNIHB managed facilities operating in remote and isolated First Nation communities. The document identifies four levels of care that should be considered as part of primary care services. It is important to note that at a minimum, triage, emergency resuscitation and stabilization, and emergency ambulatory services should be accessible.

For the purposes of this Guide, what had been called a "Nursing Station" is identified as a "primary care facility". This more appropriately describes the scope of services that may be accessed by the community. Ambulatory (outpatient) non-urgent services are determined by community needs and availability of resources. Examples of these services include: preventive services (e.g., diabetes screening), chronic mental health management, dental care and hygiene, and chronic disease management.

Triage and Assessment	Emergency Resuscitation and Stabilization	Emergency Ambulatory Services	Non-urgent Ambulatory Services
• Triage is the first step in directing clients to appropriate services based on their need for urgent (immediate), emergent (unexpected, sudden worsening health status requiring prompt action), or non-urgent (minor health conditions and/or routine care). • Triage involves collecting client information, completing a clinical assessment, and starting a decision-making process that prioritizes the clients' needs.	• These services are required to maintain the lives of clients presenting with urgent or emergent conditions and requiring more specialized personnel or equipment than what is easily available in remote or isolated communities. • In these situations, the treatment goal is to stabilize and transport the client to a secondary or tertiary care facility as soon as possible.	• These services are required for clients who need urgent care, but can be effectively treated within the remote or isolated facility and safely discharged home without the need for medical evacuation. • This level of service is based on stable vital signs and predictable outcomes for conditions that are of limited duration and that do not require specialized tests to confirm a diagnosis or to guide time-sensitive treatments.	• These services consist of episodic, non-urgent care provided on an outpatient basis to treat non-urgent conditions for clients who would be more reasonably treated within the community.

Quality is being addressed across all your health and wellness planning, however there are specific considerations related to primary care. All the considerations have several actionable items that your health team should address while planning programs and services.

Accessibility

- There is a policy and a procedure or protocol to respond quickly to emergency calls.
- There is a policy and a procedure or protocol for safe and effective phone consultation.
- There are mechanisms, standards and/or procedures for the tracking and management of waiting lists to ensure that clients with the most urgent needs, are seen first.
- The primary health service has access to a physician and/or a nurse practitioner for urgent or periodic on-site services.

Effective

- Primary care team members have the right skill mix to safely and effectively offer the required primary care services.

- The primary care team has access to on-site clerical and support personnel required to ensure an optimal team approach to health service delivery.
- The facility has telehealth equipment and the necessary training and protocols in place to support healthcare activities. If telehealth isn't currently available, there is a plan for future access to telehealth.
- An effective charting/medical records system is in place.
- There are continuous quality improvement processes in place to monitor, measure, and evaluate strengths-based practice including community control and community engagement.

Efficient

- There are policies and procedures in place for clinical decision-making.
- A tracking system is in place for test results, monitoring prescriptions, and appointment follow-ups, etc.
- There is a straightforward process to retrieve information such as a list of clients by diagnosis, client medication lists, etc.
- There are standardized processes for referring clients and discharging from the hospital.

Client-Centred

- All new clients participate in a thorough, standardized assessment of their health and wellness needs.
- All clients participate in the development of an individualized care plan.

Cultural Safety

- There is a process for the community to determine how best to accommodate harm reduction and cultural approaches in primary care.

GUIDES AND RESOURCES

The following resources provided by ISC-FNIHB can assist in the development of mandatory programs and services.

A Guide for First Nations: Developing and Implementing a Facility Operations and Maintenance Management Plan

Clinical and Client Care Essential Services Standards (uncompleted, completion estimated late 2018)

Community Health Professionals – Roles and Responsibilities (2010)

FNIHB Quality Improvement Policy Framework (2012)

Clinical Practice Guidelines

MEDICAL OFFICER OF HEALTH AND ENVIRONMENTAL HEALTH OFFICER

Provision of Medical Officer of Health Services

In accordance with provincial/territorial health regulations, every community health program must have the services of a Medical Officer of Health (MOH). The roles of an MOH vary from province to province and are based on the needs of the community, but always include responsibilities related to public health and safety. The MOH must be a physician licensed in the province or territory who has specific qualifications and experience in public health and who has been given the designation of MOH within the province or territory. A qualified MOH should be available by phone at all times and should be able to visit the community if urgent situations arise. The ISC-FNIHB Regional office has information on the options your community has for ensuring the provision of MOH services.

The MOH will assume primary responsibility for the following mandatory roles:

- Immunization – immunization schedules, supervision of program delivery, and surveillance (e.g., monitoring adherence to schedules, ensuring records are kept, and responding to significant adverse events).
- Communicable Disease Control (other than immunization) – surveillance, laboratory testing, disease screening, diagnosis, case management, contact tracing, source of infection, and outbreak management.
- Environmental Public Health (working with the Environmental Health Officer) – providing advice on possible health effects of environmental factors, investigating health concerns to determine potential associations with environmental factors.
- Public Health Legislation – defined responsibilities and obligations under provincial public health legislation including, but not limited, to communicable disease control and public health emergencies.
- Emergency Response – review and approval of a community's Communicable Disease Emergency Plan, and key roles in emergencies involving communicable diseases, environmental situations with imminent risk to health, or any situation requiring evacuation of residents.

Your Health and Wellness Plan must indicate how the services of a MOH are being provided and should describe:

- Who will act as the MOH for the community;
- Where the MOH will be located and when and how often the MOH will be accessible to community healthcare professionals providing primary health care;
- How provision of the service has been or will be arranged;
- The estimated cost of this service.

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How to Procure Appropriate MOH service:

Here is a list of steps to follow in securing appropriate MOH service. The MOH needs to meet the needs of your community and ensure your community is seamlessly part of the provincial and national public health system.

1. Identify who is currently providing your MOH service and confirm that they are recognized under the provincial Public Health Act as an MOH.
2. If they are recognized as an MOH, make sure you have appropriate paperwork documenting this and that you have entered into agreement with them to provide such service.
3. If they are not, you must explore some options for getting appropriate MOH services into place. It is advisable that you connect with your ISC-FNIHB Regional Medical Officer for assistance with this. They will be able to connect you with different parts of the public health system to make the appropriate arrangements. Here are the options:
    a. Your community can approach the province or neighbouring local health unit MOH to have them named as your MOH. In this situation, a formal agreement should be drawn up to stipulate what the mutual expectations for service are and how this person would connect with your other health staff. This may involve having a member of your Band Council also sit as a member of the Health Board that oversees the work of the MOH at the local health unit. Speak to your ISC-FNIHB Regional Medical Officer about templates for this.
    b. Your community can form an alliance with other communities, so you have enough of a population base to hire your own MOH. The MOH in this situation will also need to be formally recognized and delegated as an MOH by the provincial public health authorities under the provincial ***Public Health Act.*** To be acceptable, the physician will need to be licensed in your province to practice medicine and have recognized credentials in public health such as a certification in Community Medicine or a Master's degree in Public Health.
    c. Your community can retain the ISC-FNIHB Medical Officer to provide some of the MOH services that are not covered by the legislation and engage the neighbouring local health unit MOH to cover the services required by legislation. Here again, it's essential to have a clear written agreement of how roles/responsibilities will be divided and how the MOH and ISC-FNIHB Medical Officer connect with your health staff and each other.

Provision of Environmental Health Officer Services

Every community must ensure that services are available from an Environmental Health Officer (EHO). The EHO must have and maintain a Certificate in Public Health Inspection (CIPHI) (Canada) issued by the Canadian Institute of Public Health Inspectors, or the acceptable authorized equivalent, and be entitled to practice his or her profession in accordance with the professional governing body (Board of Certification of Public Health Inspectors of the Canadian Institute of Public Health Inspectors) and laws of the province/territory where the services are to be provided.

The roles and responsibilities of an EHO will vary depending on community needs. Overall, the EHO is responsible for environmental public health activities in the following eight core program areas, as per the *National Framework for Environmental Public Health Programming in First Nations Communities South of 60°*:

- Drinking Water;
- Wastewater;
- Housing;
- Food Safety;
- Facilities Inspections;
- Solid Waste Disposal;
- Environmental Communicable Disease Control;
- Emergency Preparedness and Response.

To maintain their CIPHI certification and ensure continuing professional competencies, EHOs must complete a specified number of professional development hours (PDHs) on an annual basis. Communities must assure support for EHOs to complete these training and professional development activities.

GUIDES AND RESOURCES

The following resource provided by ISC-FNIHB can assist in the outlining the roles and responsibilities.

Community Health Professionals – Roles and Responsibilities (2010)

Check with your provincial/territorial regulatory colleges for standards of practice.

HOME AND COMMUNITY CARE

The Home and Community Care Program provides essential home and community based health and personal care services to persons with disabilities, those with chronic or acute illnesses, and the elderly to receive the care they need within their home and community. Although this section provides some useful information for planning the delivery of home and community care, it is important that these services link across the continuum of care including public health, primary care, social programs such as Assisted Living, other ISC-FNIHB programs such as on-Insured Health Benefits, and provincial and territorial health services. Such planning may require you to work directly with your ISC-FNIHB regional contacts as well as your contacts from local provincial and territorial health units, community health centres, and other health facilities.

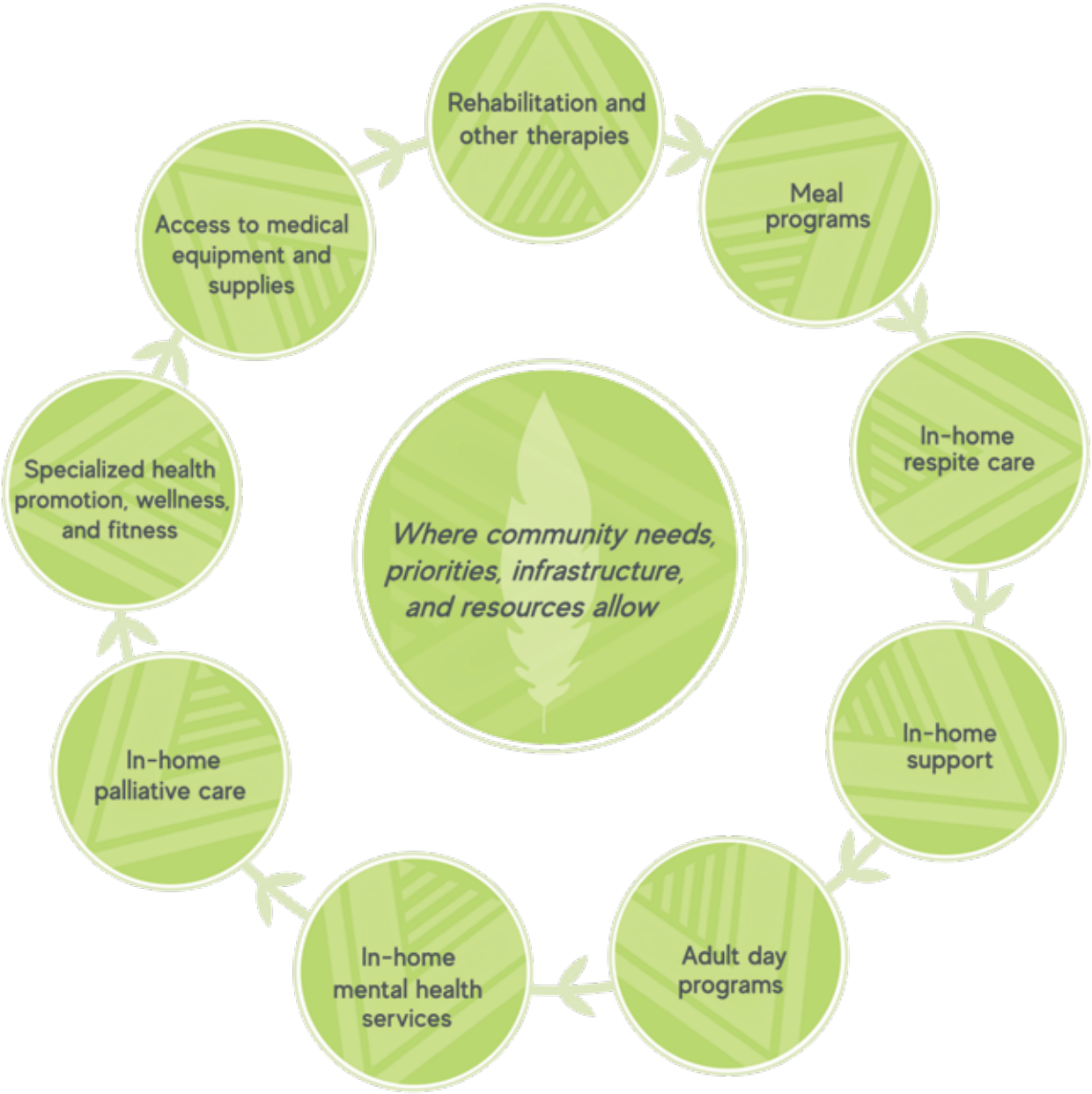
In First Nations communities, home and community care usually involves the development of a home and community care service plan based on the needs of community members. This involves a mapping of programs and services that could be accessed by community members through provincial and territorial health agencies, other Indigenous Service Canada programs, and those services to be provided through the Home and Community Care Program. It is important to encourage the active participation of your community in the Home and Community Service Plan so that these services are designed to respond to the needs of community members and reflect your community's culture and traditional knowledge.

Home and community care is delivered primarily by provincially registered home care nurses as well as trained and certified personal care workers. Sometimes other allied health professionals such as physiotherapists, occupational therapists etc. are included as part of the home and community care team. Personal Care Workers or Home Support Workers are care providers who are not licensed or registered by a regulatory body and have no legally defined scope of practice. They always work under the supervision of a regulated health care professional. It is important to think about liability coverage for these workers as well as for the regulated health care professionals who supervise them.

Elders and Traditional Healers can serve important roles within your home and community care team. They are guided and governed by the community who affirm their knowledge and skills. Traditional medicines or ceremonial practices can complement care.

You should also consider the role of family care providers and involve them in care planning as appropriate. You will also want to consider the needs of family care providers and offer them support services as these are required.

Consider the type and variety of services that will be offered in or accessible to your community. Components of a Home and Community Care Program can include the following:


Rehabilitation and other therapies
Meal programs
In-home respite care
In-home support
Adult day programs
In-home mental health services
In-home palliative care
Specialized health promotion, wellness, and fitness
Access to medical equipment and supplies
Where community needs, priorities, infrastructure, and resources allow

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Service delivery is based on assessed need and follows a case management process. Home care is provided in a client's home, which can be defined as an individual residence, a family residence, an Elders' lodge or other settings where the client resides in the community. Sometimes, clients may be seen by home care staff at the community health centre for services such as a dressing change.

You will want to consider the quality of care provided by the Home and Community Care Program through a systematic approach to program management that includes:

- Structured client-centred assessments and re-assessments.
- A managed care process that incorporates client case management, care planning, referrals, and linkages to other services and resources on- and off-reserve.
- Home and Community Care Program policies and procedures that are regularly reviewed and updated.
- Information and data collection through client record keeping, program planning and evaluation, and reporting and analysis of program utilization and trends.
- Funding recipients are required to report to ISC-FNIHB using the electronic Service Delivery Reporting template (e-SDRT) and the electronic Human Resource Tracking tool (e-HRTT), or any other electronic solution of the recipient's choosing (contact your ISC-FNIHB Regional office to discuss the reporting tool that best suits your needs). In addition, funding recipients are required to provide ISC-FNIHB Regional offices with an annual financial audit.
- Quality monitoring and care supervision.
- Cultural safety to accommodate cultural approaches in home and community care.
- Liability coverage as well as a mechanism to confirm the licensure/registration or certification of all health care providers.

PHARMACY, MEDICATION MANAGEMENT, AND TRADITIONAL MEDICINES

Access to pharmacy services in First Nation communities supports the delivery of mandatory programs such as Primary Care, First Nations and Inuit Home and Community Care, and Public Health. While these health services have different roles in medication management, a collaborative approach to pharmacy services is important to prevent medication errors and near misses. The functions include selecting and procuring medications and pharmacy supplies, receiving and storing medications, reviewing the prescription/medication order, dispensing and delivering medications, administering medications and client monitoring, evaluating the medication management system, monitoring inventory, and medication disposal.

It is important to note that medication management implies prescribed medications as well as over-the-counter (OTC) medications and any traditional medicines.

If your community is taking on the responsibility for delivering pharmacy services, then your Health and Wellness Plan must provide details of the relevant elements identified in this section.

There are several ways to think about how to set up access to pharmacy services in your community. Medication management is patient-centred care that optimizes safe, effective, and appropriate drug therapy. Care is provided through collaboration with patients and their healthcare teams. Medication management is a key component of ensuring safe medication use.

Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal, and mineral based medicines, spiritual therapies, and manual techniques and exercises. While traditional Indigenous medicine is not regulated in Canada, it is present in many First Nation organizations for example, All Nations Healing Hospital in Saskatchewan, Sioux Lookout Meno Ya Win Health Centre, and the Ontario Aboriginal Health Access Centers.

Planning for medication management requires consideration of your community vision for traditional medicine so that culturally relevant policies, processes and protocols for managing such medicines can be created. In fact, some First Nation communities talk about their procurement, storage, and dispensing of traditional medicines as an “Indigenous pharmacy”. However, it’s common (some reports say up to 92 percent) that Indigenous people who use traditional medicine, do not share this information with their primary care provider. Additionally, in Indigenous health settings, up to 40 percent of those clients who receive care for geriatric or chronic mental health issues are also receiving traditional healing services such as the use of traditional herbal medicines.

Regulatory Compliance

The handling of medications (i.e., medication management) must be in accordance with applicable federal and provincial legislation and with regulations governing the management of medications. Medication management should also comply with provincial pharmacy and nursing standards of practice.

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The professional regulatory body can hold a professional to account and take corrective action if their standards are not met. Furthermore, health professionals are also accountable to adhere to the policies and guidance provided by their employing organization.

There are two Section 56 exemptions under the ***Controlled Drugs and Substances Act*** (CDSA) and its regulations for delivering primary care services at a health facility in a remote/isolated community. These two exemptions authorize:

1. RNs who deliver primary healthcare services at a health facility in a remote/isolated community to conduct certain activities with controlled substances;
2. Persons in charge of a hospital to supply controlled substances to a health facility in a remote/isolated community.

The two Section 56 exemptions are considered legal documents. As these documents exempt RNs and the person in charge of a hospital from provisions of the CDSA and its regulations, certain terms and conditions need to be met for the exemption to be valid. The exemption also specifies that RNs must follow any policies or procedures developed by the healthcare service provider to support the proper conduct of activities with controlled substances in remote/isolated facilities. If your community has no policies and procedures developed, please contact the ISC-FNIHB Regional office for information.

Functions under Medication Management

Organizations are responsible for ensuring that the functions under medication management are completed by qualified individuals in line with applicable regulations and their scope of practice.

The table includes the functions under medication management including traditional medicines.

Selection of Medications
Pharmacy Services The selection of medications is normally based on a list of medications or a formulary depending on the type and range of services being provided at the health facility.
Traditional Medicines The process for mixing traditional Indigenous medicines is dependent upon the scope of practice of the cultural practitioner and may occur at any of the following stages: procurement, receiving and storage, prescribing, dispensing, or administering. The mixing of various medicines is done primarily by the cultural practitioner or Elder but may at times be done with instructions from them for the family or the patient.
Procurement [Ordering and Purchasing]
Pharmacy Services Medications may be purchased from a private licensed dealer or manufacturer (e.g., wholesaler), or from a Drug Distribution Centre (DDC) (e.g., ISC-FNIHB DDC Edmonton, Wendake in Quebec). Generally, the assistance of a pharmacist, physician, nurse practitioner, or other parties with medication purchasing authority will be required for medication inventory purchases.
Traditional Medicines Traditional Indigenous medicines are gathered from the land, prepared, and stored in very specific culturally defined ways by cultural practitioners. Procurement is spiritually guided and bound by cultural protocols which may include gifting, trade, and purchase.
Receiving and Storage
Pharmacy Services There must be a method in place to track routine and emergency stock orders of controlled substances while in-transit between the supplier (licensed dealer) and the registered nurse at the health facility, using a commercial carrier and using a chain of signatures. All medications must be stored securely in the designated locked pharmacy room in a secure zone of the facility, where the public does not have access and employee access is restricted to authorized staff only.

Traditional Medicines

Traditional Indigenous medicines may be received by the community health organization through culturally specific protocols. Stored traditional Indigenous medicines may include prepared and unprepared medicines. For example, dried medicines stored in glass jars or unprepared medicines that have been harvested and are stored as part of a process of preparing them for use. Labeling traditional Indigenous medicines (often in the Indigenous language of the community) is important for storage, inventory control, and for monitoring the shelf life of the medicine.

Prescribing

Pharmacy Services

Prescribing medications is a standard practice for physicians, most nurse practitioners, and some pharmacists. It is governed by a complex legislative framework. Note: in different jurisdictions, other practitioners are able to prescribe, such as optometrists, podiatrists, hygienists, dieticians, etc.

Traditional Medicines

Prescribing is done by cultural practitioners with the sanctioned rights for traditional Indigenous medicines. This would include instructions for use concurrent with or without western medicines.

Dispensing

Pharmacy Services

Dispensing refers to providing a medication in accordance with the requirements of a prescription and includes all the steps from the receipt of the prescription/order through to the delivery of the medication to the client.

Dispensing software is recommended, to enable quick retrieval of dispensing records and detection of drug interactions.

Dispensing is typically a restricted function defined in Pharmacy Acts and performed by a pharmacist. Due to the uniqueness of the delivery of health services in First Nation communities, this function may be performed by another authorized health professional.

Traditional Medicines

Traditional Indigenous medicines may be dispensed in many forms and may be prepared with instructions for storage, preparation, and use.

Monitoring, Evaluation, and Education
Pharmacy Services Monitoring a client's response to medications is a process that ensures the medication therapy is appropriate and effective, while minimizing the occurrence of adverse events. All medication incidents (e.g., errors, near misses) and adverse events are to be documented and corrective action taken. In addition, adverse drug events are to be reported to Canada Vigilance at Health Canada.
Traditional Medicines Cultural practitioners who have sanctioned rights for traditional Indigenous medicines receive education through culturally defined methods. Monitoring and evaluation for the use of traditional Indigenous medicines is based on cultural practice and protocols.
Inventory Control
Pharmacy Services An effective inventory management process is vital to maintain the quality of services, patient safety, and the efficiency of a pharmacy room.
Traditional Medicines The gathering, storage, and preparation of traditional Indigenous medicines are guided by seasons, availability, environment, and cultural protocols. Managing the life span of the collected medicines is required in consultation with the cultural practitioner.
Disposal
Pharmacy Services Medications must be stored in a safe and secure place until proper disposal. There should be a dedicated secure place in the health facility, away from clients, service providers, and medications preparation areas, to store expired medications.
Traditional Medicines The process for disposal of traditional Indigenous medicine is culturally defined and is primarily focused on returning the unused medicine to the earth with respect for the spirit of the medicine.

GUIDES AND RESOURCES

The following resources are provided by ISC-FNIHB to assist in planning your pharmacy services.

Pharmacy Policy and Procedures
FNIHB Nursing Station Formulary
Pharmacy Standard of Practice for FNIHB Health Facilities

For additional information about the requirements in providing access to pharmacy services, please check with the ISC-FNIHB Regional office.

COMMUNICABLE DISEASE CONTROL AND MANAGEMENT

All Communicable Disease Control and Management (CDCM) programs are mandatory and every community must include them in their Health and Wellness Plan regardless of whether the community or ISC-FNIHB is responsible for the program delivery. These programs are mandatory because of their direct impact on the health and safety of community members and the broader population. For more discussion on medical social emergencies, see the Crisis Prevention and Response section, which supports the linkages between medical emergencies such as communicable disease and social issues that must be addressed within the context of social determinants of health. The ISC-FNIHB Regional office can provide information to assist in the preparation of this aspect of your Health and Wellness Plan.

The goals of the CDCM programs are to reduce the prevalence, incidence, and spread of communicable diseases, as well as improve health through prevention and health promotion activities. CDCM is comprised of four mandatory programs with associated mandatory reporting:

- Vaccine Preventable Diseases – Immunization;
- Tuberculosis (TB);
- Sexually Transmitted Blood Borne Infections (STBBI) – HIV/AIDS;
- Communicable Disease Emergencies and Infection Prevention and Control.

To ensure delivery of these mandatory programs, certain minimum requirements for professional services have been identified as essential for meeting mandatory program requirements. They are:

- Access to the services of a Medical Officer of Health (MOH) or Regional Medical Officer (RMO);
- Physicians in good standing with their relevant colleges associations who are entitled to practice their profession in accordance with the laws of the province or territory where the services are provided;
- Community Health Nurses, who are professionally designated as Registered Nurses (RNs) that have the appropriate community health and public health competencies required to fulfill their role in the specific practice setting;
- Access to professional collaboration and consultation for RNs, RPNs/LPNs and supervision for non-regulated healthcare providers.

The health and wellness planning process must address CDCM programs by tracking and documenting the following for example, the report on Public Health Surveillance activities as per the schedule found in the Contribution Agreements:

- A description of the types of activities required to deliver the mandatory programs under CDCM, including a schedule of the activities;
- The indicators that will be used in each of the program areas to evaluate the effectiveness of CDCM programs in meeting their objectives;
- A process for investigating contacts of cases of infectious disease according to ISC-FNIHB/provincial/ territorial guidelines;
- A current list of, or a reference to the reportable/notifiable diseases of which provincial/ territorial health officials and the ISC-FNIHB Regional office must be notified (can be obtained from the ISC-FNIHB Regional office);
- Keep track of the number of each type of communicable disease for monthly reporting to the province or ISC-FNIHB Regional office (reportable disease needs to be reported within 48 hours of receiving lab results or medical diagnosis). In addition, immunization records and rates, animal bite cases, and other required data are to be tracked and submitted. Information from these records is also required so that the Health Committee can complete the annual audit and program review and evaluate the effectiveness of its program as required;
- A list of the staff positions required to deliver CDCM programs;
- The processes for the following tasks associated with the CDCM Program; health promotion, disease prevention, screening, harm reduction, immunization and cold chain management, diagnosis, treatment, outbreak management, contact tracing, and follow-up;
- The provision and support of disease prevention programs (e.g., chronic disease, TB, STBBIs), harm reduction measures as well as care/treatment services, and education and training to healthcare professionals to ensure maintenance of knowledge and competencies in their program area;
- The provision and support of community-based educational information and awareness materials to community members and community health workers as required.

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The program-specific descriptions and objectives for Vaccine Preventable Diseases (Immunization), Tuberculosis, Sexually Transmitted Blood Borne Infections, and Communicable Disease Emergencies are outlined below.

Vaccine-Preventable Diseases – Immunization Program

This program focuses on increasing the uptake of routine infant and preschool immunization series as well as routine immunization across the lifespan. The expected outcomes are to improve coverage rates for routine immunizations, reduce Vaccine-Preventable Disease incidence and outbreaks, and develop an enhanced immunization surveillance system.

The program objectives are to:

- Provide immunization to infants, children, and adults according to provincial/territorial immunization schedule requirements;
- Improve data collection and surveillance by keeping updated immunization records and coverage levels for decision-making and to comply with reporting requirements for each program area (e.g., ISC-FNIHB, the province);
- Forecast vaccine equipment needs while monitoring wastage;
- Support the implementation and maintenance of vaccine cold chain management processes (including in case of power outages);
- Conduct contact investigation of infectious disease cases according to ISC-FNIHB/provincial/territorial guidelines to prevent and control the spread of disease;
- Inform, educate, and create awareness on vaccine-preventable diseases and immunization;
- Support development of healthcare workers' knowledge and skills;
- Describe, within the context of the overall Tuberculosis program, the use of the Bacillus Calmette-Guérin (BCG) vaccine if applicable.

Tuberculosis (TB) Program

Working towards the World Health Organization (WHO) targets of having fewer than 10 cases per million by 2035, the TB program focuses on equitable and timely access to diagnostics, treatment, and follow-up care for those exposed to or diagnosed with TB. In addition, the program provides TB prevention awareness and education activities targeted to healthcare workers, community health workers, and community members.

The program objectives are to:

- Screen, detect, and diagnose TB disease early to eliminate the cycle of transmission among those exposed to TB and to prevent transmission to other people;
- Provide treatment to those with active TB disease and latent TB infection to prevent the emergence of drug resistance;
- Provide TB incidence trends which involve the collection, analysis, and dissemination of aggregated information regarding active TB disease as well as latent TB infection and case findings needed to evaluate TB program interventions and develop or enhance existing policies;
- Ensure timely access to recommended laboratory processing, testing, and reporting of results;
- Implement effective case management practices for managing clients who may have active or latent TB;
- Participate in related clinical, research, and project efforts between local, regional and provincial/territorial departments as appropriate;
- Support the development of culturally appropriate education and awareness materials and community education campaigns to increase awareness of TB and reduce the stigma associated with the disease;
- Offer relevant training opportunities to healthcare workers to increase their knowledge and skills to deliver TB prevention and control activities.

Sexually Transmitted Blood Borne Infections (STBBI) Program

This program focuses on STBBI prevention, education, awareness and community capacity-building, facilitating access to culturally-appropriate testing, and cultural teachings related to care, treatment, and support including for HIV/AIDS. The program goals include preventing the acquisition and transmission of STBBIs, increasing the early detection and treatment of STBBIs, and improving the quality of life for those living with and affected by STBBIs.

The program objectives are to:

- Develop culturally appropriate initiatives for the prevention and control of STBBIs, including HIV and hepatitis C by strengthening partnerships to address issues such as the determinants of health, with the aim of reducing the health, social, and economic impacts of HIV and other STBBIs in community;
- Encourage and support STBBI programming in community;
- Identify options and strategies for the provision of on-reserve HIV and other STBBI testing, treatment, care and support, and provide timely, comprehensive, and culturally relevant STBBI education and prevention programs;
- Work towards achieving the global target of eliminating AIDS as a public health threat by 2030;
- Identify options for harm reduction strategies based on community needs, which can include but are not limited to client-centred counselling, skill building and education, referral to mental health, addictions and other social services, and provision of condoms and sterile drug-use equipment as well as mechanisms for their safe disposal;
- Increase the knowledge base of HIV/AIDS and other STBBI risk factors and availability of testing, prevention, care and support options in community;
- Support the development of community readiness and capacity in addressing STBBI stigma and discrimination, to increase STBBI testing uptake;
- Support the development and roll-out of culturally safe community-based integrated STBBI care models which take a holistic and individual-centred approach in providing health and social services to address STBBIs and other co-infections and co-morbidities (e.g., addictions and mental health issues) as well as outbreak management for STBBIs;
- Identify and support opportunities to address social determinants of health that foster or sustain ongoing STBBI transmission and affect long-term treatment outcomes.

Communicable Disease Emergencies (CDE) Program

This program works closely with partners and stakeholders to strengthen the capacity of First Nation communities in developing and implementing comprehensive and coordinated preparedness and response activities related to public health emergencies (including communicable disease emergencies such as an influenza pandemic) in First Nation communities. The CDE Program is also responsible for the development and implementation of Infection Prevention and Control (IPC) activities, and provides IPC expertise, guidance, and advice to national and regional staff within ISC-FNIHB.

The program objectives are to:

- Facilitate comprehensive and coordinated response activities in communities, and facilitate access to financial, material, and human resources (such as personal protective equipment [PPE], additional healthcare providers, etc.);
- Support the preparation and planning for communicable disease emergencies such as influenza pandemics, by facilitating the development, strengthening, and testing (revising as needed) of a community-level CDE plan;
- Ensure community and leadership engagement in the development, strengthening, testing, revision, and implementation of the community-level CDE plan;
- Support community response to a CDE by implementing the community's CDE plan (e.g., roll out mass immunization clinics which may include providing training, community awareness materials, etc.);
- Ensure health facilities and staff have ready access to sufficient quantities of PPE (e.g., facial protectors, gloves, gowns) as well as proper training, in the event of a CDE.

Communicable Disease Emergency Preparedness Planning for First Nation Communities

The national CDE Program, in collaboration with the regional CDE Coordinators, has developed CDE planning considerations to support the development, strengthening, and implementation of CDE plans, formerly referred to as pandemic plans, at the community level. CDE plans identify and document the mitigation/prevention, preparedness, response, and recovery activities that are critical for the well-being of a community during communicable disease emergencies, such as a pandemic event.

These guidelines were created by conducting an analysis and synthesis of international, national, provincial, regional, and local influenza pandemic planning documentations, and applying the recurring themes for the six main preparedness components – surveillance, health services, public health measures, communication, vaccines, and antivirals, as per the Canadian Pandemic Influenza Plan (CPIP) for the Health Sector.

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Even though these guidelines stemmed from influenza pandemic planning documents and experiences, the advice listed below is encompassing and can be applied to other types of CDE events, such as outbreaks of gastro-intestinal illnesses or respiratory illnesses (e.g., tuberculosis). The influenza pandemic-specific guidelines have been identified separately in a table at the end of this section.

Throughout the six main preparedness components, there are two recurring themes: collaboration and integration. As evidenced during the 2009 H1N1 pandemic, collaborative relationships between First Nation communities and local leadership, National Indigenous Organizations, regional, provincial and federal (including ISC-FNIHB Regional offices) partners are crucial for seamless, comprehensive and coordinated planning and response activities. When developing a CDE plan, communities need to engage all appropriate partners and/or stakeholders, in particular provincial/regional/local public health partners, such as district health authorities or local public health units, in discussions from the beginning of the planning process.

Another important component in planning for and responding to emergencies is integration. For that reason, communities need to strengthen relationships and partnerships with federal, provincial, regional, and local authorities responsible for all-hazard emergency preparedness and response (EPR). All-hazard emergency planning is a key activity, at all levels of government, to identify measures that are essential for protecting public health, property, the environment, and safety in different emergency scenarios, including CDE events.

Business Continuity Planning (BCP), within an all-hazard Emergency Preparedness and Response (EPR) plan, is also a key component as it identifies mitigation strategies to ensure the delivery of critical services and/or products during a disruption (e.g., floods, power outages, pandemic, etc.). ***Therefore, your community's CDE plan should be integrated with your community's all-hazard EPR plan; this will aid your community in responding to a CDE event.***

These guidelines can assist and support your community emergency planning committee in CDE planning efforts. Throughout these guidelines, useful links have been added to provide additional information on a particular topic. All the guidelines presented should be incorporated in your CDE plan, based on your community's needs and realities. CDE planning is a continuous activity, and a CDE plan should be reviewed, tested, and updated on a yearly basis.

Guidelines

Planning

All-hazard emergencies, including communicable disease emergencies, may pose a risk to health, environment, and society. Most emergencies require urgent actions to minimize the impact of hazards and a rapid response to manage the immediate needs. Planning is essential to improve the effectiveness of preparedness and response activities.

Emergency Preparedness and Response (EPR) Planning, including Business Continuity Planning (BCP)

- Establish linkages with emergency preparedness and response partners such as ISC-FNIHB and provincial/regional/local EPR personnel.
- Be aware of the community's all-hazard EPR and BCP and be familiar with their content.
- Prioritize community programs/services, including health services, in case of lack of staff availability depending on emergency event.
- Prepare a list of community members (e.g., volunteers, Elders, etc.) with specific skillsets to help maintain essential services during an emergency.
- Discuss the possibility of mutual aid and sharing of resources with neighbouring communities.

CDE Planning

Community Planning Committee

- Engage local/regional partners in the development of a CDE plan to ensure comprehensive and coordinated planning and response activities.
- Assemble a planning committee with internal/external members from all areas of responsibility within/outside the community (e.g., community leaders, health staff, etc.).
- Structure the planning/response team based on the National Emergency Response System, available at: http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ntnl-rspns-sstm/index-eng.aspx
- Specify clear roles and responsibilities for both the planning and response phases for all partners. Examples are available at:
  http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ntnl-rspns-sstm/index-eng.aspx#role
  http://www.training.fema.gov/emiweb/is/icsresource/positionchecklists.htm

CDE Plan

- Build on existing preparedness and response mechanisms and processes (i.e., build on what already works).
- Review the regional/community governance structure, which has to be flexible for different CDE scenarios, and include it in the plan.
- Integrate the CDE plan with other local/regional plans and ensure its preparedness and response activities are complementary to theirs.
- Integrate the CDE plan into the community's all-hazard EPR plan.
- Build adaptability and scalability into the plan to deal with different CDE scenarios.
- Assess the CDE plan at least yearly by having a table-top exercise (i.e., discuss a simulated emergency situation).
- Update and revise the CDE plan based on the results of the testing exercise.

Surveillance and Laboratory

Surveillance activities are critical for creating the public health response to a CDE event. They support the early detection and description of potential health threats and identify adverse drug reactions and drug resistance. Community planners should be aware of the existing provincial, regional, and local surveillance systems used in their jurisdictions. During a CDE event, laboratories will also be key in the delivery of rapid and appropriate public health responses. It is essential for community planners to be familiar with established provincial testing guidelines and processes to ensure that laboratory specimens are dealt with appropriately.

- Link with District/Regional Health Authority systems to track community members' illnesses, including influenza-like illnesses, in different settings such as health facilities, schools and daycares.
- Communicate CDE information with appropriate partners such as ISC-FNIHB Regional offices and District/Regional Health Authorities.
- Plan to work with other local/regional public health authorities to monitor CDE activity.

Health Services

During a CDE event, the need for additional resources, both human and material resources, may be required to meet the increased demand on health services at the community-level. The way in which health services are delivered may also need to be modified.

Service Delivery

- Educate community staff regarding outbreak management protocols.
- Plan for BCP in health services, (e.g., assess the staff capacity of your health facilities/community and determine the need to bring in additional staff, retired staff and/or volunteers).
- Plan for the provision and delivery of health services in the homes and in the community for those who are sick, but not needing hospital care (e.g., Home and Community Care, family members, etc.).
- Identify and plan for alternate means for client transportation within and outside the community, for both infectious and non-infectious clients (e.g., influenza-like illness clients, dialysis clients requiring ongoing treatment, scheduled specialist visits, etc.).

Supplies and Storage

- Stock the health facilities (e.g., primary care facilities and other health facilities as appropriate) with a four to six week stockpile of PPE.
- Store PPE, and other medical supplies/equipment, in a safe and secure location.

Public Health Measures

Public health officials, with designated authority at all levels of government, are responsible to develop recommendations regarding public health measures to prevent, control, or reduce communicable disease emergencies within their jurisdictions. These measures can be population-based (e.g., cancelling public gatherings, closing schools) or individual-based (e.g., hand washing, cough etiquette, wearing of a mask), and their effectiveness may vary depending on the type and the severity of CDE event, the availability of other interventions, such as vaccines and antivirals, and access to healthcare services.

The implications of these potential measures must be recognized by all potential stakeholders, including community planners, and discussed during the planning phase. Some examples are:

- Promote and encourage routine public health activities, including hand washing, cough etiquette, washing common surfaces, staying home when sick, and vaccination.
- Develop a plan to inform community staff and members regarding public health messaging.

Communications

Communications planning for a CDE event is based on openly discussing potential risks, identifying response options, and creating a plan that will be clear and accessible to all community members. The communication plan needs to ensure consistent messaging to the community during a CDE event. The plan should also specify the communication processes with other stakeholders (e.g., neighbouring communities, regional and district health authorities, etc.) as well as align with the provincial communication plan.

- Develop a plan to determine how CDE-related information will be shared with community staff and members.
- Develop a plan to determine how CDE-related information will be received and/or shared with external partners, including the province, ISC-FNIHB Regional offices, while respecting confidentially and privacy laws.

Vaccines and Medications

Vaccine procurement and management, including obtaining supplies and ensuring appropriate storage and handling, and administration is part of day-to-day operations at the community level. All these activities are already well aligned within provincial immunization programs. Therefore, during a CDE event, the management of possible additional vaccines will build on day-to-day processes, although these processes may need to be adapted to the evolving situation.

Since the development and production of a new vaccine takes four to six months (e.g., H1N1 vaccine), pharmaceutical interventions, such as antivirals and antibiotics, and other public health measures will be the first line of defence against the CDE-related event until the vaccine becomes available. Key activities will include:

- Engaging in discussions with the province and the ISC-FNIHB Regional office regarding the process of receiving CDE-related vaccines;
- Assessing current vaccine delivery processes and determining if changes need to be made to allow for quick delivery of vaccines during a CDE event (e.g., mass immunization plan, linking with neighbouring communities, etc.);
- Developing a communication plan that will inform the community (staff and members) of CDE-related vaccine information (e.g., priority groups, mass immunization clinics, etc.).

Conclusion

These guidelines reflect current thinking on CDE planning and response activities, as well as lessons learned from the 2009 H1N1 pandemic. These guidelines are a useful tool to support communities as they develop, strengthen, and revise their CDE. Many types of CDE events can occur, therefore it is important for CDE plans to be flexible to scale up or scale down the response activities depending on the circumstances.

At the start of a CDE event, communities need to access the CDE plans and use them to guide response activities during the event. As more information and evidence from research becomes known, the CDE plans may need to be tailored.

GUIDES AND RESOURCES

The following resources are provided by ISC-FNIHB to assist in the development of the communicable disease control and management programs and services.

Influenza Pandemic Specific Resources
CDE Planning • Canadian Pandemic Influenza Plan for the Health Sector (CPIP) available at: http://www.phac-aspc.gc.ca/cpip-pclcpi • Influenza Pandemic Planning Consideration in On-Reserve First Nation Communities of the CPIP available at: http://www.phac-aspc.gc.ca/cpip-pclcpi/assets/pdf/annex_b-eng.pdf • Provincial resources available below. o British Columbia o Alberta o Saskatchewan o Manitoba o Ontario o Quebec o Nova Scotia o New Brunswick o Prince Edward Island o Newfoundland and Labrador

Surveillance and Laboratory

- Pandemic Influenza Surveillance Guidelines of the CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-n-eng.php
- Pandemic Influenza Laboratory Guidelines of the CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-c-eng.php
- Flu Watch available at:
  http://www.phac-aspc.gc.ca/fluwatch/index-eng.php
- Provincial Influenza Surveillance Links available at:
  http://healthycanadians.gc.ca/diseases-conditions-maladies-affections/disease-maladie/disease-maladie/flu-grippe/surveillance/links-liens-eng.php

Supplies and Storage

- Health Services: Clinical Care Guidelines and Tools of CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-g-eng.php
- If appropriate for your community, develop a plan for the establishment and management of alternate care sites. Guidelines for Non-Traditional Sites and Workers of the CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-j-eng.php
- Business Planning Influenza Pandemic Checklist available at:
  http://www.flu.gov/planning-preparedness/business/businesschecklist.pdf

Public Health Measures

- Public Health Measures of CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-m-eng.php

Communications

- Communications – of CPIP available at: http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-k-eng.php

Vaccines and Medications

- Annex D – Preparing for the Pandemic Vaccine Response – of the CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-d-eng.php
- Annex E – The Use of Antiviral Drugs during a Pandemic – of the CPIP available at:
  http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-e-eng.php

EMERGENCY MANAGEMENT

Broader than the CDE Plan, your Health and Wellness Plan requires a Health Emergency Plan that includes responses to all types of health emergencies that could be faced within your community. Also critical is that your Health Emergency Plan is linked to your community All Hazards Emergency Management Plan.

Here's an example of what your Emergency Plan could cover.

Introduction

1. Purpose/Goal

    - Define "emergency" (may be dependent on jurisdiction).
    - Indicate the aim and objectives of the Emergency Plan.
    - Define the scope of what the plan will cover.
    - Include information on any Council Resolution(s).

2. Definitions

    - Define key terms used in the document.
    - Include glossary of acronyms.

3. Authority

    - Indicate the authority for the Emergency Plan (e.g., the Health Board, Chief and Council, etc.)

Planning Details

4. List the essential services that need to be covered during an emergency.

5. Have an up-to-date list of vulnerable clients, with addresses and contact information.

6. Activation Levels
    - Describe the various levels of activation of the Emergency Plan.
    - Include overview of activities to be completed at each level.

7. Emergency Response Phases
    - Outline the various phases such as; Identification, Notification, Activation, etc.
    - Describe the activities that should occur in each phase.

8. Implementation Criteria
    - Explain what it means to “implement the Emergency Plan”.
    - Provide a list of circumstances/triggers for activating the Emergency Plan.
    - Include a list of situations caused by the forces of nature, accidents, man-made intentional/non-intentional, and natural (communicable disease).

9. Notification System
    - Describe the system, who is responsible, and how it works.
    - Include an Emergency Notification List (should include names of alternates).

10. Declaration of Emergency
    - Specify who can declare that an emergency exists.
    - List, in order, who needs to be notified.
    - Identify who can declare that the emergency is terminated.

Location and Resources

11. Emergency Operations Centre (EOC)
    - Identify a primary and secondary location.
    - Include the layout of each EOC and a list of equipment.

12. Emergency Management Team
    - Describe the team, their mandate, and functions.
    - Include a table with the functional reporting and responsibilities/tasks for each position. An organizational chart would be useful.

13. Control Groups/Teams
    - Identify the other groups/teams that will be involved in the delivery of the Emergency Plan.
    - Include the teams’ key roles and responsibilities.

14. Individual Responsibilities
    - Identify the various officials that may be involved. Specify their position and responsibilities, (e.g., Chief, Community Health Representative, Fire Technician, Emergency Response Coordinator, First Nation Constables, Evacuation Coordinator, etc.).

15. Support and Advisory Staff
    - Identify any additional resources that may be required to provide support and advice to any of the Emergency Management Team or Control Groups.
    - List their individual responsibilities.

16. Other Agencies and Services
    - Identify other agencies that may assist, (e.g., hospitals, volunteer groups, community-based organizations, provincial ministries, school boards, etc.).
    - Describe each of their roles.

17. Identify backup systems for utilities and other services (e.g., electricity, heating, water, phones, etc.).

Communication

18. Communication Plan
    - Provide information on coordinating the release of accurate information to the news media, issuing instructions to the public, and responding to requests for reports/information concerning any aspect of the emergency.
    - Include any community-defined cultural protocols.
    - Describe how updates and communications will go out to the community and key stakeholders.
    - Describe how to resume services as the emergency abates.

Plan Maintenance

19. Emergency Plan Documents
    - Indicate when, how, and which position will be responsible for updating and maintaining the Emergency Plan and all other documents linked to it, for example the Evacuation Plan, the Contingency Plan, etc.

20. Testing the Emergency Plan
    - Provide information on the regular testing of the Emergency Plan; who is responsible for coordinating the test, how often it will be done, how the results will be evaluated, and how the plan will be adjusted according to the results.

Annexes in the Emergency Plan

- List of Emergency Management Team members
- Contact/Resource list
- Evacuation Plan
- Checklist for group leaders
- Contingency Plan
- Sample forms
- List of emergency equipment and supplies
- Schedule of drills and simulations (at least quarterly)

CRISIS RESPONSE AND PREVENTION

As part of, or in addition to your Health Emergency Plan, it's important to have a plan to address emergencies or social crises such as suicides, serious violence, significant substance or prescription drug misuse, or other issues that have a community-wide impact. This section is based on the belief that response and healing from crisis begins first within your community, grounded in your community strengths and wisdom, and is then supported by external partners and resources. Even though it's almost impossible to prepare for all possible events, having a plan can guide your community through many of them and give more of a sense of control.

Preplanning will require the community to examine existing strengths that can be drawn upon to address a crisis within the community. It may also involve access to external supports to help your community respond to the immediate needs of individuals, families, and the community beyond what the existing community workforce can provide. The steps below can help guide the development of the crisis response and prevention section of your Health and Wellness Plan.

1. Describe the community and its strengths.

   One important cultural tradition across Indigenous peoples is to introduce oneself through culture: spirit name, clan, nation, family lineage, and connection to the land you come from. These cultural identifiers are the foundation of strength. This same principle applies to the community identity as a whole. It's important for communities to describe the meaning of its traditional or cultural name, the clan families of the community, relationship with other nations/tribal council affiliations, the family ties common to other communities, and the history of how the community came to be on the land it currently knows as home.

   Although it can sometimes feel like a denial of the hurt, pain, and struggle in a community, telling a story of community strength is also empowering. The story of strength is an important tool in helping a community work effectively with the external supports coming in to assist with the crisis. It communicates the message that there are strengths within the community even though it needs support to deal with the crisis. It lets everyone know that, with these strengths, the community can lead and direct external supports.

   The community strengths identified through your Asset Mapping exercise (done as part of your community assessment) will be a good resource here.

To Consider…

"Wise Practices" are locally-appropriate actions, tools, principles, or decisions that contribute to the development of sustainable and equitable social conditions.

"Wise Practices" recognize that Indigenous cultures are diverse and ever-changing. Therefore a "best practice' in one situation may not be relevant or appropriate in another situation.

Adapted from the Banff Centre, 2010

2. Assess Potential Risks

   A comprehensive crisis response plan will enable the community to draw upon formal (e.g., program data, accreditation results, research, etc.) and informal (e.g., community perspectives, knowledge keepers, etc.) information systems within the community. Consider the populations possibly at risk (e.g., youth, LGBTQ2, individuals in care, etc.) and examine the factors that increase their risks (e.g., substance misuse, mental illness, family violence, etc.). Answer the following questions:

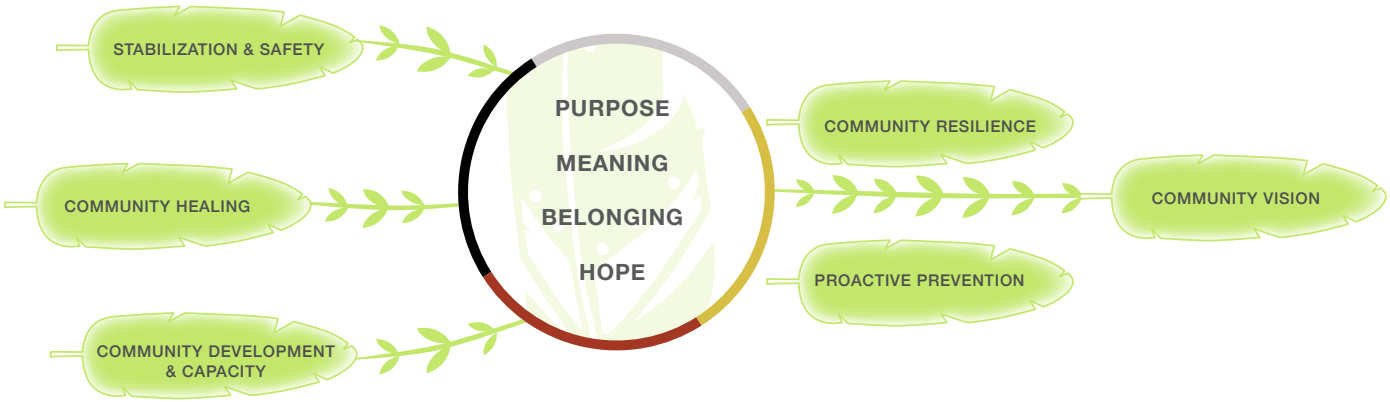
   - What does each of the populations at risk need in relation to each risk factor?
   - What factors may be increasing the risks of a potential crisis?
   - What can be done to intervene early to limit the extent of a crisis?
   - What can be done to reduce the impact of a crisis?
   - What can be done to prevent future crises?

3. Establish Principles to Guide Crisis Response

   Some examples of principles that can effectively guide how external resources come into the community to respond to crisis are:

   - The response is coordinated by our people.
   - The health and safety of children and youth come first.
   - There are partnerships already in place with neighbouring communities, municipal/provincial/federal governments.
   - External supports are responsive to and respectful of cultural protocols and community diversity.
   - Prevention and response activities are more successful when they enhance local capacity and reduce dependency.

The diagram illustrates how key aspects of crisis response can also contribute to crisis prevention, reducing the risk of reoccurrence and increasing community resilience.



Stabilization and Safety

At the individual and family levels, crisis response requires access to community-based and external supports to respond to urgent needs, assist with stabilization, and where needed, transition clients to other services or some form of continuing care. An essential component of crisis response is coordinated and timely follow-up and debriefing at an individual, family, and community level. Using a trauma-informed approach, the debriefing may focus on the individuals through a counselling session or follow a more culturally relevant and strength-based approach using small groups that are led by community members.

Community Healing

Each community will have an approach that helps to guide the healing process. It may include some or all of the following elements:

- Assessments – family-based, recognizing community resources, and how the community responds in times of crisis and celebration.
- Cognitive behavioural therapy – can incorporate traditional cultural activities.
- Restorative practices – although commonly thought of as a process, such as a circle or facilitated dialogue, can be any approaches that repair harm.
- Cultural practices – could be Indigenous language, prayer, use of smudge, sweat lodge or other ceremonial cleansing, traditional cultural teachings, access to Elders and cultural practitioners, addressing complicated grief through feast for ancestors/loved ones who have passed on, culturally-informed burial practices, access to creation stories to support decolonization, sharing circles, etc.

Community Development and Capacity

Community development can empower communities to define and manage their own services, utilize their cultural knowledge, and build on their unique strengths. Some examples of skills that support these activities include:

- Building relationships;
- Engaging natural or information supports within the community;
- Encouraging community dialogue and communication;
- Team-building;
- Training in trauma-based practices that address inter-generational trauma;
- Building linkages across the community (social determinants of health);
- Supporting the community through change;
- Creating opportunities for knowledge exchange and mentoring (including with other communities).

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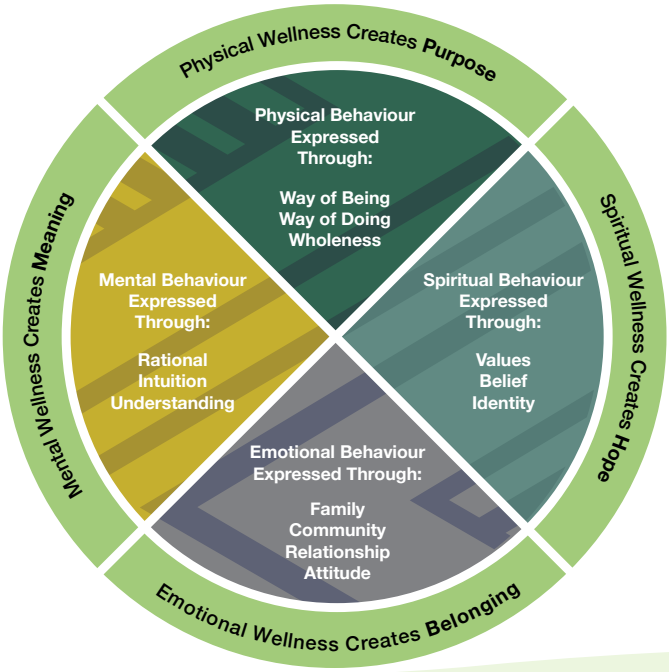
The First Nation Mental Wellness Continuum Framework (2015) can provide a foundation for monitoring and measuring the improvement in both individual and community wellness.

SPIRIT Wellness – This aspect of a whole and healthy person (wellbeing) is expressed through belief (comes from the spirit and belief creates reality, perception and vision), values (belief causes us to value life and to value all aspects of life in a certain way), and identity (a way of knowing ourselves and a way of being, includes, spirit name, clan, nation). The broad outcome or result of the spirit aspect of wellness is Hope. (belief + values + identity = hope).

EMOTIONAL Wellness – The Heart Level of a whole and healthy person (wellbeing) is expressed through attitude (the central desire to live and to be), relationship (relatedness to every being in Creation, Clan, Family), and family/community (is central to connection). The broad outcome or result of the emotional aspect of wellness is Belonging. (attitude + relationship + family/community = belonging).

MENTAL Wellness – This aspect of a whole and healthy person (wellbeing) is expressed through intuition (heart level knowledge, often referred to as "blood memory" because it comes from spirit), rational knowledge, and understanding (integration and balance of emotion and cognitive knowledge). The broad outcome or result of the mental aspect of wellness is Meaning. (intuition + rational knowledge + understanding = meaning).

PHYSICAL Wellness – This aspect of a whole and healthy person (wellbeing) is expressed through wholeness (the physical body is the vessel for the other three aspects of self and all aspects of being are interdependent to create wholeness), way of being (describes the expression of identity as it is influenced centrally by spirit), and way of doing (the expression of values). The broad outcome or result of the physical aspect of wellness is Purpose. (wholeness + way of being + way of doing = purpose).



GUIDES AND RESOURCES

The following resources can assist in the development of these services.

First Nations Mental Wellness Continuum Framework (2015) (Assembly of First Nations, Health Canada)
Indigenous Wellness Indicators (2016) (Thunderbird Partnership Foundation)
First Nations Mental Wellness Continuum Framework Implementation Guide (2017)
(Thunderbird Partnership Foundation)

ENVIRONMENTAL PUBLIC HEALTH

The health and wellness planning process must address environmental public health issues and your Health and Wellness Plan will ensure the provision of environmental public health services in your community.

Whether or not the community is responsible for this program, your Health and Wellness Plan must include details about the following:

- The objectives of the Environmental Public Health Program; to identify environmental public health risks that could impact the health of your community and recommend actions to reduce the risks.
- The name of the Environmental Health Officer(s) (EHO) who will deliver the environmental public health services, and the names of community environmental public health staff (e.g., community-based water monitors, public educators) that support the EHO(s) to collect samples, perform tests and other monitoring activities, and undertake community education activities, etc.
- A description of the environmental public health activities to be carried out in the following eight core program areas, as per the ***National Framework for Environmental Public Health Programming in First Nations Communities South of 60°***:
    - Drinking water;
    - Wastewater;
    - Housing;
    - Food safety;
    - Facilities inspections;
    - Solid waste disposal;
    - Environmental communicable disease control;
    - Emergency preparedness and response.

The description of program activities should include details about:

- Environmental Public Health Assessments/Public Health Inspections:
    - Scope, parameters and frequency of inspections for;
        - Housing
        - Food service facilities
        - Solid waste (garbage) disposal sites
        - Drinking water and wastewater systems

    - Community and public facilities;
        - Health, community care and institutional facilities
        - Administration offices, schools, businesses, recreational facilities
        - Temporary special event facilities such as Pow Wows, etc.
- Roles, responsibilities, and processes for investigating and responding to suspected and confirmed environmental public health communicable disease outbreaks (e.g., *E. coli*, West Nile virus, salmonella, etc.).
- List of environmental public health considerations – as well as roles, responsibilities, and activities in the case of an emergency – to be included in the Health Emergency Plan.
- Education, training, and activities to raise awareness, promote safe practices, and educate about risk reduction within the community on food safety and handling, drinking water safety, solid waste and wastewater disposal, safety and sanitation of facilities, and communicable disease control (environmental public health component).
- Description of plans and persons responsible for entering data on program activities and the results of assessments (including inspections, investigations, training, sampling, professional development, and public education activities) in a suitable information system, to facilitate record keeping, and public health data analysis and reporting.

For communities participating in a community-based Drinking Water Program, your Health and Wellness Plan must also describe:

- A plan including the designation of (an) individual(s) (to be trained by the EHO) responsible for drinking water quality monitoring in the community, referred to as a Community-Based Drinking Water Quality Monitor (CBWM) and a designated back-up alternate who is available and trained to sample and test drinking water in the absence of the CBWM.
- Objectives of the CBWM program, which are to:
    - Sample and test drinking water supplies for *E. coli*, total coliforms, and chlorine residuals, as per the ***Drinking Water Program Manual*** and other supporting documents.
    - Reduce the possibility of waterborne disease outbreaks by increasing and improving the monitoring of, and reporting on, community drinking water supplies in your community/ organization.
    - Build community capacity through the community-based Drinking Water Quality Monitoring Program activities.
- CBWM Program activities which include:
    - Sample and test drinking water in public and semi-public water systems for *E. coli*, total coliforms, turbidity, and chlorine residuals once per week, with a minimum of two samples from different locations in the distribution system, as per the ***Drinking Water Program Manual***.
    - Sample and test drinking water from private wells and cisterns for *E. coli* and total coliforms at least once per year or upon request as per the ***Drinking Water Program Manual***.
    - Record all results of bacteriological and chlorine residual testing results on water quality data sheets and send results to the EHO for interpretation and recommendations for further

action, if necessary. At minimum, results are to be provided to the EHO weekly, or more often as identified by the EHO. In cases where the EHO is employed by the organization, results are also to be provided to ISC-FNIHB.

- Input all water quality testing results into the designated database after results are determined, where access to a drinking water database is available.
- Perform quality control procedures once a month as trained by the EHO.
- Immediately notify the EHO of any positive bacteriological results or unacceptable chlorine residual test.
- Participate in the development and implementation of community emergency response plans pertaining to the water and wastewater system.
- Provide additional water samples as identified by EHO based on the ***Guidelines for Canada Drinking Water Quality, Drinking Water Program Manual*** and/or other supporting documents.

GUIDES AND RESOURCES

The following are guidelines that are provided by ISC-FNIHB to assist in the development of the mandatory programs and services.

National Framework for Environmental Public Health Programming in First Nations Communities South of 60° Drinking Water Program Manual

PULL IT ALL TOGETHER

Beyond the specific mandatory programs and services, there are several other programs and services that your community will be including in your health and wellness planning. Some examples of these are maternal child health programs, Aboriginal Diabetes Initiative or chronic disease programming.

Depending on the type of funding agreement you have, most of these programs offer significant flexibility in how they are implemented. This is where your community assessment process (where you identified needs and assets) will be valuable, as it will have demonstrated the key areas where programs and services can have an impact.

In your Strategic Plan, you have identified the key goals your organization is seeking to achieve within five to ten years (depending on the length of your plan). How you implement and manage your programs and services is how you will achieve those goals. In the past, programs and services tended to be seen as individual approaches; now, ***your Health and Wellness Plan views all your activities as working together to achieve your goals.*** Both mandatory and community-guided programs are in place to help improve your community's health and wellness.

In your planning, identify all the programs and services you'll be offering to your community. For each of your programs and services, it's important to be clear on the following:

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- How is this program or service contributing to the health and wellness of your community?
- How is this program or service helping to achieve your medium- or long-term Strategic Goals?
- Are there any specific objectives that must be met as a requirement of the funding?
- What are your organization's objectives related to this program or service?
- What resources does this program or service require?
- What is the delivery model and who are the target clientele of this program or service?
- What are the key activities of this program or service?
- What are the challenges or risks of implementing or managing this program or service?
- What are the indicators that demonstrate that this program or service is making a difference and helping to achieve the organization's annual objectives or Strategic Goals?

This information could be put into a table where it could be referenced for different documents such as your annual plan or other reports. An example is below:

Program/ Service	How contribute to Strategic Goals	Program Objectives	Resources	Delivery Model	Target Clients	Key Activities	Indicators

EVALUATION PLAN

Evaluation is the process of measuring processes, activities, and outcomes against expectations (that use indicators) to make improvements. It is a natural process and is part of the everyday work in your organization. When you change the time of a workshop, so more people can attend, it's because you've evaluated (informally), based on feedback and poor attendance, that the original time wasn't filling the needs of your community. Evaluation means to assess whether all the activities of your programs and services are achieving what you want them to achieve. Essentially, are they making a difference and how?

Evaluation of your Health and Wellness Plan is a more formal activity and is an essential element of your overall planning process. In the past, evaluations were primarily conducted for the funder, to demonstrate accountability and provide evidence of activities. However, health organizations now realize the power of evaluations for ***them***, for assessing the impacts of ***their*** programs and services on the health of ***their*** community. This also provides community decision-makers with necessary information on the effectiveness and efficiency of programs and services and allows for ongoing adjustments while supporting continuous improvement. An effective evaluation will provide information on:

- How well the programs and services are operating;
- How well programs and services are meeting their objectives;
- Whether programs and services are using resources efficiently;
- Whether programs and services are meeting community needs;
- What needs to be modified to better suit community needs;
- Whether new or emerging priorities have arisen;
- Whether there have been changes in health status in the community.

Ongoing monitoring and evaluation based on effective indicators, are essential continuous quality improvement practices and are key to becoming an effective organization. Using a quality improvement lens, you can start by assessing your programs and services by asking these questions:

- Did we provide equitable, timely, and appropriate health programs and services? (accessible)
- Did we actively involve and respect the needs and preferences of individuals, families, and our community? (client-centred)
- Did we integrate knowledge about our community into specific health programs and services standards, policies, practices, and attitudes? (culturally competent)
- Did we achieve the best possible health outcomes, supported by current evidence? (effective)
- Did we make the best use of resources to optimize benefits and results? (efficient)
- Did we minimize risk and avoid harm? (safe)

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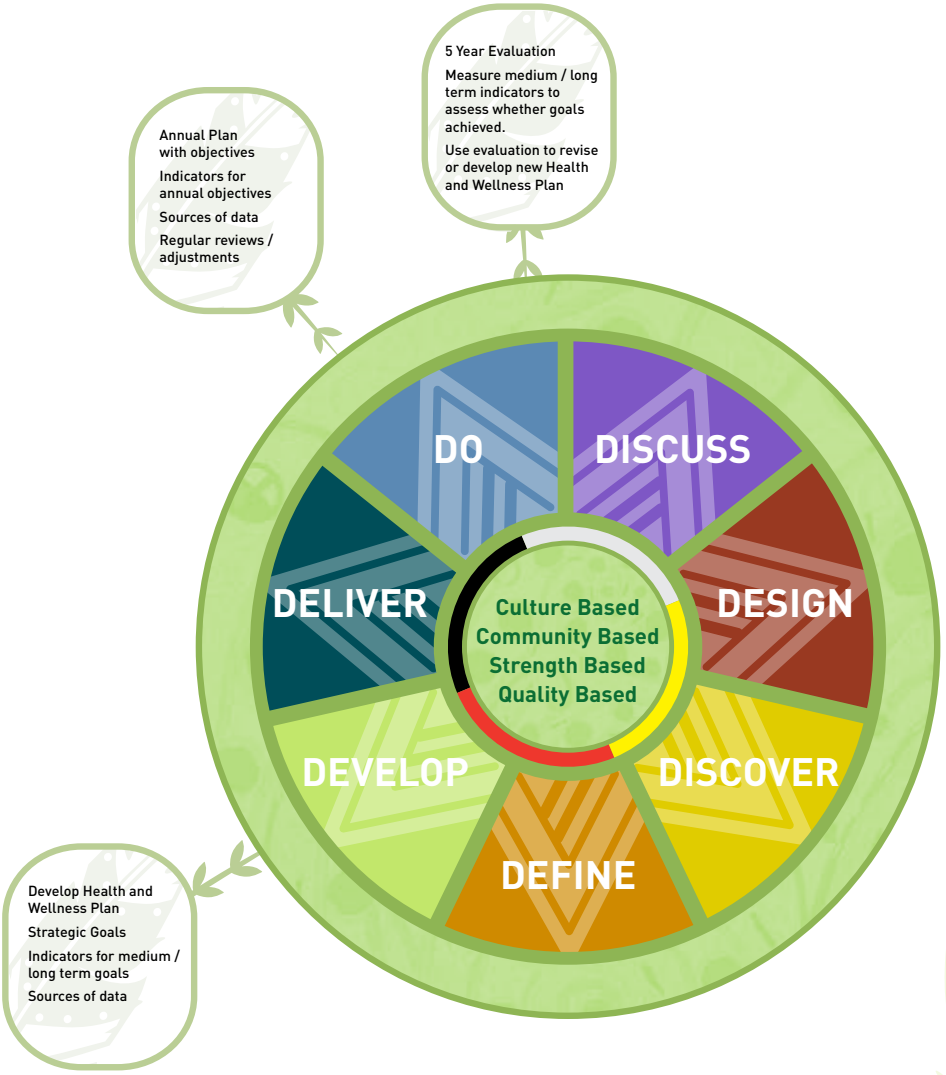
When and how do we evaluate?

If the goal of evaluation is to support continuous quality improvement, then the answer is "all the time". However, evaluation does have specific roles: first, in the Strategic Planning process; secondly, in the ongoing review of program and services; and thirdly, in the more formal five-year Health and Wellness Plan evaluation. What should be perfectly clear is that evaluation is NOT an activity that is only considered at the end but is an essential component of your planning process from the beginning.

The diagram illustrates where evaluation activities should be included throughout the health planning process.



Let's explore in more detail, the role that evaluation plays at different stages in your Health and Wellness planning process, and who would be involved.

1. The first step is understanding what you want to achieve and identifying how you will measure your progress. When creating your Strategic Plan, you have set medium/long term goals, which include indicators that allow you to measure progress. For example, you may have identified as a medium-term goal "***Within five years, reduce the rate of new teenagers smokers by 40%***" (or by xxxx year). That gives you a target to which you can compare your data each year to see how well you're doing in achieving that goal. As part of identifying your goals and objectives, you will have considered which indicators would measure the results and tell you whether you are achieving your goal and where you would get these data.

   Who is involved?
   Your planning team would be involved in setting the indicators related to the goals. However, they would be advised by management and program front-line workers to ensure that the indicators are realistic (i.e., we can collect these data), valid (i.e., the data are providing information on what we think we are), and relevant (i.e., the data are related to the issue at hand). In addition, you may find it helpful to get advice from an evaluation specialist.

2. The second step is to regularly assess how well you're doing in achieving your goals and objectives. During your annual planning you will assess (evaluate) how well you have done so far in achieving each strategic goal. This will help you determine your objective for the upcoming year. Each objective (or mini-goal) for this year will include an indicator that will demonstrate whether you've achieved your objective. To continue the example above ("***Within five years, reduce the rate of new teenagers smokers by 40%***"), one of your objectives this year may be to reduce the peer pressure to smoke and "establish 15 youth 'Butt Out' champions to become role models in the community". You can create indicators for that particular objective that can guide your workplan this year.

   At key points during the year (e.g., quarterly, or semi-annually), you would conduct program reviews, which would demonstrate whether you are on track to achieve the objectives. When your annual objectives are clearly laid out, with indicators and tactics, it is easier to report back on your results.

   In addition, a focus on the process or implementation of your Strategic Plan and your Annual Plan is extremely helpful as it determines whether program activities have been implemented as intended. That provides you an opportunity to make adjustments going forward. This ongoing assessment is a very helpful process for your organization and embeds continuous quality improvement into your operations.

Who is involved?
Determining your annual objectives (that tie into your Strategic Goals) would usually be done by your Management Team (Health Director, managers, etc.) as they develop the Annual Plan. Again, you'd likely include program front-line workers to ensure you're identifying appropriate indicators for your Annual Plan. For the mid-point reviews, it might be program managers, or health management, depending on who would be leading this work. It is important to include these responsibilities in job descriptions and annual work planning, to ensure consistency and timeliness.

3. The third step is the stage of evaluation that most people think of – the outcome evaluation, or the formal five-year evaluation. This evaluation looks at the activities and results of the past five years and determines whether the goals were achieved. Some health outcomes can be measured (although changes in most health outcomes are not generally seen for ten years or more), but the evaluation is more focused on effectiveness (i.e., whether the goals and objectives have made a difference, based on the indicators) and efficiency (i.e., whether the results gave the best value for resources – financial, human resources, and infrastructure). This process is extremely valuable, as it provides an objective "look back" over the past five years, identifies what has been successful, illustrates whether there are new challenges, and lays a good foundation for starting the next Health and Wellness Plan. It is information that your organization needs to move forward in a good way.

   Who is involved?
   The five-year evaluation of your Health and Wellness Plan requires some evaluation experience to ensure a robust process and to produce meaningful results. Usually an outside evaluator is hired by the organization to guide the evaluation process, however, some organizations have expertise within their community that they can draw upon. Ensure that the evaluator you choose has experience in working with First Nation communities or organizations and is aware of your protocols. Whether you contract an outside evaluator or use someone from within, it's important to use this opportunity to strengthen evaluation skills within your organization. Build in time to have the evaluator share findings with your teams or conduct a short training session on some aspect of evaluation (e.g., conducting a focus group). In that way, you are building capacity within your organization for ongoing evaluation elements.

This table may help you organize who is working on the stages and types of evaluation.

	Evaluation Planning	Process Evaluation/ Regular Reviews	Outcome Evaluation/ Formal Five-year Evaluation
Purpose	• Identify the process and indicators of your Evaluation Plan	• Confirm progress to date • Make mid-course adjustments • Set objectives and indicators for the upcoming year	• Examine past five years and assess if Strategic Goals were met • Measure effectiveness and efficiency • Identify gaps or emerging priorities
Main person/ people involved	• Health and Wellness Planning Group, management, frontline workers	• Senior management, Program managers, people who know the programs and services well	• Outside evaluator • Senior management
Expected outcomes	• An Evaluation Plan created through a participatory process • An organizational focus on evaluation	• Clear directions on what is working and what needs adjustments • Engaged employees • Updated and current annual objectives and indicators	• Clear picture of progress toward achieving Strategic Goals • Sense of pride at achievements • Valuable data for future planning
Expected deliverables	• Evaluation Plan	• Reports • Presentations • Annual Plan	• Evaluation Report • Presentations • Summary

INDICATORS

If you are ever asked "***How can we ensure that our organization is actually making a difference in the health of our community***?" … hopefully you can answer "***Because we use effective indicators that measure the right activities using the right data***".

Indicators are ***measures*** that help us understand what is going on in a system, allow comparison over time, and guide improvements. Indicators can be used for:

- Understanding how a system works and how it can be improved;
- Monitoring whether a system is performing to an identified standard.

Types of Indicators

This Guide will discuss three key types of indicators – Process, Outcome, and Balancing measures.

- Process indicators: These inform about the process or implementation of the program or services activities. They track the extent to which the program or service is being implemented as designed and is accessible to its target population. They can provide an "early warning" as to whether ongoing system components, interventions, or services are performing as intended. An example would be "the rate of clients discharged from the hospital who received a visit from the home care nurse within 48 hours".
- Outcome indicators: These tell what happened to a client because of the care they received. They measure the impact of the system, interventions, or services on a client's values, experience, health, or well-being. An example would be "the number of clients who are now cooking with vegetables from the community garden on a weekly basis".
- Balancing measures: These ensure that interventions or services designed to improve one area of the system are not creating problems in other areas. They point to the unintentional negative consequences of quality improvement activities. An example would be, "if the goal is to return clients to the community quickly after hospital stays, what is the additional requirement for Home and Community Care services?" The increase in demand for Home and Community Care services due to clients being sent home to the community with more severe needs, is a balancing measure and should be considered.

Selecting the right indicators is critical if you want quality improvement. Once a team establishes a clear and specific objective, the appropriate indicators should be simple to identify. If teams are struggling to identify an appropriate indicator they should revisit and refine their objective.

Consider the following suggestions when using data collection processes for quality improvement initiatives:

- Focus on a few concrete indicators that make it clear what you are improving.
- Do not overly rely on process indicators. It is important to pair these with outcome indicators while determining if there are any balancing measures.
- Regularly collect and plot the data visually. Make this information available routinely to team members.
- Try to integrate data collection into work processes that already exist.

Common problems with performance indicators:

- The wrong indicator is being used. What is being measured is not what is needed to demonstrate value to the clients;
- The right indicator is being used, but a wrong measurement for that indicator is being applied;
- The calculation is too complex to be useful as an indicator of performance, or is too simple without considering other conditions;
- Too many indicators are used;
- The focus is only on things that are easy to measure, whether or not they are the key indicators actually needed by the organization;

- Indicators that only use numbers to quantify results tend to overlook or not capture the perceptions and experiences of clients;
- Indicators are associated with fault-finding, rather than helping to understand performance.

Activity to be evaluated	Less effective indicator	More effective indicator
Whether a workshop on cooking traditional foods was effective	Number of people who attended the workshop (only counts attendance, doesn't measure a change in attitude or practice)	Percentage of people who reported cooking with traditional foods after attending the workshop, compared to before the workshop. (measures change in practices due to the workshop)
Increased number of children who are immunized following the provincial schedule	Number of immunization awareness campaigns (pamphlets, radio shows, posters) (counts tools/methods, not results)	Immunization coverage rates (the percentage of children who are now following provincial immunization schedules as compared to last year.) (measures changes in behaviour over time. Whether it was a result of the tools/methods can be established by further data collection)

However, it is important to remember that indicators do just that – indicate. They don't tell the whole story, so when developing your evaluation, be sure to include other sources of information that capture the richness of the client experience and the complexity of your organization. Some examples could be through using stories and sharing client perspectives in reports and evaluations. Determining useful and effective indicators can take time and practice.

FIRST NATIONS MENTAL WELLNESS CONTINUUM FRAMEWORK – INDICATORS AND OUTCOME MEASURES

The ***Indigenous Wellness Framework*** of the Thunderbird Partnership Foundation identifies Hope, Belonging, Meaning, and Purpose as outcomes measures of any investments towards wellness. The outcomes of effective community health and wellness planning should be represented by relevant community health indicators.

Community Wellness Indicators

Health indicators are measurements. They measure different aspects of health within a community or group. Each indicator is like a piece of a puzzle contributing to an overall picture. When indicators are tracked over time, the picture becomes a movie, allowing us to see how the health story is changing.

Indicators can measure both health status and elements that determine health.

1. **Health status** indicators measure different aspects of the health of a population. Examples include life expectancy, infant mortality, disability, or chronic disease rates.
2. **Health determinant** indicators measure things that influence health. Examples include diet, smoking, water quality, income and access to health services. First Nations also consider language, culture, and spirituality to be health determinants.

Indicators help to answer important questions related to evaluating the impact of community health and wellness planning and can include:

1. How healthy is our community?
2. Is our community in balance?
3. What things affect health in our community?
4. Are our programs, services, or policies working?
5. Are we moving towards or away from our vision of health?

Wellness from an Indigenous perspective represents a whole and healthy person expressed through a sense of balance of spirit, heart, mind, and body. Central to wellness is the belief in our connection to language, land, beings of creation, and ancestry, supported by a caring family and environment. Wellness of a whole and healthy person is described as follows:

Spiritual wellness is the quality of being alive in a qualitative way. The spirit causes us to live, gives us vitality, mobility, purpose, and the desire to achieve the highest quality of living in the world. Spirit is central to the primary vision of life and worldview and thereby facilitates ***hope***.

Emotional wellness is nurtured by our ***belonging*** within interdependent relationships with others and living in relation to creation, including beings in creation, and is at the heart level of our being. Within an Indigenous worldview, being rooted in family, community, and within creation as extended family is the foundation of ***belonging*** and relationships.

Mental wellness is the conscious and intelligent drive to know and activate our being and becoming. Having a reason for being gives ***meaning*** to life. The mind operates in both a rational and intuitive capacity.

Physical wellness is that way of behaving and doing that actualizes the intention and desire of the spirit in the world. This, and the knowledge that the spirit has something to do in the world, generates a sense of ***purpose***, conscious of being part of something that is much greater than they are as an individual. The body is the most outer part of our being and is comprised of the most immediate behavioural aspects of our being.

CREATE AN EVALUATION PLAN

This section refers to developing an Evaluation Plan for the regular and ongoing assessments and reporting, as well as for your five-year evaluation of your Strategic Plan. Even if your Health and Wellness Plan covers ten years, a formal evaluation is completed every five years.

An effective Evaluation Plan would include the following sections.

1. Evaluation Objectives

This is where you describe what you want to accomplish because of the evaluation activities. Why are you conducting the evaluation?

Consider all the ongoing evaluation activities (monitoring program results, data collection, etc.). What is the reason you are conducting these? What questions are you seeking to answer? Do the same for your formal five-year evaluation.

2. Evaluation of Programs and Services

In your Evaluation Plan, outline all your programs and services and include for each:

- A brief description of each program and service including;
    - Program- and service-specific objectives,
    - Target clientele for the program or service,
    - Key activities of the program or service (high level).
- How each program and service will help you achieve your Strategic Goals (including both mandatory and community-guided programs);
- Any specific goals or requirements for the programs and services;
- The indicators for all goals;
- Sources of data.

3. Strategic Goals

As noted earlier in this Guide, your Strategic Goals are the medium/longer term goals that you aim to achieve over the five-year term of your Health and Wellness Plan. They are higher level goals and are based on the priorities that were identified according to the data that came from your community assessment process. The Strategic Goals will be used each year to guide the formulation of the annual objectives in your Annual Plan.

4. Indicators for the Strategic Goals

Each Strategic Goal requires indicators that will help measure whether the goal is being met or not. Use the section on indicators to ensure your indicators are realistic, relevant, and valid.

To Consider …

Some examples of good practices in evaluation:

- Make monitoring a participatory process, including clients, families, community, and staff
- Make an inventory of available data sources
- Use the information collected as part of the monitoring process for reporting purposes
- Use results to make concrete recommendations for improvement
- Make evaluation results easily available to clients and community
- Celebrate successes and hard work

5. Sources of Data

The Evaluation Plan should include the program and services data that staff will collect day-to-day, to support the measurement of indicators, including any indicators that ISC-FNIHB specifies for its minimum reporting requirements. For each indicator, you will explain where the data will come from. There are many sources of data that you can use (e.g., program reports, chart reviews, previous evaluation reports, CBRT, eSDRT, Regional Health Survey data, provincial or RHA statistics, community surveys, focus groups, etc.). It is important that your indicators are supported by robust data to ensure valid results. Include a description of how this information is recorded and stored so that it is available in a timely manner and remains secure.

6. Evaluation Methods

This section is where you identify the different methods that will be used to conduct the evaluations – both the ongoing reviews and reporting, and the formal five-year evaluation. Describe how ongoing reviews and assessments will be completed and provide any specific templates or tools that will be used.

For the formal five-year evaluation, describe the approach that will be followed. How will the Strategic Goals be assessed? What processes will be used? For example, how will the evaluation integrate both qualitative and quantitative data sources? Do you have specific community protocols around evaluations that need to be considered? At this point, you are developing an overview, as the actual five-year evaluation is years away. What is important is that you are planning up front, which will ensure you put the necessary processes in place to collect and measure the data as you go along.

7. Evaluation Deliverables

You will have different deliverables for the various evaluation processes. For your periodic and ongoing reviews, you would develop reports (e.g., quarterly reports, annual reports) that provide a "snapshot in time" on how your organization is doing. It would answer "Are you meeting your annual objectives?" and provides valuable information on whether you need to make any mid-course adjustments based on your interim data.

For your formal five-year evaluation, you would generate an Evaluation Report that outlines both the process and outcomes of your evaluation.

8. Timelines

Clearly explain when the various evaluation activities will be performed. What are the timeframes for the ongoing reviews? When will interim reports be issued? When will the formal five-year evaluation be conducted? This requires planning to secure an evaluator and potentially set up a contract. A timeline or calendar could be useful here.

9. Roles and Responsibilities

In this section, describe who is responsible for which activities. Include both the ongoing reviews and reporting, and the formal five-year evaluation. It is effective to identify only one person who is accountable for each activity, and then separately note everyone who may be involved.

10. Resources

Conducting your evaluation will require resources, both financial and human resources. For the ongoing monitoring, it might require that you add additional activities to a job description. For the five-year evaluation, you would include evaluation expenses in the budget in year five for an evaluation consultant[2]. In addition, consider the time required by someone in your team to coordinate with the evaluation consultant.

11. Communication

It is very important to keep your organization, your leadership, your clients, and your community informed. This may be a simple update in a community meeting that shares interim results of your programming, a regular briefing with Chief and Council, or notices that explain the upcoming five-year evaluation. Who do you need to keep informed? How would you inform them? (e.g., radio spots, posters in the health centre). Add this to your Communication and Engagement Plan that you developed in the Design stage.

Key elements of your Evaluation Plan could be summarized in a table format, such as the following example.

[2] ISC-FNIHB provides some evaluation funding in the overall contribution agreement. Confirm with your ISC-FNIHB Regional office.

Program	How contribute to Strategic Goals	Specific Program/ Service Objectives	Indicators	Sources of data	Timelines	Responsibility for data collection
Home and Community Care	Programming helps to reduce the rate of preventable diabetes-related hospital admissions	Assist First Nations and Inuit living with chronic and acute illnesses	Rate of diabetes-related hospital admissions	eSDRT	Apr-Mar	Home and Community Care nurse

As you develop your evaluation plan, consider the following tips adapted from ***Safer Healthcare Now***! (2011):

- Collect your data and plot it over time. By tracking a few indicators and plotting these data over time, your team can examine trends and determine if positive changes are occurring and if not, adjust as required.
- Use a representative sample. Collecting indicators on all clients every day, all day, is not sustainable. Collect data on a sample of days, from a sample of clients.
- Make data collection a part of your regular activities or processes. Whether you're using existing or new tools to collect data, ensure the tools are user-friendly and can be integrated into the daily routines of the staff involved in data collection or the service measured. This will yield better compliance with the data collection process.
- Collect what is meaningful and useful. Don't get caught stockpiling data that ***may*** be useful. Stay focused on what ***will*** inform your evaluation process.

EVALUATION REPORTS

You will plan for, organize, and present your evaluation results in different formats depending on the type of evaluation and the audience. For example, your ongoing review and reporting might be shared as a quarterly report, an interim report or an annual report. In addition, depending on the audience, the report may be a briefing note, a website update, or a printed report. What is essential is that you understand the most effective way to share your information, you have a plan for developing the report, and you provide the right results.

For your formal five-year evaluation, your Evaluation Report is a more structured document that provides valid and credible results. The Evaluation Report could include the following sections:

1. Cover Page – explains what the report is about
2. Table of Contents – lists all the key headings
3. Foreword or "Message from…" – this can be written by Chief and Council or Health Authority or Health Director
4. Executive Summary – summarize the report, a brief overview of each section
5. Profile of the Health Programs – overview of health programs, service delivery, funding
6. Profile of the Community – population, demographics, social determinants of health
7. Health Programs and Priorities – priorities of overall evaluation and for specific programs
8. Evaluation Approach – context, indicators, methodology
9. Evaluation Findings – governance, management, administration, individual programs
10. Recommendations – evaluator's recommendations on all evaluated aspects of health programs
11. Appendices – Evaluation Committee members, data collection tools, key data, communications

The ISC-FNIHB document ***Evaluation Report Guide (2005)***, provides a more detailed explanation of how to structure your Evaluation Report.

There is a tendency to relax data measurement and data collection once a change has been fully implemented. It is important for teams to consider what data they will periodically monitor to ensure that their change is sustained over time. Indicator monitoring is important at all phases—planning, implementation, evaluation, and sustaining the change over time.

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Integrate respect into Strategic Plan
- Consider alternatives based on cultural practices
- Incorporate traditional knowledge and practices
- Include knowledge keepers and ceremonialists as assets
- Incorporate culture into health and healing
- Include seven teachings
- Define "cultural competence" and "cultural humility"; incorporate into orientation and training
- Find out from clients what "culturally safe care" means to them

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Build on what's been done
- Understand the approaches that have been most successful in your community
- Seek outside funding (e.g., not-for-profits, corporations, provinces, etc.)
- Share your stories of success
- Be flexible to include new programs or services if required

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Ensure plan is needs-based
- Ensure integration across the plan
- Understand and include community protocols
- Blend community priorities with required programs and services elements
- Seek community input/feedback at different stages of process to ensure it reflects their needs
- Build in ongoing capacity building
- Ensure the entire process is community-driven
- Share community stories
- Include OCAP® data principles (Ownership, Control, Access, Possession)

QUALITY-BASED

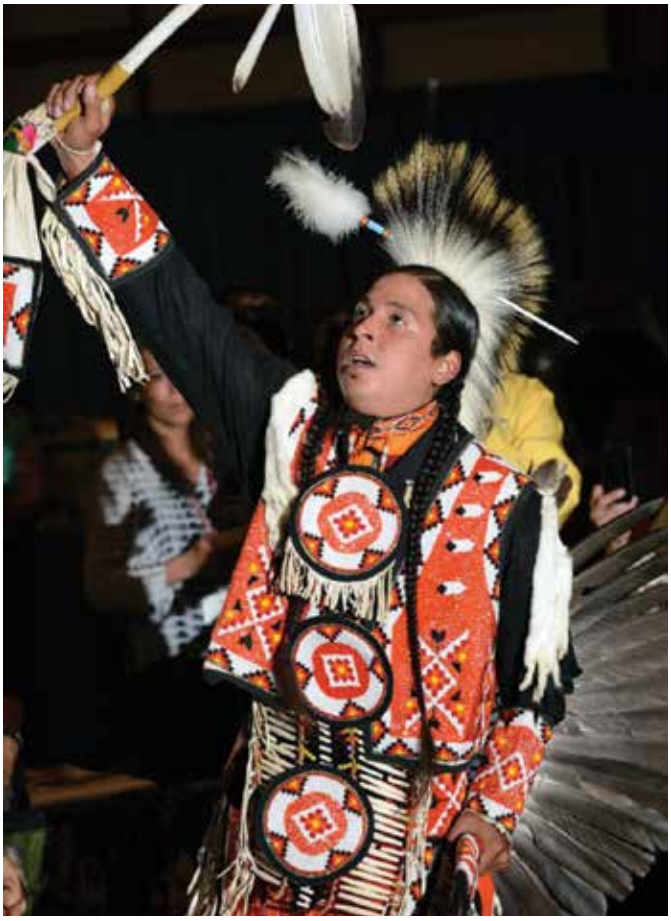
Some examples that demonstrate **quality** as a guiding value:

- Incorporate SMART goals and objectives (Specific, Measurable, Achievable, Relevant, Time-based)
- Ensure compliance with regulations and legislation
- Develop programs and services based on guidelines where required
- Keep the client at the centre of planning
- Ensure all mandatory programs are implemented appropriately
- Focus on client safety
- Include indicators for all programs and services
- Engage in accreditation to incorporate standards of excellence with an Indigenous focus
- Seek and incorporate feedback from clients and community members
- Include evaluation as part of upfront planning
- Consider how to ensure programs and services can be "scalable" (i.e., able to be increased or decreased as required)

TRAINING THAT COULD BE HELPFUL

Some examples of training that could help in the "**Develop**" stage:

- Creating Strategic Plans
- Indicators
- Evaluation
- Client safety
- Accreditation
- Program planning
- Program/service specific training
- How to lead teams
- Effective communication



DELIVER
THE PLAN

DELIVER …THE PLAN

The "**Deliver**" stage is where you take your completed draft Health and Wellness Plan and move it forward. It represents the next step of sharing your draft plan to get approval and buy-in before you begin implementation. This includes knowing who needs to review and approve your Health and Wellness Plan, whether it goes to leadership first, such as Chief and Council or your Health Board, or whether it is brought to the community first for review and comment. Follow the protocols that have been established in your community and organization. Your Health and Wellness Plan may be finished, but don't neglect the communication during this stage, as it's important to keep everyone, leadership, staff and community up-to-date and involved.

Share with your employees

Your employees have been involved throughout the planning process, so be sure to include them and give them an opportunity to see or review the finished draft. This honours the work that they have done so far and helps with ongoing buy-in for implementation. The saying "the more eyes the better" applies here, as your employees can catch any errors or oversights. Consider an overview presentation for the entire organization, and then distribute the draft to your senior management for review and to share with their teams.

Present for approval

Be clear on who needs to review your Health and Wellness Plan, when and how. For example, your community protocols might be to bring it to the community first, and then to leadership, or vice versa. You might need to make presentations or submit a briefing note. Be prepared to update your plan after leadership review. Because you have involved your community throughout the process, (through meetings, focus groups, surveys, etc.), there shouldn't be too many surprises in your Health and Wellness Plan. There is no right or wrong; it's just important to keep people informed and give them an opportunity to comment. Follow what is right for your community.

Submit to funder

Once you've received approval and signoff from your leadership and community, you can submit to the funder (e.g., ISC-FNIHB). Ensure you have submitted all the required elements; these will vary depending on the type of funding agreement you are in. If you're not sure what is required, ask your ISC-FNIHB contacts, as they are keen to help. Be in touch regularly with your ISC-FNIHB contacts to share your progress and your successes.

Distribute to community and stakeholders

Consider creating a one- or two-page summary of your Strategic Plan, which can demonstrate the strategic direction your organization is taking and can also be used for annual planning. Post this on your website and have copies available to share at events (e.g., health fair, community days, etc.).

Depending on the earlier approach with your community (e.g., whether they've seen the entire Health and Wellness Plan or an overview presentation), consider making the entire Health and Wellness Plan available to the community. This shows your gratitude at their involvement and (hopefully) keeps them engaged for implementation.

You've also included stakeholders in the planning process. Be sure to share your summary with them and thank them for their involvement. Use your interactions thus far to help strengthen relationships, which can lead to new opportunities for partnering and improved services for your community.

Because your development process was comprehensive, structured, and transparent, you are demonstrating that you have planned in a good way and hold yourself accountable to your Health and Wellness Plan.

Communities in Action

"Our strategy was to make findings visual, fun and easy to access. We had a logo contest to help brand our health process. The winning logo was printed on t-shirts that were distributed to community members. We updated members on the progress of our process through regular newsletters, reports, radio announcements, summaries at events, and translating all of these into our language."

DELIVER
THE PLAN

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Follow protocols for sharing your Health and Wellness Plan
- Allow enough time for all voices to be heard

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Honour the work of the Health and Wellness Planning Group
- Showcase the achievements
- Set the organization up for success in helping the community achieve better health outcomes
- Use all strengths – people, knowledge, plans, practices, stakeholders, etc.

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Share your Health and Wellness Plan with your community for feedback
- Access your Health and Wellness Plan regularly
- Acknowledge the contributions of the community

QUALITY-BASED

Some examples that demonstrate **quality** as a guiding value:

- Include your Health and Wellness Plan as part of orientation for new staff and leadership
- Ensure staff input as the draft is finalized
- Maintain clear lines of communication with staff and leadership
- Evaluate and tweak the process

TRAINING THAT COULD BE HELPFUL

Some examples of training that could help in the "**Deliver**" stage:

- Effective communication
- Leading community meetings

DO …THE WORK

The "**Do**" stage is where you get to start the implementation of your Health and Wellness Plan! Because you've created and followed a workplan, engaged with community, developed a Strategic Plan, and received the necessary approvals, you're ready to implement. Bravo!

Create the Annual Plan

Throughout the development of your Health and Wellness Plan, we've referred to your Annual Plan. The Annual Plan is where your organization makes its plan for the year ahead, based on what you can do this year to help achieve the Strategic Goals. It is the reason why you don't have precise details in your Strategic Plan, because it's almost impossible to plan years ahead for that level of detail. The details come in the Annual Plan, which "operationalizes" the Strategic Goals. The Annual Plan is developed every year, as part of your ongoing planning, quality improvement, and evaluation cycles.

Set up planning sessions with your Management Team. Put the Strategic Goals front and centre and discuss how each program/service/team can contribute to achieving the goals this year. By planning as an entire Management Team, it can also encourage a more collaborative approach to programs and services and help to reduce any silos. Collectively, determine the organization's objectives for the year. Each team can offer tactics on how their work can help achieve the objectives. This helps ensure coherence in planning, reduces duplication, and avoids significant gaps in services. Discuss who would be the key person responsible for ensuring the activities are completed, the types of resources needed, and any specific timelines. Identify indicators, what types of data would be required, and where those data would be found.

Communities in Action

"Bringing both Elders and youth into the implementation process is essential. The Elders' vision, insight, stories, and their ability to know whether the strategy is working are needed. It is also an important opportunity to involve youth and promote inter-generational knowledge transfer and role models."

The template below shows the Strategic Plan template with the addition of the Annual Plan.

Strategic Plan (5-10 years)					
Vision					
Mission					
Values					
Priorities					
Goals *(**what** you want to accomplish over the next five-ten years)*					
Strategies *(**how** you will accomplish the goals)*					
Annual Plan - Operational (1 year)					
Objectives (SMART mini-goals) *(what)* **What we will accomplish this year to help achieve our Strategic Goals**	1. Objective 1 2. Objective 2 3. Objective 3 4. Objective 4 5. Objective 5 6. Objective 6				
Tactics (Actions to achieve the objectives) *(how)* **How we will achieve the objectives**	**Who is responsible**	**Timeline**	**Resources**	**Indicator**	**Sources of data**

So now, you have a Strategic Plan (high level five-year goals, key strategies) and an Annual Plan (annual objectives, tactics, timelines, indicators, etc.). This has been created at an organizational level, supporting a cohesive approach to achieving your Strategic Goals.

This sets the stage for each team to now take the Annual Plan and further develop it into a team workplan. Below is an example of a template for annual team workplans that could guide teams as they demonstrate how they are helping to achieve your annual objectives (which are linked to your Strategic Goals). It is similar to the Annual Plan but can be modified to accommodate more detail and program/service-specific elements.

Name of Program/Service Team						
Objective	**Activity**	**Responsible**	**Timeline**	**Resources**	**Indicator**	**Notes**
Objective 1						
Objective 2						
Objective 3						

Each year you will go through the process of reviewing the previous Annual plan and identify any areas that need to be revised. There could be emerging priorities that weren't apparent during the development of the Strategic Plan, or some activities may be behind or ahead of schedule. These would all inform the development of your Annual Plan each year.

Consider implementation requirements

Are there any specific requirements for implementation that are new or different from past plans? Perhaps you are initiating new programming based on your updated priorities, this may require different implementation elements such as adherence to different practice guidelines or creating new shared services agreements.

Identify training requirements

Another consideration is whether any requirements for training were identified through the development of your Health and Wellness Plan. This could relate to the activities in the Plan or the competencies of the personnel providing the services. Create your training plan that supports the activities required to achieve your Annual and Strategic Plans. You may need to submit your Training Plan to ISC-FNIHB.

Ensure ongoing monitoring and reporting

Identifying performance indicators for all your work means that ongoing monitoring is easier because you have metrics that help you see whether you are achieving your annual objectives. By monitoring, reviewing, and reporting, you can make 'course corrections' earlier and get back on track. These activities are part of your ongoing quality improvement and evaluation processes.

Reporting to the funder is outlined in your contribution agreement, and is based on the type of funding model you are in. For organizations with flexibility, ISC-FNIHB will require your Strategic Plan (your five-year Strategic Goals and key strategies), and your first Annual Plan (objectives and tactics) as well as a budget forecast that links to the identified health priorities that are to be addressed.

During your planning cycle, as you review the past year and assess how well you achieved your annual objectives, consider your progress toward your Strategic Goals. This will help you in two ways: first, you can review your Strategic Goals and confirm that they are still your top priority or reveal that there are new emerging priorities that weren't considered during the development of your Health and Wellness Plan; second, you can gauge whether you're on track for achieving your Strategic Goals, which will guide the identification of your SMART objectives in your Annual Plan.

Evaluate the Health and Wellness Plan

You have created an Evaluation Plan as part of your Health and Wellness Plan, you have been monitoring the performance indicators of your programs and services, and you have committed to ongoing communication to ensure accurate information is available. Conducting your Health and Wellness Plan formal five-year evaluation will be much easier due to all the efforts during your planning process and your ongoing monitoring.

Keep communicating

Keep communication active throughout the entire process, so leadership, staff, community and stake-holders are kept in the loop.

Communities in Action

"We coordinated a common look for all our communications which made them easily recognizable for the community. It was like our 'brand'."

DYNAMIC VALUES

CULTURE-BASED

Some examples that demonstrate **culture** as a guiding value:

- Access your Health and Wellness Plan regularly
- Incorporate cultural practices into planning

STRENGTH-BASED

Some examples that demonstrate **strength** as a guiding value:

- Share successes regularly and often
- Incorporate performance appraisals to build a strong workforce
- Communicate progress regularly

COMMUNITY-BASED

Some examples that demonstrate **community** as a guiding value:

- Understand community trends
- Incorporate emerging issues into Annual Plans
- Develop Annual Plans using an inclusive process
- Share Annual Reports and Annual Plans with community
- Ensure transparency in your annual planning processes

QUALITY-BASED

Some examples that demonstrate **quality** as a guiding value:

- Follow all mandatory requirements for programs and services
- Incorporate continuous quality improvement (e.g., PDSA)
- Encourage a “no blame” culture
- Identify risks and make plans to avoid, mitigate, or lessen the impact
- Follow change management principles
- Create a performance management framework for your organization
- Include performance indicators in your Annual Plans
- Review Annual Plan indicators monthly or quarterly to confirm on track
- Support staff training to build competencies
- Conduct mid-year mini-evaluations
- Use templates to keep track of work and ensure consistency

TRAINING THAT COULD BE HELPFUL

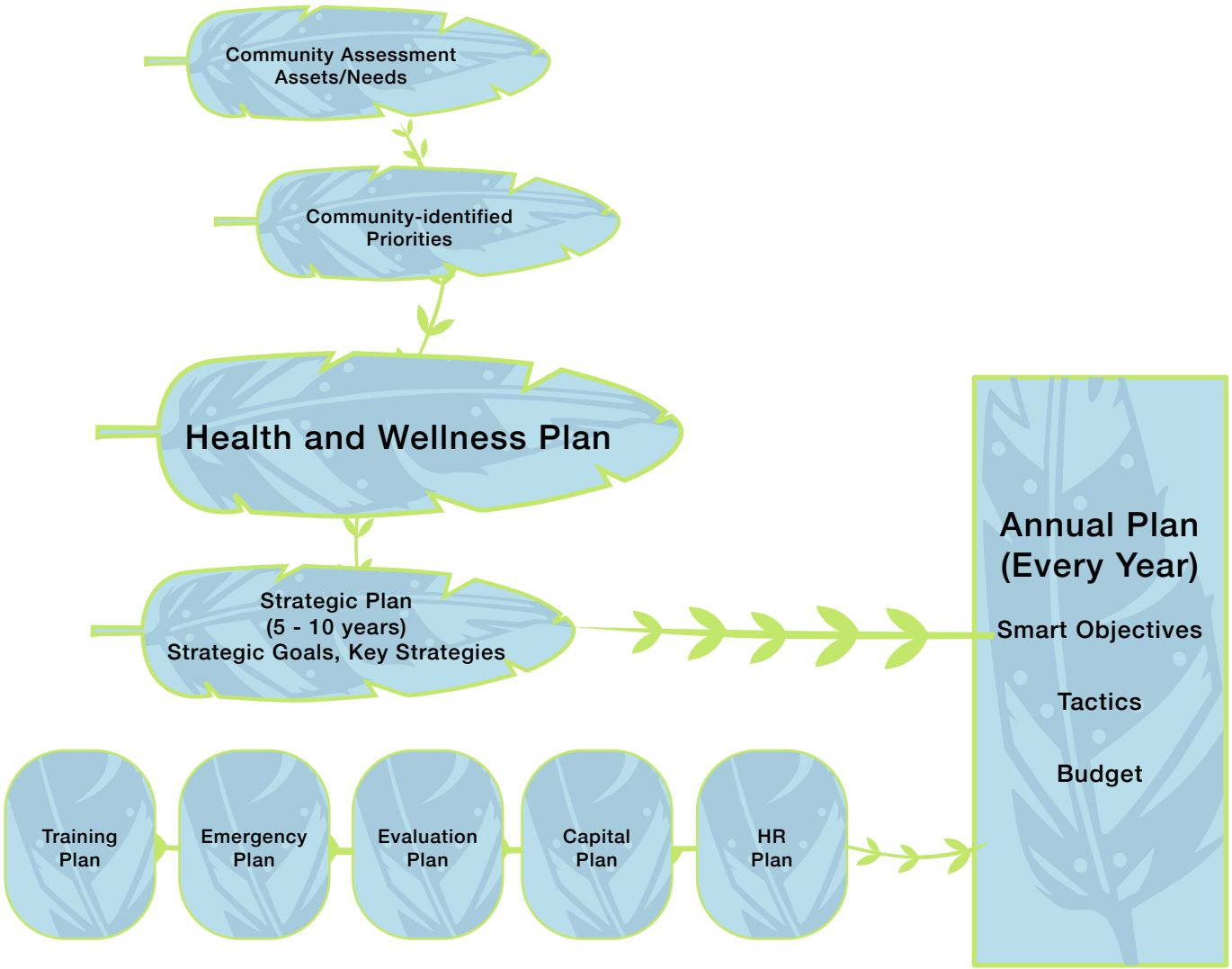
Some examples of training that could help in the "**Do**" stage:

- Quality improvement (e.g., PDSA)
- Creating Annual Plans
- Effective indicators
- Change management
- Creating a performance appraisal program
- Creating a performance management framework
- Evaluation

CONCLUSION

Most First Nations communities live by sacred teachings; these teachings honour community values and guide everyday life. Your health and wellness planning can be a trusted bridge that connects your community's culture with traditional and non-Indigenous health programs and services.

As such, your Health and Wellness Plan is a living document – one that needs to be in every office, not up on the top shelf collecting dust, but front and centre as the guiding plan for all your work. The development process has been comprehensive and inclusive, now keep the momentum going by regularly directing your teams back to your Strategic Plan, as you review your progress and make your Annual Plans every year.



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