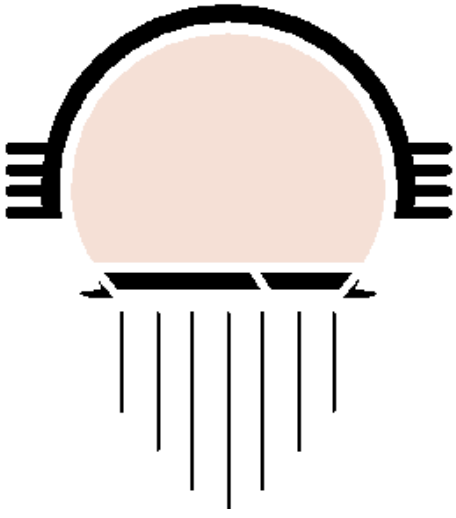
First Nations and Inuit Health

Program Compendium 2011/2012



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INTRODUCTION

The First Nations and Inuit Health Branch (FNIHB) aims to provide effective, sustainable, and culturally appropriate health programs and services that contribute to the reduction of gaps in health status between First Nations and Inuit and other Canadians.

FNIHB's objectives are to support the health needs of First Nations and Inuit by: ensuring availability of, and access to, quality health services; supporting greater control of the health system by First Nations and Inuit; and, supporting the improvement of First Nations health programs and services through improved integration, harmonization, and alignment with provincial/territorial health systems.

Purpose of this document

The Program Compendium provides information about health-related programs and services available to First Nations and Inuit. The compendium includes an inventory of the program's description, their elements, goals and objectives, as well as the different types of service providers and their qualification requirements.

The compendium is a reference tool for First Nations and Inuit Health - Regions and Programs Branch (RAPB-FNIH) and FNIHB employees in determining what types of activities they can engage in under each program; understand funding model restrictions and reallocation of funds and/or senior management decisions by program as well as determine if there are any additional reporting requirements needed when entering into an agreement with a recipient.

First Nations and Inuit communities can use the compendium to better understand the objectives of the various programs and services being delivered in their community either directly by Health Canada staff or through contribution agreements.

The compendium can be used as a reference for recipients when developing their multi-year work plans and/or health plans.

Performance Measurement

FNIHB has developed Performance Measurement Strategies which demonstrate the department's intention and capacity to measure performance against key results commitments on an ongoing basis (ongoing performance measurement) and periodically through program evaluation and/or specific research projects. The performance measurement strategy covers:

- main activities of the program, and its clients or target populations;
- expected results;
- performance indicators; and
- data collection sources and methods.

An evaluation strategy for FNIHB has been developed as part of the Performance Measurement Strategy.

Community-Based Reporting

Recipient reporting is captured in the Community-Based Reporting Template (CBRT) which was implemented in 2008. This new approach to collecting national data about health programs and services delivered by First Nations and Inuit is designed to provide detailed information for monitoring, performance reporting, evaluation and decision making.

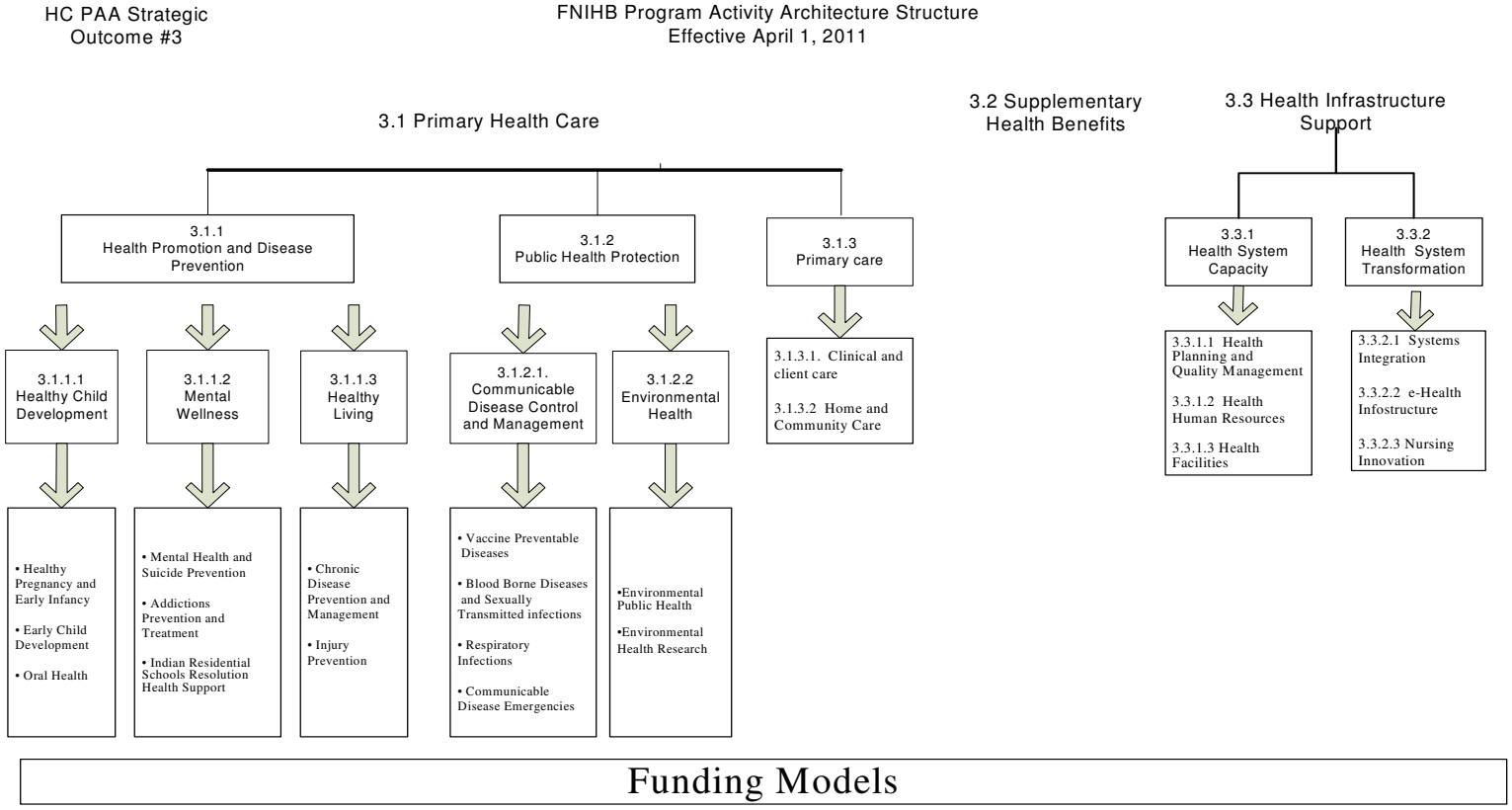
Where programs have additional reporting requirements that fall outside of the annual reporting, and are required in order to respond to Treasury Board or Departmental reporting, these are set out in the Program Compendium under *Exceptions* and will be found in the contribution agreements under Other Reporting Requirements.

Time-Limited Initiatives

The compendium does not include information on time-limited initiatives or initiatives that are designed for a targeted group of eligible recipients.

Program Activity Architecture Structure

The diagram below illustrates the realignment of programs



Funding Model Comparison Chart

Requirements	Set	Fixed	Flexible (Transitional)	Block	
				(Flexible)	(Flexible-Transfer)
Planning	Recipient follows multi-year Program Plan. This plan will include: objectives, activities that will be delivered	Budgetary estimate of program costs	Recipient establishes Multi-Year Work Plan including a health management structure. This Plan will include a budgetary plan, key priorities, objectives and activities that will be delivered	Recipient establishes a Health Plan including a health management structure. The Health Plan will include key priorities, objectives, activities, mandatory health programs and other programs and services, evaluation strategy and annual reporting requirements	Recipient establishes a Health Plan including a health management structure. The Health Plan will include key priorities, objectives, activities, mandatory health programs and other programs and services, evaluation strategy and annual reporting requirements, as well as information on the provisions of the professional / program advisory functions
Reallocation of Funds	Recipients only able to reallocate funds within the same sub-sub activity on written approval by the Minister within the fiscal year reporting period	No reallocation of funds	Recipients able to reallocate funds in the same Program Authority	Recipients able to reallocate funds across authorities (with the exception of specifically identified programs)	
Duration	up to 3 years	up to 5 years	2 to 5 years	5 years	5 to 10 years
Financial Reporting	Interim and final (year end) financial reports	Interim financial report and Annual (year end) audit report	Annual year end audit report	Annual year end audit report	
Annual Program Reporting	Annual Report based on performance indicators	Annual Report based on performance	Annual Report based on performance indicators	Annual Report to recipient's members and to the Minister based on annual reporting guide	
Evaluation Report	No Evaluation Report	No Evaluation Report	No Evaluation Report	Evaluation Report every 5 years	
Surplus	No retention of surplus and no carry forward of funds into the next fiscal year	Retention of any unexpended funding remaining at the expiry of the agreement provided all objectives are met. Funds are to be used for purposes consistent with program objectives or any other purpose agreed to by the FNIHB	Recipients, with the written approval of the Minister, are able to carry forward program funding for reinvestment the following fiscal year within the same Program Authority	Recipients able to retain surpluses to reinvest in health priorities	
MUST ENSURE THE PROVISION OF ALL MANDATORY PROGRAMS					

*Exception: funds provided via capital construction contribution agreements supporting the Health Facilities sub-sub activity are only to be used for health capital projects.

1.0 PRIMARY HEALTH CARE

Primary Health Care funds a suite of programs, services and strategies provided primarily to First Nations and Inuit individuals, families and communities living on-reserve or in Inuit communities. It encompasses health promotion and disease prevention programs to improve health outcomes and reduce health risks, public health protection, including surveillance, to prevent and/or mitigate human health risks associated with communicable diseases and exposure to environmental hazards, and primary care where individuals are provided diagnostic, curative, rehabilitative, supportive, palliative/end-of-life care and referral services. All of these services will be provided by qualified health providers who have the necessary competencies and meet the regulatory and legislative requirements of the provinces in which they practice.

Mandatory Programs/Services
Mandatory programs are those that have a direct impact on the health and safety of community members and the population. They have a strong public health and/or clinical component and require that health staff have certain credentials/certification/licensing and meet practice standards to ensure quality public health and client care services are provided.

Mandatory Programs within Primary Health Care include:

- Communicable Disease Control and Management;
- Environmental Public Health within the Environmental Health;
- Clinical and Client Care; and
- Home and Community Care.

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1.1 Health Promotion and Disease Prevention

The Health Promotion and Disease Prevention component funds a suite of community-based programs, services, initiatives and strategies that collectively aim to improve the health outcomes of First Nations and Inuit individuals, families and communities. This is addressed through the provision of culturally relevant health promotion/disease prevention programs and services that focus on three targeted areas: Healthy Child Development, Mental Wellness, and Healthy Living. These areas support the healthy development of children and families, and aim to improve mental wellness outcomes and reduce the impact of chronic disease. Many of these programs and services are linked and although are often delivered as separate and distinct programs/services, there are a number of components that can be delivered in a collaborative model.

1.1.1 Healthy Child Development

The Healthy Child Development component funds and supports community-based and culturally-relevant programming, services, initiatives and strategies that aim to improve health outcomes associated with First Nations and Inuit maternal, infant, child, and family health. The areas of focus include prenatal health, nutrition, early literacy and learning, physical, emotional and mental health, and children's oral health. Programming aims to improve health outcomes for First Nations and Inuit infants, children, youth, families (including pregnant women) and communities.

More specifically, programming provides increased access to a continuum of supports for women and families with young children from preconception through pregnancy, birth and parenting. Funding also supports knowledge development and dissemination, monitoring and evaluation, public education and outreach, capacity building, program coordination, consultation, and other health promotion and disease prevention activities related to healthy child development. Healthy child development activities are provided through community-based programs such as Fetal Alcohol Spectrum Disorder, Canada Pre-Natal Nutrition, Aboriginal Head Start On Reserve, and Maternal Child Health programs.

Overall Objectives:

- Collaborate with First Nations, Inuit, governments, and community partners in the regions to improve the coordination of, and access to, maternal and child health and healthy child development programs and services.
- Aid the development, delivery and management of culturally appropriate programs, services and initiatives for First Nations living on-reserve, and Inuit living in Inuit communities, providing increased support for women and families with young children from preconception through pregnancy, birth and parenting.
- Ensure that programs and services are evidence-based, using a continuum of care model that includes prevention and health promotion (awareness and education), intervention (assessment, referrals and counselling) and support.

- Build capacity among First Nations and Inuit individuals, families and communities to deliver community-based health promotion and disease prevention programs and services by supporting activities such as training and asset mapping.

1.1.1.1 Healthy Pregnancy and Early Infancy

Description

Programming in this area relates to the promotion of healthy pregnancies and the health of infants and young children and focuses on prenatal nutrition, maternal and child health and Fetal Alcohol Spectrum Disorder (FASD).

Objectives

- **Prenatal Nutrition**
  - Support the improvement of maternal and infant nutritional health. Activities fall under three core elements which include: nutrition screening, education and counselling; maternal nourishment; and, breastfeeding promotion, education and support.
- **Maternal Child Health**
  - Implement support services which include: screening and assessment of pregnant women and new parents to assess family needs; reproductive and preconception health promotion; as well as home visiting by nurses and community-based workers to provide follow up, referrals and case management as required.
  - Enable home visiting to offer education and support to pregnant women and families with infants with respect to parenting skills and knowledge, healthy child development, positive lifestyle changes, preconception health, improved maternal reproductive health, and access to social supports.
- **Fetal Alcohol Spectrum Disorder (FASD)**
  - Support the development of culturally appropriate and evidence-based prevention and early intervention programs related to FASD.
  - Support capacity building and training of community workers and professional staff, development of action plans, and prevention, education and awareness activities.
  - Implement prevention programs through mentoring projects, using an evidence-based home visitation model. (Mentors help a woman identify her strengths and challenges; link her to appropriate services/supports that can help to reduce her risk of having a baby affected by FASD).
  - Implement intervention programs through case management and community coordination to facilitate access to diagnosis, and to help families connect with multi-disciplinary diagnostic teams and other supports and services.

Elements

A. Home Visiting

Home visiting by community health nurses or community-based workers positively affects the health of mothers, infants, children and families. During the home visit, the nurse or the

community-based worker provides information, education and support on: reproductive health; women and families' mental health needs; children's mental health; children's development; breast feeding support and nutrition; healthy habits and lifestyles; healthy parenting skills and knowledge and parent-infant attachment; fathers' involvement; and, access to health and social supports and services. Regular and consistent home visiting allows home visitors to establish a solid rapport and trusting relationship with families, thereby increasing the receptiveness of families to new information. This results in meeting family needs, improving family functioning and positive family outcomes.

B. Screening, Education and Counselling

Various screening and assessment tools are used by nurses and community-based workers to identify the needs of families and to determine the level and type of services that will be of most benefit. Comprehensive screening and assessments are crucial for early identification and referral of pregnant women and families with young infants/children who may be at risk of poor health outcomes. Screening may be done prenatally for risk factors such as substance use during pregnancy, sexually transmitted infections, blood glucose level, or postnatally for risk factors such as post partum depression, and developmental delays in children. Once risk factors are identified, the programs can provide education, linkages to support services, as well as resources needed to reduce high-risk behaviours and promote healthy birth outcomes or identify needed services.

C. Case Management

Case management helps women and families link to services and support they need. Case management includes the coordination of services and access to culturally competent care for women and families, for early intervention and access to early diagnosis. Core activities may include:

- completing the initial individual/family assessment;
- identifying individual/family strengths and assets;
- working with women and families to identify and prioritize their needs and concerns;
- working in partnership with women, the family, home visitors, the community, and other service providers to develop a service plan that reflects the individual/family's goals and concerns and the individual, family and community strengths;
- identifying the need for special needs services and helping the family access these services;
- facilitating referrals when necessary; and,
- evaluating the individual/family service plan on a regular basis, making adjustments based on the family's needs and desired outcomes.

D. Integrating Culture into Care

The prevention components of care can be enhanced for women and families with children by moving beyond the scope of medically-based prenatal and postpartum services to integrate culturally-relevant approaches into all program components. Services delivered at the community level should be designed and delivered in a culturally competent manner that acknowledges and respects cultural differences and the uniqueness of the communities that are served.

E. Health Promotion
Health promotion strategies improve maternal and child health in communities in many ways. Examples of health promotion interventions include promotion of physical activity and healthy nutrition, problematic substance use prevention, preconception health counselling, parenting including traditional parenting, and injury prevention. Health promotion activities are linked to all programs in this component. This element may include community education awareness events, supplementing the diet and improving the food security of pregnant women, infants and mothers through the use of healthy snacks, food coupons, food vouchers and food baskets. Community kitchens and cooking classes are also supported in an effort to provide women with skills related to food preparation as well as knowledge regarding healthy eating.

F. Evidence and Capacity Development
A range of evidence-based capacity building activities are supported at the national and regional levels (such as training initiatives for community-based service providers and pilot projects to implement promising practices).

G. Coordination and Integration
The programs support the coordination and integration of services and the sharing of information including best practices. National and regional activities related to the development, implementation, and evaluation of the programs are also located under this component.

Clients
The primary target populations for this component are pregnant First Nations and Inuit women, mothers and their infants and young children (ages 0-6 years), who live on-reserve or in Inuit communities, particularly those identified as high risk. The secondary target group includes First Nations and Inuit women of childbearing age on-reserve or in the North.

Types of Service Providers
Community-based workers (such as home visitors and mentors), community health workers, Community Health Nurses, Community Health Representatives, and local project coordinators are the key service providers. Additional services may be provided by dietitians/nutritionists, lactation consultants, physicians, early childhood educators, community volunteers and Elders.

Provider Qualifications
Certification/registration according to provincial/territorial legislation is required for all dietitians, nutritionists, nurses and other professionals providing services through the programs. Community-based workers and home visitors do not require the same qualifications; however, job-specific training for these providers is necessary.

Exceptions
Not applicable

1.1.1.2 Early Childhood Development

Aboriginal Head Start on-Reserve (AHSOR) funds early childhood intervention strategies that support the health and developmental needs of First Nations children from birth to age six, and their families. The goal is to support programming that is designed and delivered by First Nations communities in an effort to meet their unique needs.

Objectives

- Support the spiritual, emotional, intellectual and physical growth of each child.
- Support and encourage children to enjoy life-long learning.
- Support parents, guardians and extended family members as the primary teachers.
- Encourage parents and the broader First Nations community to play a role in planning, developing, implementing and evaluating the AHSOR Program.
- Build relationships and coordinate with other community programs and services to enhance the effectiveness of the program.
- Encourage the best use of community resources for children, as well as for their parents, families and communities.

Elements

A. Culture and Language

This component promotes and supports children experiencing their First Nation culture and learning their language. This includes activities and events that allow children to develop a sense of belonging and identity as a First Nations person, and to learn and retain their First Nations languages. Programming also includes cultural resources to support children's learning, as well as activities that support the linkage between the program and community cultural events.

B. Education

This component promotes life-long learning by promoting activities and events that encourage children's readiness to learn skills and focus on their physical, spiritual, emotional, intellectual and social development needs. For example, children can learn early literacy skills such as printing, recognizing sounds and words and gross and fine motor activities. The environment is organized around routines that encourage children's active learning and positive social interactions, including opportunities for children to learn through play.

C. Health Promotion

This component encourages children and families to live healthy lives by following healthy lifestyle practices. Programming provides activities and events that promote physical activity, such as outdoor playground activities and traditional games. Staff are also provided with opportunities and activities that promote self-care, such as helping children to brush their teeth. Staff encourages the appropriate physical, visual, hearing and developmental assessments of children. Programming provides visits with health professionals such as nurses (for immunizations), dental hygienists, speech therapists, and physicians. Support is also offered to parents and families through access to other professionals such as drug and alcohol addictions counselors, mental health therapists, and /or environmental health officers.

D. Nutrition
This component teaches children and families about healthy foods that will help them meet their nutritional needs. Programming offers nutritious snacks and/or meals using *Eating Well with Canada's Food Guide-First Nations, Inuit and Métis,* and can provide children with opportunities to participate in traditional food gathering activities. In addition, the Nutrition component ensures that parents/guardians have opportunities to meet with health professionals such as nutritionists.

E. Social Support
This component assists parents and guardians to become aware of the resources available to them in achieving a healthy and holistic lifestyle. Programming includes activities and events that allow young children and their families to gain information about, and access to other community service sectors and service providers. Programming provides a variety of learning opportunities and training for parents and families.

F. Parental and Family Involvement
This component recognizes and supports the role of parents and family as the primary teachers and caregivers of their children. Programming provides opportunities for parents/guardians, families and community members to participate directly in the program, including attending parent/guardian committees, monthly family dinners, children's field trips or other after hour activities. Outreach services/home-visits support parental and family involvement by bringing information into the home, including on how to register their children in the AHSOR Program.

Clients
The AHSOR Program provides services and/or supports for children from age 0 to 6 years, and their families living on-reserve.

Program Delivery
The AHSOR Program can be delivered through centre-based programming, outreach services/home visiting, or through a combination of the two. AHSOR centre-based programs are encouraged to follow the applicable child care or preschool legislation, or day-care licensing regulations in their province.

Types of Service Providers
Early childhood educators, community-based workers, Community Health Nurses, Community Health Representatives, administrators, parents and community volunteers.

Provider Qualifications
AHSOR staff are encouraged to participate in accredited training to enable credentialing toward attainment of an early childhood diploma/degree. Additional training offered through workshops and conferences provide opportunities for specific skill development or knowledge.

Exceptions
Not applicable.

1.1.1.3 Children's Oral Health Initiative (COHI)

Description

The Children's Oral Health Initiative (COHI) is a program that strives to improve, and ultimately maintain the oral health of First Nations living on-reserve and Inuit living in Inuit communities at a level comparable to other Canadians living in similar conditions. This initiative is supported by Dental Therapy as described under 3.1.1.3, Healthy Living.

The Children's Oral Health Initiative services are delivered by federal employees, or through contractual agreements or contribution agreements with regional or local First Nations health care organizations or provincial/territorial health authorities. All oral health service providers, including dental therapists, dental hygienists and dentists, increase access to dental care for First Nations living on-reserve and for Inuit living in Inuit communities. They deliver and/or manage a broad range of oral health activities including dental disease prevention, promotion of good oral health practices and basic clinical services. The Children's Oral Health Initiative serves children aged 0-7, their parents, caregivers and pregnant women.

The Children's Oral Health Initiative activities are delivered mostly in communities south of 60˚. In collaboration with the governments of Nunavut and the Northwest Territories, they are also offered in a number of First Nations and Inuit communities in the north where there are dental therapists employed by the territorial governments to provide the services.

Objectives

- Reduce and prevent oral disease through prevention, education and oral health promotion.
- Increase access to oral health care

Elements

A. Service Delivery

Preventive dental services are provided in select First Nations on-reserve communities and in selected Inuit communities. Services include screenings, topical fluoride applications, placement of dental sealants, alternative restorative treatment, oral health information sessions and referrals to other dental care professionals for treatments beyond their scope of practice.

B. Disease Prevention and Health Promotion

Prevention and promotion activities at the community level include awareness campaigns and presentations to target sites and groups such as Aboriginal Head Start locations, daycares, preschools, nurseries, parent participants, immunization clinics and other community groups. Oral health promotion also includes promotion via different media, home visits by dental service providers and promotion of professional oral health training, such as dental therapy. In addition, there are opportunities to inform and build capacity among parents, caregivers, and community members through clinical and educational activities.

Clients
The Children's Oral Health Initiative clients are, First Nations living on-reserve and Inuit living in Inuit communities, children 0-7 years of age, their parents and caregivers and pregnant women.

Types of Service Providers
Federally employed, contractual or contribution agreement funded oral health professionals including dentists, dental therapists, dental hygienists, as well as dental assistants, trained community members (aides), Community Health Nurses and community-based dental support staff such as Community Health Representatives or educators.

Provider Qualifications
Oral health professional staff must be licensed as required by the specific jurisdiction.
The community members providing limited Children's Oral Health Initiative services need to go through structured training before being referred to as "aides".

Exceptions
Not applicable.

1.1.2 Mental Wellness

The Mental Wellness component funds and supports community-based programming and services that aim to reduce risk factors, promote protective factors, and improve health outcomes associated with the mental wellness of First Nations and Inuit. The goal of this component is to provide First Nations and Inuit communities, families, and individuals with mental wellness services and supports that are responsive to their needs.

Community mental wellness needs are met through Mental Health and Suicide Prevention programming, Substance Abuse Prevention and Treatment programs, and the Indian Residential Schools Resolution Health Support Program. Programming provides a range of culturally-relevant mental health and addictions programs and services which are guided by community priorities. The Mental Wellness component seeks to support a continuum of care that includes primary, secondary, and tertiary prevention activities and knowledge development.

1.1.2.1 Mental Health and Suicide Prevention

Mental Health and Suicide Prevention programming provides funding to First Nations and Inuit communities so that they may address broad wellness issues through programs focused on mental health, child development, crisis intervention, solvent abuse, and youth suicide. Funding flexibility allows communities to allocate resources to meet local needs and priorities, address gaps, and work towards a cohesive and holistic community health program.

Mental health and suicide prevention programming is comprised of Brighter Futures, Building Healthy Communities, and the National Aboriginal Youth Suicide Prevention Strategy. Programming in this area has distinct, but closely related goals with respect to community mental wellness.

Brighter Futures

Objective

To improve the quality of, and access to, culturally appropriate, holistic and community-directed mental health, child development, and injury prevention services at the community level.

Elements

A. Mental Health

Improve the quality of, and access to, culturally appropriate mental health services at the community level. Activities include: training; planning; consultation and information exchange; promotion of linkages among health, children and families; and, comprehensive community projects.

B. Child Development

Strengthen the existing child development network of social, health, medical, educational and cultural services. Activities include the provision of resource centres, infant stimulation programs, and behavioural and developmental counselling involving parents and children.

C. Injury Prevention

Reduce death and acute and long-term disability due to childhood injuries. Activities targeted at preventing injury include: public education; training of community workers; knowledge development; and, assisting communities to develop appropriate by-laws/regulations.

D. Healthy Babies

Improve the physical, mental and social health and well-being of mothers and infants through: nutritional education; emphasis on regular medical examinations during pregnancy; education on the dangers of alcohol and other drug use during pregnancy; and, training for community-based workers.

E. Parenting Skills

Promote culturally appropriate parenting skills by providing funding to support the development and delivery of training programs for parents of children aged two and older.

Building Healthy Communities

Objectives

- To assist communities in preparing for and managing mental health crises such as suicide and substance abuse.
- To address community capacity-building by training caregivers and community members to deliver programs and services within their own communities.

Elements

A. Mental Health Crisis Intervention

Provides funding for a variety of activities related to mental health crisis intervention including: assessment and counselling programs; referrals for treatment and follow-up; after-care and rehabilitation to individuals and communities in crisis; culturally-sensitive accredited training for community members and caregivers on crisis management; intervention; trauma and suicide prevention; and, community education and awareness of mental wellness and suicide prevention.

B. Solvent Abuse

Provides funding for culturally-appropriate, community-based prevention and intervention programming, for youth solvent abusers.

The National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) Objectives

- To increase protective factors (e.g. youth leadership) and decrease risk factors (e.g. loss of traditional culture) for Aboriginal youth suicide. This includes increasing community capacity to deal with the challenge of youth suicide, enhancing community understanding of effective suicide prevention strategies, and supporting communities to reach youth at risk and intervene in times of crisis.
- To target resources that support a range of community-based solutions and activities which contribute to improved mental health and wellness among Aboriginal youth, families and communities.

Elements

A. Primary Prevention

Support for activities that focus on mental health promotion activities that increase resiliency and reduce risk among Aboriginal youth.

B. Secondary Prevention

Support for activities that focus on supporting collaborative, community-based approaches to suicide prevention.

C. Tertiary Prevention

Support for activities that focus on increasing the effectiveness of crisis response, stabilization and after care for survivors.

D. Knowledge Development

Support for activities that aim to improve what we know and what works in the field of Aboriginal youth suicide prevention.

Clients

First Nations and Inuit including: infants, children, youth and parents.

Types of Service Providers
Youth workers; wellness workers; crisis counsellors; Elders and traditional teachers; mental health para-professionals; Community Health Nurses and Community Health Representatives; and, recognized mental health service providers.

Provider Qualifications
Professional health care providers must be registered members in good standing with the college and/or professional association applicable to the provider's profession, and entitled to practice his or her profession in accordance with the laws of the province or territory as applicable.

Qualifications for para-professionals/community-based workers such as parent support workers and addictions workers are determined by each community in consultation with Health Canada.

Exceptions
Not applicable

1.1.2.2 Substance Abuse Prevention and Treatment

Substance Abuse Prevention and Treatment programming provides a range of community-based prevention and treatment services and supports. Community-based programming includes prevention, health promotion, early identification and intervention, referral, aftercare and follow-up services in more than 550 First Nations and Inuit communities. These services are integrated with a network of addiction treatment centres which provide culturally-relevant in-patient, out-patient and day or evening programs for alcohol, solvents and other drug addictions.

Objective
To support First Nations and Inuit communities to establish prevention and treatment programming and interventions aimed at reducing and preventing alcohol, drug, and solvent abuse among on-reserve populations and supporting overall community wellness.

Elements
A. Prevention
Prevention initiatives strive to: prevent substance use and/or abuse, delay age of first substance use, and avoid high-risk substance use. Initiatives aim to strengthen protective factors and minimize risk factors for substance abuse and addiction within individuals, families and communities. Prevention is linked with overall health promotion aimed at changing the underlying social, cultural and environmental determinants of health.

B. Early Identification & Intervention
Early identification involves identifying and then screening people who may be at risk for developing, or already have, a substance use or mental health issue. By identifying those who may be at risk, service providers may be able to intervene in a tailored, specific way that is brief and focused and, if necessary identify mental health and/or addiction-related resources and supports that may be required.

C. Screening, Assessment and Referral
Screening, assessment and referral services are provided to identify individuals at elevated risk for substance abuse, collect the information required to refer the client to the appropriate course of treatment (such as outpatient, day or evening treatment, or a residential treatment centre) and identify any additional services that might be required (such as detoxification, job support services, mental health treatment).

D. Treatment
Services and supports are provided for people with substance use problems of at least moderate severity or complexity. These can be community-based, outpatient extensions of residential programs, or residential treatment programs. Programming is tailored to the individual's needs and may include the use of medications, behavioural therapy (such as individual or group counselling), cognitive behavioural therapy, or culturally-based activities.

E. Discharge Planning and Aftercare
The discharge planning and aftercare services seek to build on the strong foundation set by the treatment process. These services provide an active support and structure within communities that facilitate the longer term journey of individuals and families toward healing and integration back into a positive community life.

F. Performance Measurement, Research and Knowledge Exchange
Performance measurement and research supports the ongoing development and delivery of effective programs and services to enhance program approaches to better meet the needs of clients while getting the most value from available resources. This component of the program tracks client outcomes, and supports more effective case management, program quality assurance, evaluation activities, and identification of potential areas of research.

Knowledge exchange helps with the transfer of information among research, policy and practice at a community, regional and/or national level. Knowledge exchange supports the development of new approaches to care and helps to refine services at these levels through face-to-face meetings, conferences and web-based forums.

Clients
First Nations on-reserve and Inuit living in Inuit communities.

Types of Service Providers
Support intervention and outreach workers, child and youth workers, alcohol, drug and crisis counsellors, solvent abuse workers and, Elders and cultural practitioners, Community Health Nurses and Community Health Representatives. Mental health professionals (e.g. social workers and psychologists) also provide services with some treatment programs.

Provider Qualifications
Professional health care providers such as psychologists and social workers must be registered members in good standing with the college and/or professional association applicable to the provider's profession, and entitled to practice his or her profession in accordance with the laws of the province or territory as applicable.

Qualifications for para-professionals/community-based workers are determined by each community in consultation with Health Canada.

Exceptions
Not applicable

1.1.2.3 Indian Residential Schools Resolution Health Support

The Indian Residential Schools Resolution Health Support Program provides mental health and emotional supports to eligible former Indian Residential School students and their families before, during and after their participation in Settlement Agreement processes, including: Common Experience Payments, the Independent Assessment Process, Truth and Reconciliation Commission events and Commemoration activities.

Objective
Ensure that eligible former students of Indian Residential schools, and their families, have access to an appropriate level of mental health, emotional and cultural support services so that they may safely address a broad spectrum of mental wellness issues related to their experience of Indian Residential Schools.

Elements
A. Cultural Support
Cultural supports are provided by local Aboriginal organizations that coordinate the services of Elders and/or traditional healers. Cultural supports seek to assist students and their families to safely address issues related to the legacy of Indian Residential Schools as well as the disclosure of abuse during the Settlement Agreement process. Specific services are determined by the needs of the individual and include dialogue, ceremonies, prayers, or traditional healing.

B. Emotional Support
Services are provided by local Aboriginal organizations and are designed to help former students and their families safely address issues related to the legacy of Indian Residential Schools as well as the disclosure of abuse during the Settlement Agreement process. An aboriginal mental health worker will listen, talk and guide former students and their family members through all phases of the Settlement Agreement process.

C. Professional Counselling
Professional counsellors are psychologists and social workers that are registered with Health Canada and have experience working with Aboriginal people. A professional counsellor will listen, talk, and assist former students to find ways of healing from Indian Residential Schools experiences.

D. Transportation
Assistance with the costs of transportation is provided when professional counselling and cultural support services are not locally available.

Clients
Program clients include all former Indian Residential School students, regardless of status or place of residence within Canada, who attended an Indian Residential School identified in the 2006 Indian Residential Schools Settlement Agreement.

In recognition of the intergenerational impacts of the legacy of Indian Residential Schools on families, Resolution Health Support Program services are also available to family members. The family of former students is defined as a spouse/partner, those raised by or raised in the household of a former Indian Residential School student, and any relation who has experienced effects of intergenerational trauma associated with a family member's time at an Indian Residential School.

Partnerships, Roles
The cultural and emotional support components of the Indian Residential Schools Resolution Health Support Program is managed independently by First Nations, Inuit, Métis, or Aboriginal-affiliated organizations through regionally held contribution agreements.

Types of Service Providers
Services provided through the Indian Residential Schools Resolution Health Support Program are delivered by community Elders and traditional healers, aboriginal mental health workers, psychologists, and social workers.

Provider Qualifications
Professional counsellors must be a member in good standing with his/her provincial/territorial college or association and meet the following criteria:

- Registration as a psychologist in the province/territory in which the service is being provided with clinical or counselling orientation; or
- Registration as a social worker in the province/territory in which service is being provided (MSW or PhD in social work with clinical orientation).

Cultural and Emotional supports are provided through contribution agreements with an Aboriginal or Aboriginal-affiliated organizations currently working in the area of Aboriginal health and with Aboriginal communities.

Exceptions
Not applicable

1.1.3 Healthy Living

The Healthy Living component funds and supports a suite of community-based programs, services, initiatives and strategies that aim to improve health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families and communities. Initiatives promote healthy behaviours and supportive environments, particularly in the areas of healthy eating, food security and physical activity, and address chronic disease prevention, screening and management, and injury prevention.

Funding also supports: knowledge development, dissemination and exchange; research; monitoring and evaluation; public education and outreach; capacity building; program coordination; consultation; and, other health promotion and disease prevention activities related to Healthy Living.

1.1.3.1 Chronic Disease Prevention and Management

In the program cluster that addresses chronic disease; community-based programs deliver services and activities that aim to reduce the rate of chronic diseases such as type-2 diabetes among Aboriginal people.

The key objective is to improve the health status of First Nations and Inuit individuals, families and communities through actions designed to contribute to the promotion of healthy living and supportive environments (important for the prevention of all chronic diseases) and specifically, the reduction of the prevalence and incidence of diabetes. To that end, focus is placed on addressing healthy eating, food security, physical activity and obesity, as well as increasing awareness of diabetes, its risk factors and complications and supporting diabetes screening and management. Activities include sharing community knowledge and promising practices, supporting community planning, and training health service providers and community workers.

Diabetes

Diabetes programming aims to reduce Type 2 diabetes through health promotion and disease prevention programs, services and activities delivered by community diabetes workers and health service providers. The initiative provides training opportunities and continuing education to community diabetes prevention workers and health professionals, and increases community access and capacity to deliver diabetes prevention programs and services. These activities aim to increase awareness and knowledge of risk factors and approaches to diabetes prevention, and provide access to health promotion initiatives targeted at diabetes prevention, screening and management.

Objectives

- Increase awareness of diabetes, diabetes risk factors and complications as well as ways to prevent diabetes and diabetes complications in First Nations and Inuit communities.
- Support activities targeted at healthy eating and food security.
- Increase physical activity as a healthy living practice.

- Increase the early detection and screening for complications of diabetes in First Nations and Inuit communities.
- Increase capacity to prevent and manage diabetes.
- Increase knowledge development and information-sharing to inform community-led evidence-based activities.
- Develop partnerships to maximize the reach and impact of health promotion and primary prevention activities.

Elements

A. Health Promotion and Primary Prevention
Supports a wide range of community-led, and culturally relevant health promotion and prevention activities offered in First Nations and Inuit communities to promote diabetes awareness, healthy eating and physical activity as part of healthy lifestyles.

B. Screening and Treatment
Supports complications-screening initiatives in remote and rural areas in some regions. In other regions, program funding has been directed towards diabetes education, complications prevention including foot care programming and diabetes self-management.

C. Capacity Building & Training
Supports training for community diabetes prevention workers including continuing education for health professionals and para-professionals working in communities in areas such as: diabetes education, health promotion, foot care, and cultural competency. Regional Multi-Disciplinary Teams provide subject matter expertise to communities in areas including diabetes, nutrition, food security and physical activity.

D. Research, Surveillance, Evaluation and Monitoring
Supports activities related to research, surveillance, evaluation and monitoring of diabetes prevention and promotion initiatives, and supports efforts to build the evidence base for nutrition and food security.

Clients

First Nations on-reserve and Inuit living in Inuit communities.

Types of Service Providers

Service providers may include but are not limited to: Community diabetes prevention workers, physical activity specialists, nutritionists/dieticians, Community Health Nurses and Community Health Representatives, and doctors.

Provider Qualifications

When using a professional health care provider, projects must ensure that the provider is:

- a registered member in good standing of the college or professional association of that province or territory; and,
- entitled to work in accordance with the laws of the province or territory where the care is to be provided.

Exceptions
Not applicable

1.1.3.2 Injury Prevention

The key objective of injury prevention activities is to work with national and regional partners, including National Aboriginal Organizations, non-government organizations, provinces and territories, researchers, communities and other partners to gather existing data and statistics to: monitor injury trends; promote best practices; identify priorities for knowledge development, dissemination and exchange; and, contribute to the development of tools to assist First Nations and Inuit communities to create supportive environments and prevent injuries.

Injury prevention education is provided through community-based programs, such as Aboriginal Head Start and Brighter Futures, to help First Nations and Inuit children understand the importance of injury prevention from an early age.

1.1.3.3 Dental Therapy

Dental Therapy supports and complements the Children's Oral Health Initiative (COHI), as described under 1.1.1.3, Healthy Child Development. Dental Therapy strives to improve, and ultimately maintain the oral health of First Nations living on-reserve and Inuit living in Inuit communities at a level comparable to other Canadians living in similar conditions.

Dental Therapy services are delivered by federal employees, or through contractual or contribution agreements with regional or local First Nations health care organizations or provincial/territorial health authorities. This occurs in all Health Canada regions except Ontario and Quebec, where there are no dental therapists, due to provincial legislation. Under the supervision of a dentist, dental therapists deliver a range of basic services including oral health promotion activities, clinical care, emergency and preventive services. They also refer clients to dentists for services beyond their scope of practice.

Health Canada-funded dental therapy services are offered south of 60˚.

Objectives
- Reduce and prevent oral disease through prevention, education and oral health promotion.
- Increase access to oral health care.

Elements

A. Service Delivery

Dental Therapy increases access to care in First Nations and Inuit communities, particularly in remote and isolated locations, by offering basic clinical care, emergency and preventive services as per their scope of practice. Dental therapists combine clinical functions with oral health promotion and disease prevention activities.

B. The Children's Oral Health Initiative (COHI)

Some dental therapists play a key part in the Children's Oral Health Initiative in their communities. This is an add-on to the services already rendered by the dental therapists. See 1.1.1.3 for the activities carried out under COHI.

Clients

In most FNIH regions dental therapists serve all members of a community. Where they are associated with COHI, their target clientele is children aged 0-7, their parents and caregivers, and pregnant women.

Types of Service Providers

Federally or band-employed dental therapists.

Provider Qualifications

With few exceptions, dental therapists currently working in First Nation or Inuit communities south of 60˚ are graduates of the two-year dental therapy program offered at the National School of Dental Therapy in Prince Albert, Saskatchewan. Dental therapists are unregulated provincially outside of the province of Saskatchewan (they are regulated in the Northwest Territories, Yukon and Nunavut). Dental therapists employed by the federal government work under the supervision of a licensed dentist.

Exceptions

Not applicable

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1.2 Public Health Protection

Health Canada's FNIHB works with First Nations and Inuit, provincial authorities and other federal departments and agencies to support a public health system that works to prevent and/or reduce risks to human health associated with communicable diseases and exposure to hazards within the natural and built environment. This is addressed through a range of programs and activities, including: public health services and measures to prevent, manage and control communicable diseases and help assure the safety of food, water and living environments; promotion and education efforts to encourage healthy behaviours; research to identify and reduce environmental health risks; and community development and capacity building initiatives. FNIHB also works in collaboration with partners to address the determinants of health, many of which are beyond the direct control of the public health system.

FNIHB's communicable disease control and management programs as well as the environmental public health programs described below are mandatory because of their direct impact on the health and safety of community members and the broader population. Health Canada does not have public health legislation that applies on-reserve and is guided by provincial legislative frameworks. The Medical Officer of Health/Medical Health Officer (MOH/MHO) role is an important part of the provincial legislative framework. The MOH/MHO is a public health physician with designated roles in health protection in the provincial public health act. In order to ensure a comprehensive and integrated approach to public health protection on reserve, it is important each community can clearly identify their MOH/MHO.

1.2.1 Communicable Disease Control and Management (CDCM)

Communicable disease control and management programs aim to reduce the incidence, spread and human health effects of communicable diseases, as well as improve health through prevention and health promotion activities, of on-reserve First Nations and Inuit living in Nunatsiavut and Nunavik.

The burden of communicable diseases remains of particular concern in some on-reserve First Nations and Inuit communities and can be linked to common underlying risk factors which enable further exposure and spread of disease. Significantly elevated levels of communicable diseases (such as Tuberculosis and HIV, as well as HIV-TB co-infection) are further complicated by issues of remoteness, limited access to health services, social stigmatization, and socio-economic issues.

CDCM programs and initiatives support public health measures to mitigate these underlying risk factors by:

- preventing, treating and controlling cases and outbreaks of communicable diseases (e.g., immunization, screening, directly observed therapy);
- promoting public education and awareness to encourage healthy practices;

- strengthening community capacity (e.g., to prepare for and respond to pandemic influenza); and
- identifying risks (e.g., surveillance, reporting)

In collaboration with other jurisdictions, CDCM programming focuses on vaccine preventable diseases, blood borne diseases and sexually transmitted infections, respiratory infections, and communicable disease emergencies. A number of these activities are closely linked with those undertaken in the environmental health programming area, particularly as they relate to waterborne, foodborne and zoonotic infectious diseases.

1.2.1.1 Vaccine Preventable Diseases – Immunization Program

Description

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

Objectives

- Ensure access to newly recommended vaccines.
- Improve the coverage rates of routine immunizations.
- Improve data and understanding of immunization coverage rates, the incidence of vaccine preventable diseases, barriers to immunization and best practices in implementation.

Elements

A. Service Delivery

Direct immunization-related services are provided on-reserve, such as: administering vaccines according to appropriate provincial schedules; notifying residents when they are due for vaccines; and, forecasting effectively for vaccine equipment needs while monitoring wastage. Each Region either delivers or supports the delivery of an immunization program that is reflective of its respective provincial immunization program with the goal of ensuring basic immunization services on are comparable to those delivered by provincial governments to the general population.

B. Public Health Education and Awareness

The program supports activities that inform, educate and create awareness on vaccine-preventable diseases and immunization through mechanisms such as workshops, posters, and social marketing campaigns.

C. Capacity Development

The program supports activities that enhance and support development of health care workers' knowledge and skills through mechanisms such as training, workshops and professional certification as required.

D Surveillance Data Collection and Evaluation
The program supports activities that enhance and support development of the technical strategies required to improve data collection and surveillance through ongoing investigation of new data collection mechanisms and arrangements.

Clients
First Nations on-reserve and/or Inuit living in Nunatsiavut and Nunavik. Client population may change depending on the specific program element.

Types of Service Providers
Physicians, nurses and community health care workers.

Provider Qualifications
Providers must be registered members in good standing with their relevant colleges and/or professional associations, and be entitled to practice their profession in accordance with the laws of the province or territory where the services are provided. A variety of training, including on-the-job training is required for community health workers.

Partnerships
The program works closely with federal partners, such as PHAC, other FNIHB service programs, NGO's, provincial health authorities, as well as First Nations and Inuit organizations to support culturally appropriate communicable disease prevention and control programming.

Exceptions
In addition to the mandatory CBRT, communities are expected to report on public health surveillance activities as per the schedule found in the contribution agreements entitled, "Mandatory Programs and their Reporting Requirements" for communicable disease.

1.2.1.2 Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) - HIV/AIDS Program

Description
The BBSTI-HIV/AIDS program focuses on prevention, education, awareness and community capacity building, as well as facilitates access to quality diagnosis, care, treatment, and social support.

Objectives
- Increase awareness of BBSTI-HIV/AIDS through improved community-based knowledge development.
- Increase the availability of evidence-based BBSTI-HIV/AIDS interventions.
- Reduce the stigma of BBSTI-HIV/AIDS within communities.
- Promote testing, access to prevention, education and support, and supportive social environments for those vulnerable to and living with BBSTI-HIV/AIDS.

- Increase effective collaboration towards the achievement of a coordinated and integrated response to BBSTI-HIV/AIDS across jurisdictions.

Elements

A. Service Delivery

The program facilitates access to quality diagnosis, care, counselling, support and treatment through partnerships with physicians, community partners, health service centres, community health representatives and other health service providers, and through referrals, when appropriate, to provincial health services.

B. Public Education and Awareness

Activities include supporting culturally appropriate public awareness campaigns to help prevent further spread, and reduce stigma and discrimination to encourage care-seeking behaviour. Education on risk factors is provided through mechanisms such as knowledge-exchange initiatives.

C. Capacity Development

The program facilitates access to skilled health professionals and provides relevant training opportunities to those supporting program delivery in order to develop their capacity to respond to BBSTI-HIV/AIDS and related health issues.

D. Surveillance, Data Collection and Evaluation

The program supports activities such as evidence-based analysis and the development and dissemination of knowledge resources leading to improved surveillance data analysis and effective programming.

Clients

First Nations on-reserve and/or Inuit living in Nunatsiavut and Nunavik. Client population may change depending on the specific program element.

Types of Service Providers

Physicians, nurses, community health care workers and volunteers.

Provider Qualifications

Providers must be registered members in good standing with their relevant colleges and/or professional associations, and be entitled to practice their profession in accordance with the laws of the province or territory where the services are provided. A variety of training, including on-the-job training is required for community health workers.

Partnerships

The program works closely with other federal partners, such as PHAC, other FNIHB service programs, NGO's, provincial health authorities, as well as First Nations and Inuit organizations to support culturally appropriate programming.

Exceptions

In addition to the mandatory CBRT, communities are expected to report on public health surveillance activities as per the schedule found in the contribution agreements entitled, "Mandatory Programs and their Reporting Requirements" for communicable disease.

1.2.1.3 Respiratory Infections - Tuberculosis (TB) Program

Description

The tuberculosis program aims to reduce the incidence of TB disease in First Nations and Inuit communities to 3.6 cases per 100,000 by 2015, in keeping with Canada's national goal. The goal is to assure equitable access to timely diagnostics, treatment and follow-up care for those exposed to and diagnosed with TB.

Objectives

- Reduce incidence of TB disease in First Nations and Inuit communities.
- Detect and diagnose TB disease early to eliminate the cycle of transmission among those exposed to infectious cases.
- Provide treatment via Directly Observed Therapy (DOT) to those with active TB disease and latent TB infection to prevent the emergence of drug resistance.
- Support health care workers and communities in the prevention and control of TB disease at the community level.
- Strengthen TB research through collaboration with local, regional, provincial, national and international partners.

Elements

A. Service Delivery

In collaboration with provincial TB prevention and control programs, the program is delivered through primary health care services at the community level and includes enhanced screening, contact investigation, centralized case management, Directly Observed Therapy (DOT) for disease cases, and education and awareness activities.

B. Public Education and Awareness

The program supports the development of culturally appropriate education and awareness materials (such as posters and workshops), along with community education campaigns, to increase awareness of TB and reduce the stigma associated with the disease.

C. Capacity Development

The program offers relevant training opportunities to healthcare workers for their knowledge and skills to deliver TB prevention and control services.

D. Surveillance, Data Collection and Evaluation

The program monitors 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; and the dissemination of epidemiologic information on TB to

various partners and stakeholders. Local, regional, national and international partners and stakeholders are also engaged in supporting and participating in TB related research and projects to address the burden of TB in on-reserve First Nations and Inuit in Canada.

Clients
First Nations on-reserve and/or Inuit living in Nunatsiavut and Nunavik. Client population may change depending on the specific program element.

Types of Service Providers
Physicians, nurses and community health care workers.

Provider Qualifications
Providers must be registered members in good standing with their relevant colleges and/or professional associations, and be entitled to practice their profession in accordance with the laws of the province or territory where the services are provided. A variety of training, including on-the-job training is required for community health workers.

Partnerships
The program works closely with federal partners, such as PHAC, other FNIHB service programs, NGO's, provincial health authorities, as well as First Nations and Inuit organizations to support culturally appropriate programming. FNIHB also partners with other stakeholders to support TB research and projects to meet the program goals.

Exceptions
In addition to the mandatory CBRT, communities are expected to report on public health surveillance activities as per the schedule found in the contribution agreements entitled, "Mandatory Programs and their Reporting Requirements" for communicable disease.

1.2.1.4 Communicable Disease Emergencies - Pandemic Influenza

Description
The Communicable Disease Emergencies (CDE) initiative is responsible for ensuring that the special considerations and needs of First Nation communities are reflected in overall pandemic influenza planning, for which the Public Health Agency of Canada is the lead. In First Nation communities, the initiative supports the development, strengthening and testing of community pandemic plans. In the event of an influenza pandemic, it also supports communities' responses.

Objectives
- Support communities in preparing for an influenza pandemic by facilitating testing and revision of community level plans as needed.
- Facilitate communities' response to an influenza pandemic (e.g., support mass immunization clinics, provide training, guidance documents, etc.).
- Ensure health facilities have access to personal protective equipment (e.g., masks, gloves, gowns) during a pandemic.

- Ensure that First Nations circumstances are reflected in overall pandemic planning at all levels of government.

Elements

A. Service Delivery

The CDE initiative supports the development and testing of community influenza pandemic plans as well as response efforts during an influenza pandemic. For example, during H1N1 the initiative supported mass immunization clinics, provided training, and ensured access to personal protective equipment for staff in health facilities.

B. Public Education and Awareness

The initiative supports the development of culturally appropriate education materials. Support for education on infection prevention and control is also provided.

C. Capacity Development

The initiative works with communities to strengthen their skills in planning and testing their influenza pandemic plans, as well as with health professionals, community leaders and community members to increase their ability to respond to an influenza pandemic.

D. Surveillance, Data Collection and Evaluation

The initiative conducts the periodic testing and strengthening of community influenza plans to support community-level preparedness. Surveillance is being strengthened by integrating into provincial health surveillance systems.

Clients

On-reserve First Nations communities.

Types of Services Providers

Physicians, registered nurses and community health care workers.

Provider Qualifications

Providers must be registered members in good standing with their relevant colleges and/or professional associations, and be entitled to practice their profession in accordance with the laws of the province or territory where the services are provided. A variety of training, including on-the-job training is required for community health workers.

Partnerships

The initiative works closely with federal partners, such as PHAC and AANDC, other FNIHB service programs, NGO's, provincial health authorities, as well as First Nations and Inuit organizations.

Exceptions

In addition to the mandatory CBRT, communities are expected to report on public health surveillance activities as per the schedule found in the contribution agreements entitled, “Mandatory Programs and their Reporting Requirements” for communicable disease.

1.2.2 Environmental Health

Environmental health programming aims to prevent and/or reduce risks to health associated with exposure to hazards in natural or built environments, thereby contributing to improved health and well-being in on-reserve First Nations and Inuit communities. This is done through identifying environmental health risks; contributing to community capacity to address risks and manage and administer programs; and by undertaking and funding environmental health research. Programming is carried out in partnership with First Nations and Inuit communities and organizations, and in collaboration with other federal departments and agencies, provincial and territorial governments, academia and other stakeholders.

1.2.2.1 Environmental Public Health Program (EPHP)

Description

The EPHP is delivered in First Nations communities south of 60º by Environmental Health Officers (EHOs) employed by Health Canada or First Nation communities and/or Tribal Councils in accordance with the *National Framework for the Environmental Public Health Program in First Nations Communities South of 60º.* Programming is provided in agreement with and/or at the request of First Nations Authorities. The EPHP is coordinated regionally by Environmental Public Health Services (EPHS) and supported nationally by the Environmental Public Health Division (EPHD). Key programming includes environmental public health assessments (e.g., public health inspections, investigations, drinking water quality monitoring), training, and public education and awareness. Activities are delivered in core areas such as: Drinking Water; Food Safety; Health and Housing; Wastewater; Solid Waste Disposal; Facilities Inspections; Environmental Communicable Disease Control; and Emergency Preparedness and Response.

The guiding principles of the EPHP are to:

- Work with First Nations communities as active partners in environmental public health programming.
- Collaborate with public health workers, provincial and local health authorities, First Nations organizations and other federal, provincial and municipal departments and agencies when delivering environmental public health programming in First Nations communities.
- Strive for a level of on-reserve environmental public health services comparable to that available off-reserve and generally consistent from Region to Region.

Objectives

- Identify and prevent environmental public health risks that could affect the health of community residents.
- Recommend corrective action and health promotion that may be taken by community leaders and residents to reduce these risks.

Elements

A. Drinking Water

The EPHP provides public education about safe drinking water and risk prevention; provides training and education material to Community-Based Drinking Water Quality Monitors (CBWMs); provides drinking water quality testing; and provides engineering reviews of water infrastructure project proposals from a public health perspective.

B. Health and Housing

The EPHP works with First Nations communities and other partners to address public health issues at the various stages of housing: site and design, construction, occupancy and demolition. This is accomplished through on-request public health inspections of housing, public education and training sessions.

C. Food Safety

The EPHP works with First Nations communities to prevent foodborne illness and address public health issues related to both traditional and conventional foods. Activities include public education, food handler training and routine and on-request public health inspections of permanent, seasonal and special event food service facilities.

D. Facilities Inspections

The EPHP works with First Nations communities, owners, operators, employees and users of facilities (health, community care, recreational and general facilities) to help prevent the spread of communicable disease, minimize public health risks and reduce safety hazards. Activities include providing routine and on-request inspections, providing advice, guidance and recommendations and delivering public education and awareness sessions related to public health and safety within facilities.

E. Environmental Communicable Disease Control

All regular EPHP activities aim to prevent illness and the spread of communicable diseases. Specific activities, such as, inspections, outbreak investigations, surveillance and public education are also undertaken to prevent and control foodborne (e.g., salmonella), waterborne (e.g., *E. coli*), and vectorborne (e.g., West Nile Virus, rabies) environmental communicable diseases. All activities are carried out in collaboration with local, regional, provincial and/or national communicable disease staff (including but not limited to nurses, epidemiologists and Regional Medical Officers).

F. Emergency Preparedness and Response

The EPHP works with communities and other partners to ensure environmental public health considerations are included in emergency planning, response and recovery activities. Activities include assessment of environmental public health risks during emergency planning, response and recovery situations and providing advice, guidance, and recommendations on how to minimize these risks.

G. Solid Waste Disposal

EPHP works with communities and other agencies to help limit public health risks posed by solid waste disposal. Activities include conducting environmental public health assessments of

disposal sites and transfer stations, and providing advice and public education about health waste disposal practices, and providing engineering reviews of solid waste site project proposals from a public health perspective.

H. Wastewater
EPHP identifies existing and potential hazards associated with wastewater disposal in order to reduce and prevent public health risks. Program activities focus on community wastewater treatment plants as well as on-site sewage disposal systems. Activities include conducting environmental public health assessments, providing public education, and providing engineering reviews of wastewater infrastructure project proposals from a public health perspective.

Clients
First Nations communities and individuals (on-reserve) south of 60˚.

Types of Service Providers
Environmental Health Officers.

Provider Qualifications
Environmental Health Officers must possess a Certificate in Public Health Inspection (Canada) issued by the Canadian Institute of Public Health Inspectors or the acceptable authorized equivalent. EHOs must be entitled to practice 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 and/or territory where the services are to be provided.

Public Health Engineers are professionally trained engineers who offer technical expertise in environmental areas that may impact public health. Public health is not an official designation for professional engineers in Canada, but rather a title used by professional engineers with significant experience providing technical advice from a public health perspective. Public Health Engineers within the EPHP must possess a degree from a recognized university in environmental engineering or civil engineering with a specialization in environmental engineering. Public Health Engineers must be entitled to practice in accordance with the professional governing body (i.e., be licensed by the Professional Engineering Association in their province of work) and laws of the province and/or territory where the services are to be provided.

Partnerships, Roles
First Nations community leaders and residents play a central role in environmental public health programming on-reserve. They work in collaboration with the Environmental Public Health Program to identify environmental public health priorities within their communities and to address environmental public health risks. Specifically, First Nations leadership coordinates with the Environmental Public Health Program and other stakeholders (e.g., health care workers, Aboriginal Affairs and Northern Development Canada, provinces, surrounding municipalities, etc.) to develop, approve and implement Environmental Public Health community and/or regional work plans; works in partnership with EHOs, other health workers and stakeholders to develop and implement recommendations that relate to environmental public health; provides input from a First Nations perspective on program policies, guidelines and best practice

documents; and, acts as stewards of resources and develops local policies and by-laws to protect and improve the health of the community.

The Environmental Public Health Program works with other federal departments, agencies and organizations to help assure effective environmental public health programming is available on-reserve. Collaboration and coordination with other federal partners such as Aboriginal Affairs and Northern Development Canada, Environment Canada, Public Health Agency of Canada, Canadian Food Inspection Agency and others is crucial to the development and delivery of effective and efficient environmental public health programming in First Nations communities. Environmental Public Health Program staff across Canada collaborates with other First Nations and Inuit Health programs, provincial governments, regional and local health authorities to share information and coordinate activities as appropriate.

Exceptions

In addition to the mandatory CBRT, recipients are expected to report on drinking water monitoring activities as per the schedule found in the contribution agreements entitled, "Mandatory Programs and their Reporting Requirements" for environmental health.

1.2.2.2 Environmental Health Research Program (EHRP)

Description

The Environmental Health Research Program (EHRP) focuses on research of environmental hazards and risks - physical, chemical, biological and radiological - that affect the health of First Nations and Inuit. The program assists First Nations and Inuit communities in developing capacity to work with governments, agencies, academia and other organizations to incorporate both scientific and Traditional Knowledge in environmental health studies and outreach materials. The program provides funding for community-based research programs and conducts research, monitoring, surveillance, laboratory and field studies related to environmental health.

Objectives

- Increase environmental health risk awareness and community capacity through community-based research and monitoring projects.
- Provide scientific information and knowledge to First Nations and Inuit communities as well as policy-makers, decision-makers and academia regarding human health and environmental linkages.
- Provide laboratory and statistical services for scientific research and monitoring on environmental health.
- Monitor and assess scientific developments in the field of the environment's impact on human health at local, national and international levels.

Elements

A. Research and Monitoring (RM)

EHRP provides funding for community-based research and risk assessment through the National and Regional First Nations Environmental Contaminants Programs and the Northern

Contaminants Program. It funds First Nations and Inuit educational activities such as curriculum development for Health Impact Assessment, the development of the Traditional Food Safety Manual and the ongoing conduct of Traditional Food Workshops. EHRP also provides input and funding for targeted environmental monitoring and community exposure assessments, when necessary. Under the Chemical Safety of Traditional Foods Program, EHRP supports major research initiatives, such as the First Nations Food, Nutrition and Environmental Study, which aims to provide the first regionally representative portrait of First Nations diets and the estimate of potential health risks associated with consuming various country foods that could be affected by environmental contaminants, while promoting the importance of traditional diets.

Research and Monitoring aims to:

- Scan, analyse, integrate and interpret scientific data to understand exposure levels and possible impacts of key persistent environmental contaminants on the health status of First Nations and Inuit;
- contribute to the development of human exposure standards and guidelines;
- research, monitor and report on the results of environmental contaminants programs and research initiatives in Canada and in the Arctic countries;
- identify emerging research needs to target program development; and
- communicate risk-related issues based on environmental contaminants research and analysis to First Nations, Inuit and the general public.

B. Data Analysis and Program Support

EHRP funds and conducts research and gathers and analyses data to support the drinking water component of the Environmental Public Health Program. It publishes an annual Drinking Water Performance Indicator Report, which tracks progress towards achieving drinking water program goals and objectives. Activities include:

- research and statistical analysis support and advice to other environmental public health programs within FNIHB; and
- funding of community-based research projects on drinking water quality and monitoring to support an evidence base for public health programs and policies regarding First Nations drinking water.

C. FNIHB Laboratory

EHRP provides human tissue analysis of persistent organic pollutants, including several organochlorines for initiatives such as the First Nations Food, Nutrition and Environmental Study. The laboratory specializes in international and national quality assurance studies and is a proficiency testing provider for international programs such as the Mercury in Hair Interlaboratory Comparison Program.

D. Climate Change and Health Adaptation

This funding program is directed to northern First Nation and Inuit communities. The program assists these communities to develop successful funding research proposals that identify and respond to the health impacts associated with climate change. The results of the research are used to:

- develop human health risk management plans and tools, including culturally-sensitive educational and awareness materials; and

- enhance decision-making at the community, regional, and national levels regarding health adaptation in the North.

E. First Nations Biomonitoring
EHRP, in partnership with First Nations research and statistical organizations, implements a First Nations Biomonitoring Initiative to collect baseline information on human exposure to environmental chemicals. The initiative is for First Nations living on-reserve and is similar in approach to the Canadian Health Measures Survey conducted by Statistics Canada and Health Canada. Activities include consultations with national and regional First Nations organizations to:

- determine their priorities;
- determine suitable biomonitoring parameters; and
- collect, analyze and disseminate data.

F. Environmental Health Guides
In partnership with First Nations and Inuit organizations, EHRP is developing a series of environmental health guides for First Nations and Inuit to increase their awareness of environmental contaminants that could affect their health and to identify measures to reduce harmful exposure.

Clients
EHRP works with First Nations and Inuit communities and organizations and provides funding for environmental health research under various program elements described above.

Partnerships
The Environmental Health Research Program works in partnership with First Nations and Inuit communities and organizations as well as with other federal departments, agencies and organizations to help ensure effective environmental health research programming is implemented. Collaboration, coordination and sharing of information with other federal partners such as other branches and programs in Health Canada, Aboriginal Affairs and Northern Development Canada, Environment Canada, Public Health Agency of Canada, Fisheries and Oceans, provincial and territorial governments, academia and others is crucial to the development and delivery of environmental health research programming for First Nations and Inuit.

Exceptions
Contribution funding for community-based research is allocated through a competitive request for proposal process.

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1.3 Primary Care

Primary Care is a coordinated system of health services required to maintain health and treat illness and is the first point of **individual** contact by First Nations and the Inuit with the health system at the reserve/community level. Primary care is delivered by a collaborative health care team, predominately nurse led, providing a set of integrated and accessible health care services that include assessment, diagnostic, curative, rehabilitative, supportive and palliative/end-of- life care. It is where health promotion and disease prevention actions are directed towards individuals/families in the course of provision of care. The identification of cases requiring complex care, the coordination/and or integration of care, and timely referral to appropriate provincial/territorial secondary and tertiary levels of care outside the community are also essential elements of primary care. Primary care services are provided directly to First Nations and Inuit communities or through contribution agreements in locations where these services are not provided by provincial/territorial health systems and are necessary to ensure that First Nation /Inuit individuals and communities have access to the full range of health services as other provincial/territorial residents in similar geographic locations. Funds are used to support the staffing and operation of nursing stations on reserve, home and community care programs in First Nation and Inuit communities and Federal Funded hospitals in Manitoba.

All Primary Care programs are **mandatory** because they have a direct impact on the health and safety of community members and the population. They have a strong public health and/or clinical component and require that health staff have certain credentials/certification/licensing and meet practice standards to ensure quality public health and client care services are provided.

1.3.1 Clinical and Client Care

Description

Clinical and Client Care consists of essential health care services directed towards First Nations individuals, living primarily in remote and isolated communities, which enable them to receive the clinical care they need in their home communities. It is provided either directly or through contribution agreements with First Nation Bands or Tribal Councils in locations where these services are not provided by provincial health systems. Clinical and Client Care is often the first point of individual contact with the health system and is delivered by a collaborative health care practice teams, predominantly nurse led, providing integrated and accessible assessment, diagnostic, curative and rehabilitative services for urgent and non-urgent care. The continuum of Clinical and Client Care is inclusive of health promotion and disease prevention at the client/family level in the course of treatment as well as the coordination and integration of care and referral to appropriate provincial secondary and tertiary levels of care outside the community. Physician visits and hospital in-patient, ambulatory and emergency services are components of Clinical and Client Care services provided in some First Nations communities.

Objectives

- Provide access to urgent and non-urgent health services to community members including those who reside in remote/isolated communities where access to health services is not available through provincial or regional health authorities.
- Provide access to coordination and consultation services with other appropriate health care providers and/or institutions as indicated by client needs.
- Provide access to short term in-patient services in Federal Funded Hospitals in Manitoba.

Elements

A. Urgent Care

Emergency care involves immediate assessment of a seriously injured or ill client to determine the severity of the condition and the type of care needed. It may involve treatment with stabilizing measures and arranging for immediate transport to a tertiary care centre, or keeping the client under observation. Where available, this is done in consultation with a physician. In isolated/remote communities, this is done by the nursing staff often in consultation with a physician by telephone or internet.

B. Non-Urgent Care

Non-urgent care involves the assessment, identification of problem(s) and generation of a plan of management for a client who is seeking care and treatment for a non-life threatening specific health concern. Other health care providers may be consulted depending on the nature of the condition.

C. In-Patient Hospital Services (Federal Hospitals only)

In-patient hospital care refers to admissions to hospitals for medical treatment services, palliative/terminal care or respite care. Admissions generally require at least one overnight stay, except admissions for observation which can be up to 4 hours only.

D. Coordination and Case Management

The linkages with other services may include other health, social and education programs available both within the community and outside of the community, such as therapeutic services, primary, secondary and tertiary care hospitals, and primary care and specialist physician and nursing services.

E. Access to Medical Equipment, Supplies and Pharmaceuticals

This involves the provision of and, access to, medical equipment, supplies and pharmaceuticals to provide clinical and client care. This is within the parameters of the *National Nursing Station Drug Formulary* and the *National Clinical Practice Guidelines.*

F. A System of Record Keeping and Data Collection

This component develops and maintains a client record, that may include an electronic health record, and an information system that meets best practices and health record management standards, that enables program monitoring, ongoing planning, reporting and evaluation activities.

G. A Continuous Quality Improvement Process
This component includes the capacity to review and continuously improve the delivery of clinical and client care in a safe and effective manner.

H. Diagnostics
This component includes the capacity to perform X-Rays, EKG and blood sampling to guide urgent and non-urgent clinical care in Federal Hospitals.

Clients
First Nations on-reserve of any age. Services may be provided to non-First Nations clients where these services are not otherwise readily available.

Types of Service Providers
The type of service provider is dependent on the services available in a particular location and not all are found in each facility.

Regulated health professionals: Registered Nurses (RN), Nurse Practitioners (NP), Licensed Practical Nurses (LPN), Registered Practical Nurses (RPN), Medical Radiation Technologist (MRT), Medical Laboratory Technologists (MLT), Unregulated health workers such as: Health Care Aides, Rehabilitation aides, pharmacy technician and support personnel such as health receptionists.

Provider Qualifications
Regulated health professionals that include RN, NP, LPN, MRT and MLT must all meet the Provincial Professional Association Registration and Licensing requirements of the Province in which they practice. All Regulated health professionals must have the appropriate education to meet the competencies required for work to their full scope of practice in the clinical care setting. Unregulated health workers who participate as members in the practice teams must also have the required training to work in the clinical care setting. Support personnel should also have the required training to work in this capacity in the clinical care setting. All health care team members must also have the required level of security and training for access to health records and the management of health records.

Exceptions
If a First Nation is funded for this mandatory program, it must be provided before any reallocation of funding, in line with the terms and conditions of the various agreements can occur.

1.3.2 Home and Community Care

Description

Home and Community Care is a coordinated system of home and community-based health care services that enable First Nations and Inuit people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities. It is provided primarily through contribution agreements with First Nation and Inuit communities and Territorial governments and strives to be equal to home and community care services offered to other Canadian residents in similar geographical areas. Home and Community Care is delivered primarily by home care registered nurses and trained and certified personal care workers. Service delivery is based on assessed need and follows a case management process. Essential service elements include client assessment; home care nursing; case management; home support (personal care and home management); in-home respite; linkages and referral, as needed, to other health and social services; provision of and access to specialized medical equipment and supplies for care; and a system of record keeping and data collection. Additional supportive services may also be provided, depending on the needs of the communities and funding availability. Supportive services may include but are not limited to: rehabilitation and other therapies; adult day care; meal programs; in-home mental health; in-home palliative care, and specialized health promotion, wellness and fitness.

Objectives

- Build the capacity within First Nations and Inuit communities to plan, develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.
- Assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.
- Facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan.
- Ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible.
- Assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.
- Build the capacity within First Nations and Inuit communities to support the delivery of quality client centered home care services promoting safety.

Elements

A. Structured Client Assessment

The structured client assessment process utilizes an assessment tool that includes ongoing reassessment and determines client needs and service allocation. Assessment is a structured dynamic process of continuous information gathering and knowledgeable judgments which attach meaning to the information being gathered. Assessment and reassessment processes can involve the client, family and other care givers and/or service providers.

B. Managed Care
A managed care process incorporates case management, care planning, referrals and service linkages to existing services provided both on and off reserve/settlement.

C. Home Care Nursing Services
Home nursing services include direct service delivery, supervision and teaching of personnel, providing personal care services and support to family caregivers.

D. Home Support Services
Personal care services such as bathing, grooming, dressing, transferring and care of bed-bound clients; home management assistance includes such services as general household cleaning, meal preparation, laundry and shopping. FNIHCC home support services are intended to enhance not duplicate AANDC Assisted Living services.

E. Provision or Access to In-Home Respite Care
This service is intended to provide safe care of clients and short term relief for family and caregivers so that they can continue to provide care, thereby delaying or preventing the need for institutional care.

F. Access to Medical Equipment and Supplies
This involves the provision of and access to medical equipment, supplies and pharmaceuticals that are specialized to client needs within home and community care.

G. Information and Data Collection
This component is a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities and to provide safe storage and handling of confidential client health records.

H. Management and Supervision
This component includes the capacity to manage the delivery of a quality home and community care program in a safe, efficient and effective manner including professional supervision / consultation.

I. Established Linkages with other Services
*L*inkages with other professional health and social services, both within and outside the community, may include coordinated assessment processes, referral protocols and service links with such providers as hospitals, physicians, respite, therapeutic services, gerontology programs and cancer clinics.

Clients
First Nations and Inuit people with disabilities, chronic or acute illnesses and the elderly. First Nations and Inuit of any age:

- who live in a First Nations reserve community (or in a First Nations community North of 60) or Inuit settlement;
- who have undergone a formal assessment of continuing care service needs and have been assessed as requiring one or more of the essential services; and

- who have access to services which can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice.

Types of Service Providers

Home and Community Care Nurses, Personal Care Workers, and other community health and social development team members.

Provider Qualifications

Nurses must be registered under the Nursing Act in their province of work. Personal care workers require certification from a community college or other recognized institution, based on the requirements in place for such workers in their Province or Territory.

Exceptions

If a First Nation is funded for this mandatory program, it must be provided before any reallocation of funding, in line with the terms and conditions of the various agreements can occur.

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2.0 SUPPLEMENTARY HEALTH BENEFITS

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 and Inuit. Individuals may have access to other health-related goods and services through other publicly-funded programs or through private insurance plans. The Non-Insured Health Benefits Program is a national program that provides, to registered First Nations and recognized Inuit in Canada regardless of residency, a specified range of medically necessary health-related goods and services not provided through other private or provincial/territorial programs.

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2.1 Non-Insured Health Benefits (NIHB)

Description

The NIHB Program provides benefit coverage to 846,000 eligible registered First Nations and recognized Inuit regardless of their residency. Eligible benefits under the Program supplement private insurance, provincial/territorial health and social programs, and include pharmacy, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counselling, and medical transportation to access medically required health services not available on-reserve or in the community of residence. Coverage for health care premiums on behalf of clients in British Columbia is also provided. The NIHB is publicly funded and differs from private insurance plans in a number of ways: it uses a needs-based approach and there are no client premiums, co-payments, deductibles or annual maximums.

The following principles govern the NIHB Program:

- All registered First Nations and recognized Inuit residents in Canada, and not otherwise covered under a separate agreement (e.g. a self government agreement) with federal or provincial governments are eligible for benefits under the NIHB Program, regardless of location in Canada or income level;
- Benefits are based on professional medical judgement, consistent with the best practices of health services delivery and evidence-based standards of care;
- There will be national consistency of mandatory benefits, equitable access and portability of benefits and services;
- The Program will be managed in a sustainable and cost-effective manner;
- Management processes will involve transparency and joint review structures, whenever jointly agreed to by First Nations and Inuit Organizations; and
- When a NIHB-eligible client is also covered by another public or private health care plan, claims must be submitted to the client's other health care/benefits plan first. The NIHB Program will then coordinate payment with the other payer on eligible benefits.

Objectives

The purpose of the NIHB Program is to provide non-insured health benefits to registered First Nations and recognized Inuit in a manner that:

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

Benefits delivery is administered in three ways:

- Through the NIHB Headquarters office for pharmacy benefits and orthodontics services;
- Through Health Canada regional offices for dental care, medical transportation, vision care, medical supplies and equipment and short-term crisis intervention mental health counselling benefits; and
- Through contribution agreements for select benefits.

Elements

A. Pharmacy Benefit

The NIHB Program covers pharmacy benefits to assist clients in obtaining prescription and some over-the-counter drugs that are available through pharmacies for use in a home or ambulatory setting. Eligible pharmacy benefits are set out in the current NIHB Drug Benefit List (DBL) which is published annually and updated quarterly and published annually on the Health Canada Website. Pharmacy benefits require a prescription from a NIHB-recognized prescriber, licensed and authorized to practice in their province/territory in accordance with the policies set out in the current *NIHB Provider Guide for Pharmacy Benefits*.

B. Medical Supplies & Equipment (MS&E) Benefit

The NIHB Program provides coverage in order to assist clients in obtaining medically necessary medical supplies and equipment benefits such as supplies, equipment and related services. Eligible benefits are set out in the *NIHB Medical Supplies and Equipment Benefit List.* The schedule of eligible benefits includes audiology (e.g. hearing aids), medical equipment (e.g. wheelchair, walker), medical supplies (e.g. ostomy, bandage and dressings), orthotics and custom footwear, pressure garments, prosthetics, oxygen and respiratory supplies and equipment. Most eligible medical supplies and equipment benefits, for usage in a home setting or other ambulatory setting, require prior-approval and a prescription from a NIHB-recognized prescriber. They must also be provided/dispensed through pharmacies or a NIHB-recognized provider, in accordance with the policies set out in the current *NIHB Provider Guide for MS&E Benefits.*

C. Medical Transportation Benefit

The NIHB Program covers medical transportation benefits to assist clients in accessing medically necessary insured health services (including accessing some NIHB benefits, alcohol/ solvent, drug abuse and detox treatment, traditional healers) that cannot be obtained in their community of residence. Eligible benefits may include ground, water and air travel, meals and accommodation, emergency transportation, and an approved escort. The *NIHB Medical Transportation Policy Framework* sets out a list of services for which medical transportation

benefits may be provided, the type of benefits to be provided, and criteria under which they may be provided.

D. Dental CareBenefit
The NIHB Program covers dental care benefits to assist clients in obtaining dental care services. Coverage for dental services is determined on an individual basis, taking into consideration the client's current oral health status, past client history, accumulated scientific research, and availability of treatment alternatives. Eligible benefits and services are listed in the *NIHB Dental Benefit Grid* and include diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontic, orthodontic, adjunctive and emergency dental services. Under the NIHB Program, dental care benefits and services must be provided by a licensed dental practitioner: for example, dentists, denturists, dental specialists, in accordance with the policies set out in the current *Provider Guide for Dental Benefits.*

E. Vision Care Benefit
The NIHB Program covers vision care benefits to assist clients in obtaining vision care goods and services. Eligible benefits and services are specified in the *NIHB Vision Care Framework and Benefit* list and include eye examinations (in provinces and territories where this is not an insured service), eyeglasses that are prescribed by a vision care prescriber, eyeglass repairs, and eye prosthesis (i.e. artificial eye). The vision care benefit must be prescribed and provided by a licensed vision care professional, and in accordance with the policies set out in the current *NIHB Vision Care Framework.*

F. Short-Term Crisis Intervention Mental Health Counselling Benefit
The NIHB Program may cover short-term crisis intervention mental health counselling as a benefit when no other such services are available to the client. Eligible benefits may include the initial assessment, development of a treatment plan, fees and associated travel costs for the professional mental health therapist when it is deemed cost-effective to provide such services in a community. Mental health benefits may be provided by therapists who are registered with a regulatory body from the disciplines of clinical psychology or clinical social work in the province/territory, in which the services provided. Alternative service providers may be considered in exceptional circumstances.

Clients
Registered First Nations and recognized Inuit in Canada.

Type of Service Providers
Some examples include dentists, pharmacists, opticians, optometrists, psychologists, medical drivers, audiologists, prosthetists and other licensed specialists as designated by the NIHB Program.

Provider Qualifications
Qualifications for service providers vary depending on the service being provided.

Exceptions

The Supplementary Health Benefits Authority operates under the Set Funding Model[1]. The recipient of a contribution agreement using the Set Funding Model under the Supplementary Health Benefits Authority has no opportunity to reallocate or redirect health resources to other health programs or services and shall deliver the Program in accordance with established benefit standards and guidelines that define coverage, rates and requirements.

The effectiveness of service delivery via contribution agreement under the Supplementary Health Benefits Authority is monitored through financial and program activity reports, outside of the Community Based Reporting Template. These reports are required three times per year and have the requirements set out in the contribution agreement.

[1] In certain cases, recipients with demonstrated capacity to effectively manage complex agreements may be granted ADM-approval to enter into more flexible agreements.

3.0 HEALTH INFRASTRUCTURE SUPPORT

Health Infrastructure Support underpins the long-term vision of an integrated health system with greater First Nations and Inuit control by enhancing their capacity to design, manage, deliver and evaluate quality health programs and services. It provides the foundation to support the delivery of programs and services in First Nations communities and for individuals and promote innovation and partnerships in health care delivery to better meet the unique health needs of First Nations and Inuit.

3.1 Health System Capacity

Health System Capacity is the foundation for the overall management and implementation of First Nations and Inuit health programs and services. It enhances First Nations and Inuit capacity to design, manage, deliver and evaluate quality health programs and services through planning, management and infrastructure. It also supports the promotion of Aboriginal participation in health careers, and the development of and access to health research, information and knowledge to inform all aspects of health programs and services.

3.1.1 Health Planning and Quality Management

Health Planning and Quality Management supports the enhancement of capacity for First Nations and Inuit in order to engage in, and control the design of, management and delivery of their health programs and services. It encourages the development and delivery of health programs and services through program planning and management. It also supports the on-going health system improvement by embedding quality improvement activities into health programs and services through various methods such as accreditation and the evaluation of health programs.

3.1.1.1 Health Planning and Management

Description

Health Planning and Management supports First Nations and Inuit planning and management of health programs and services. This funding supports health planning and the development of both health services and programs delivery models and its requisite infrastructure at the community, regional or national levels. Sound health planning and development of a health infrastructure are two critical conditions to access the Block (Flexible and Flexible Transfer) funding model. The Health Planning and Management funding supports First Nations and Inuit recipients in the establishment of a strong, effective and sustainable health planning, administration and delivery infrastructure at the community level.

Objectives
Health Planning and Management enables increased First Nations and Inuit control and capacity building around health programming that, when combined with the use of flexible arrangements including ongoing health planning, supports operational plans and administration, which:

- Enable recipients to design health programs, develop health plans, establish services and/or allocate funds according to their identified health priorities;
- Ensure that recipients have an optimized flexibility for health programming and services; and
- Strengthen and enhance the accountability of recipients regarding the management and the delivery of quality health programs and services.

Clients
First Nations and Inuit communities, District and Tribal Councils, First Nations Health Boards, health organizations and corporations.

Exceptions
Recipients in a Set Funding Model are not eligible for Health Planning and Management funding for the ongoing management and delivery of health programs and services unless they are in the planning phases of the health planning process.

Recipients who are not delivering community-based health programs and services will be assessed on a case by case basis to determine their eligibility for Health Planning and Management funding.

3.1.1.2 First Nations and Inuit Health Services Accreditation

Description
The objective of the accreditation initiative is to support First Nations and Inuit health services as they apply national standards to improve the quality of health care. The accreditation process supports full involvement of the First Nations and Inuit health services organizations with community leadership, educational services, provincial and territorial health services, medical professionals and community members who receive the services (clients). As well as building essential linkages within and between communities and provinces and territories, accreditation provides opportunities for community members to have an ongoing voice in the direction of their health organization. Funding assists First Nations and Inuit organizations to engage in the accreditation process and uses standards of excellence related to sustainable governance, effective organization, service excellence and positive client experience.

Objectives
- Work in collaboration with accrediting bodies to ensure standards are culturally relevant and guidance and support is available to organizations.
- Develop strong regional capacity and structures to support organizations through the accreditation process.

- Increase of number of First Nations and Inuit communities accessing accredited health services.
- Incorporate ongoing quality improvement into the First Nations and Inuit healthcare system.

Clients
The target populations for the First Nations and Inuit Health Services Accreditation initiative are First Nations and Inuit health organizations.

Exceptions
Not applicable

3.1.1.3 Health Research and Engagement

Description
Health research activities support the improvement of: a) quality and quantity of Aboriginal health data, research, and information; b) development, advancement, distribution, and knowledge translation of Aboriginal health information; and, c) capacity of First Nations and Inuit to generate and access Aboriginal health information.

Health Engagement, consultation and liaison activities support the establishment and maintenance of productive lines of communication and exchanges of policy, research, evaluation, and program delivery information between various partners (such as government and Aboriginal organizations and health care delivery agencies).

Objectives
- To establish and maintain productive lines of communications and exchange of policy, research, and program delivery information between First Nations and Inuit, health care delivery agencies, and other levels of governments.
- To ensure substantive involvement of First Nations and Inuit in decisions relating to health care policy and delivery.
- To develop and maintain awareness and expertise in the field of health care.
- Designed to increase the capacity to consult and liaise to provide policy advice, analysis, input, and guidance relating to federal health policy as a means of ensuring that such policy is reflective of Aboriginal health issues, initiatives, needs, and priorities.

Elements
A. Health Research
This activity engages in capacity-building, information dissemination, knowledge translation, and research, data gathering and analysis with a variety of institutions and organizations.

B. Health Consultation and Liaison
These activities support substantive involvement of Aboriginal leaders and community

representatives in decisions and implementation relating to Aboriginal health policy and program delivery and the development of Aboriginal awareness and expertise in the field of health care.

Clients
First Nations Bands, District, Tribal Councils and Associations; Inuit Associations, Councils and Hamlets; Canadian National Aboriginal organizations; non-governmental and voluntary associations and organizations, including non-profit corporations; educational institutions and hospitals and treatment centres; Municipal, provincial and territorial governments and Health Authorities and Health agencies.

Type of Service Providers
Not applicable

Exceptions
Not applicable

3.1.2 Health Human Resources

Health Human Resources supports the promotion of Aboriginal participation in health human resources management, health career promotion, and career development best practices, to promote and support competent health services at the community level. This sub-sub activity also supports health educational opportunities to: achieve and maintain an adequate supply of qualified health care providers who are appropriately educated, distributed, deployed and supported to ensure culturally relevant, gender sensitive, and safe health care; increase the number of Aboriginal peoples working in health care delivery, and as health care professionals to respond to client needs; and to improve the continuity of care for First Nations and Inuit leading to increased client and provider satisfaction and ultimately to improved client outcomes.

It encourages work with Aboriginal groups, communities and organizations, federal, provincial, territorial governments, health professional organizations and associations as well as post secondary educational institutions and other stakeholders to develop and implement health human resources planning.

3.1.2.1 Health Human Resources Program

Description
The Health Human Resources initiative encourages provincial and territorial and federal governments to work together with Aboriginal people to advance a health care system that is more responsive to the needs of Aboriginal people. Through the Initiative, health human resources strategies responding to the unique needs and diversity among Aboriginals will be developed and implemented while at the same time seeking to provide the right balance and numbers of Aboriginal health care providers, increase the level of cultural competency of all health care providers as well as respond to the current, new and emerging health services issues

and priorities while integrating with the pan-Canadian Health Human Resources Strategy. The goal of this collaboration is to reduce the gap in health status that currently exists between Aboriginal people and the rest of the Canadian population, through improved access to health care, and the resultant better health outcomes.

Objectives

- To lay the foundation for longer term systemic changes in the supply, demand and creation of supportive working environments for Aboriginal health human resources.
- To increase the number of Aboriginals who are aware of health careers as viable career options, focusing particularly on youth awareness.
- To increase the number of Aboriginal students entering into, and succeeding in health career studies.
- To increase the number of qualified Aboriginal health professionals and allied health workers in the Canadian workforce.
- To increase the number of post-secondary educational institutions that are supportive of and conducive to Aboriginal students in health career studies (eg., have culturally appropriate curricula; student support; access and mentoring programs; reduced barriers to admissions).
- To establish standards of practice and certification processes for Aboriginal community-based para-professional health care workers, which will help to ensure a properly trained and mobile para-professional work force, and help improve retention of para-professional community-based workers.
- To establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them.
- To initiate the establishment of baseline information (including on-going collection), and to initiate targeted research and analysis on the supply and demand for Aboriginal health care workers and best practices and approaches in order to support policy, planning and program decisions.
- To establish greater awareness of policies, standards, guidelines and best practices in health human resource planning and activities.

Clients

The target populations for the Health Human Resources initiative are:

- All First Nations, Inuit and Métis regardless of their status and where they reside;
- Health care providers providing services to First Nations, Inuit and Métis;
- Universities and colleges delivering health sciences programs that are interested in making changes to their curricula in order to provide more culturally relevant health science programming; and those that would like to provide culturally relevant health care programs; and
- First Nations, Inuit and Métis and non-Aboriginal health professional and para-professional organizations, associations and associations representing colleges and universities.

Exceptions

Not applicable

3.1.2.2 Health Careers Program

Description
The Health Careers Program (HCP) was created in 1984 in response to the disproportionately low numbers of Aboriginal people working in health professions. It is intended to increase awareness of health career opportunities and foster an interest in health science studies in Aboriginal students. It also provides the supports necessary to ensure success for the students. The overall goal of the program is to increase the number of Aboriginal health professionals. The HCP provides contributions to support Aboriginal participation in education leading to careers in the health field. The program is designed to address career needs at the national, regional and community levels - and consists of the Bursaries and Scholarships programs, which is administered by the National Aboriginal Achievement Foundation (NAAF) on behalf of Health Canada, health career promotion, including NAAF's Blueprint for the Future career fairs, career-related summer employment, community-based activities, and post secondary institutional programs.

At the Regional level, annual allocations are provided to deliver regionally based programs as well as community based programs, depending on regional priorities. The national portion of the program focuses on Bursaries and Scholarships and health career promotion activities.

Objectives
The objective is to build capacity of Aboriginal peoples by encouraging and supporting Aboriginal participation in health educational opportunities and by providing supports to learning environments. This is achieved through the promotion of health study programs, the provision of bursaries and scholarships for health career programs, provision of internship and summer student work opportunities and support for the Blueprint for the Future career fairs.

Clients
All Aboriginal peoples (status and non-status, Métis and Inuit).

Types of Service Providers
A variety of personnel are involved in the delivery of the national and regional health career initiatives, including health career coordinators, managers, volunteers and support staff.

Exceptions
Not applicable

3.1.3 Health Facilities

Health Facilities supports the development and delivery of health programs and services through infrastructure by providing funding to eligible recipients for the construction, acquisition, leasing, expansion and/or renovation of health facilities, as well as security services. These activities provide First Nations, Inuit and FNIHB staff with the space required to safely and efficiently deliver health care services in First Nations and Inuit communities.

This funds projects that support the integration of health services with, or support the transfer of health services to, health authorities and health agencies. In addition, preventative and corrective measures will be carried out to enable First Nations to improve the working conditions for Health Facilities staff and to maintain or restore compliance with building codes, environmental legislation, and occupational health and safety standards.

Health Canada /FNIHB has, or will have, no ownership or other legal interest in any capital assets (health facilities) funded through the Health Facilities and Capital Program. When Health Canada staff is requested to work in First Nation Health Facilities for the purpose of delivering health programs at the request of the First Nation recipient, the recipient will be required, as a condition of funding, to allow Health Canada to use these facilities free of charge or to enter into agreements to allow such free use by way of permit or designation under sections 28(2) and 38(2) of the *Indian Act*.

3.1.3.1 Health Facilities and Capital Program (HFCP)

Description

The Program provides funds to eligible recipients for capital investments towards First Nations and Inuit Health Facilities and associated lands. These health facilities provide the physical space and environment to enable First Nations and Inuit communities to deliver a variety of FNIHB funded health programs and services.

The HFCP supports the construction, acquisition, leasing, operation and maintenance of nursing stations, health centres, health stations, health offices, treatment centres, staff residences, and operational support buildings and the remediation or management of associated environmental and Occupational Health & Safety issues. These facilities allow First Nations and Inuit to efficiently and effectively deliver their health programs and services even in remote and isolated communities.

Objectives

- First Nations and Inuit have the facility space required to support on-reserve health programs and accommodate staff, where necessary.
- First Nations and Inuit have appropriate plans and conduct activities to ensure the operation and maintenance of their health facilities and staff residences.
- First Nations and Inuit have appropriate plans and conduct activities to ensure a safe, healing and secure physical environment for staff and clients.

- First Nations and Inuit have appropriate plans and conduct activities to ensure the effective environmental management of health facilities, staff residences, and operational support facilities.

Elements

A. Capital Investment
Provides First Nations and Inuit with funding to support FNIHB funded health programs and operations with the modern space required to effectively deliver health services.

B. Facilities Management
Provides First Nations and Inuit with guidance and best management practices to support the efficient operation and maintenance of FNIHB funded health facilities.

C. Physical Security Management and Emergency Planning
Ensures that First Nations and Inuit have appropriate plans and conduct activities to ensure that FNIHB-funded health facilities provide a safe and secure physical environment for staff, clients, and visitors, as well as for health equipment, pharmaceuticals, and medical files.

D. Environmental Management
Provides First Nations and Inuit with funding, guidance and best management practices to minimize the environmental impact of construction and operation activities stemming from FNIHB funded health facilities as well as brings these health facilities into compliance with applicable environmental regulations.

E. Real Property Planning and Policy Development
Provides guidelines, manuals, management tools and strategic direction to Health Canada and First Nations and Inuit community staff for the planning, implementation, and reporting of HFCP activities.

Clients

First Nations and Inuit communities and health facility staff and other health facility workers, such as visiting specialists.

Exceptions

The funding mechanisms to be used for the HFCP will be the Set or Flexible (Transitional) Funding Model Capital Contribution Agreements or the Set Funding Model Special Projects Contribution Agreement templates. Funds provided supporting the HFCP are only to be used for health capital projects (or special initiatives as approved by Senior Management).

3.1.3.2 Security Services

Description

Through the Health Funding Contribution Agreement, FNIHB may fund First Nations and Inuit for the planning and delivery of security services activities towards FNIHB funded health facilities to support the establishment of a safe and secure workplace environment for health

practitioners providing services in nursing stations and other health facilities on-reserve land across the country. By promoting and providing a safe and secure workplace environment, security services will contribute to the recruitment and retention of nursing staff who are vital assets for delivering upon the branch's mandated programs and services.

The provision of funds ensures that security personnel are posted in facilities where threat and risk assessments have identified personal and physical security threats. This funding is provided for the recruitment, training and retention of security guards by First Nations communities. In addition, the funding is complementary to the physical security funding provided through the Health Facilities and Capital Program.

Objectives

The overarching objectives of Security Services for FNIHB funded Health Facilities is to ensure a safe and secure workplace environment for nurses, other health facility workers and patients receiving care, through prevention, awareness, and continuous risk assessments.

Elements

Include ongoing Integrated Facility Audit (including a threat and risk component) for health facilities on-reserve and implementation of baseline security measures, including the staffing of security guards in high risk locations. Other elements include the development of policies, guidelines and procedures for the management of security functions in remote-isolated nursing stations.

Clients

Nurses and other health staff providing services in First Nations communities across the country.

Exceptions

Not applicable

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3.2 Health System Transformation

Health System Transformation supports a range of programs focusing on the integration, coordination and innovation of the health systems which serve First Nations. Activities include the development of innovative models to primary health care, investment in technologies that enhance health service delivery and the realignment of health governance structures to permit greater First Nations participation and control. Transformation will be achieved by engaging a diverse group of partners, stakeholders and clients including First Nations and Inuit communities, tribal councils, Aboriginal organizations, provincial and regional health departments and authorities, post-secondary educational institutions and associations, health professionals and program administrators.

3.2.1 e-Health Infostructure

Description

The e-Health Infostructure program supports the use of health technology to enable First Nation and Inuit community front line healthcare providers to improve people's health through innovative e-Health partnerships, technologies, tools and services. It focuses on the strategic investment in and adoption of modern systems of information and communications technologies (ICTs) for the purpose of defining, collecting, communicating, managing, disseminating and using data to enable better access, quality and productivity in the health and health care of First Nations. The program evolved out of the need for FNIHB to align with First Nations' e-health strategies, health plans and policy directions, as well as the movement by provinces/territories and the health industry towards increased use of information and communication technologies to support health service delivery and public health surveillance. Moreover, e-Health Infostructure (information + systems + technology + people) has the benefit of modernizing, transforming and sustaining health care to provide: a) optimal health services delivery (primary and community care included); b) optimal health surveillance; c) effective health reporting, planning and decision making; and d) integration/compatibility with other health services delivery.

Objectives

Long term objectives:

- An electronic health record capacity and capability for First Nations and seamless integration with provincial electronic health records systems.
- The establishment of innovative First Nations health governance appropriately integrated with other health systems (e.g., provinces).
- Improved First Nations and Inuit capacity to influence and/or control (design, deliver, and manage) health programs and services.

Supported by the following medium term objectives:

- Continue to investigate alternate service delivery mechanisms that generate new services where demand is warranted, improve access to existing services and facilitate effective decision making to improve First Nations health and health service delivery.

- Increased effectiveness and efficiency in the use of e-Health Infostructure applications.
- Increased engagement of key stakeholders in the integration of health services and the creation and maintenance of collaborative and sustainable partnerships.
- Increased First Nation management of e-Health Infostructure.
- Greater access to health data for First Nations and health care providers and decision makers.
- Increased use of e-Health systems that meet provincial and national standards.

Elements

A. Program Management, Planning, Governance and Accountability
The development, support and implementation of good management practices including but not limited to: appropriate and effective resource and activity monitoring and control systems; project reporting mechanisms; and effective financial and project planning.

B. Service Provision
Community-level health services supported and/or provided by FNIHB are Telehealth and community health infostructure services.

Telehealth services provide access to care that remote and isolated First Nations communities might not otherwise have, as well as, enhancing existing health programs and services. Telehealth services include, but are not limited to: televisitation for family members; tele-education for workers and community members; and remote clinical consultations for health issues such as diabetes and mental health.

As appropriate connectivity is the basic requirement for Telehealth, FNIHB works with First Nations leadership, private sector companies, provincial governments, and other federal entities such as Aboriginal Affairs and Northern Development Canada and Industry Canada to facilitate on-reserve connectivity and the adoption of information and communications technologies.

Building on connectivity and Telehealth, FNIHB works with First Nations and other key partners to improve and expand existing services through health infostructure initiatives. These include, but are not limited to, the development of client registries, the integration of services into a comprehensive electronic medical record, and linking on-reserve and provincial health data in a secure, private and culturally appropriate manner.

C. Capacity Building
Community-level capacity building is conducted in three main areas: human resources; infrastructure; and governance.

Training is provided to health professionals working in on-reserve First Nations communities, community health workers, and administrative and support staff on information and communications technologies. As mentioned above, Telehealth also facilitates distance training for other health services in remote and isolated First Nation communities.

Infrastructure capacity is built through efforts to improve the internet connectivity of remote and isolated communities and ensure adequate information and communication technology equipment is available.

By supporting community needs assessments, change management strategies, and new information/information technology management structures, the FNIHB works with First Nations to increase governance capacity and ensure appropriate e-Health Infostructure governance mechanisms are in place. This facilitates both the adoption of new health technologies and their effective use once implemented.

D. Stakeholder Engagement and Collaboration
The FNIHB works closely with First Nations leadership, other federal departments and entities, provincial governments, private sector and non-governmental organizations to ensure strategies and program initiatives are inclusive, well-planned, well-run and fully coordinated with other federal, provincial, and First Nation activities.

A key objective of the Branch is to promote and facilitate appropriate integration among First Nations and provincial health systems.

E. Public Health Information Systems
Through the Panorama Public Health Surveillance System (or its jurisdictional equivalent), the FNIHB is working to ensure that there is timely, accurate and useful public health and communicable disease surveillance, research and data collection systems for on-reserve First Nations. These systems are designed to improve decision making and, ultimately, lead to better health care and health outcomes for First Nations.

F. Policy Development and Knowledge Sharing
The FNIHB strives to ensure e-Health Infostructure related policy development is relevant, well-informed and coordinated with key partners; this is done by continuously sharing knowledge on health information and communications technologies and innovations with private sector organizations, other government entities at the provincial and federal levels, and First Nations through formal and informal networks.

Clients
Clients are health professionals in on-reserve health facilities who use e-Health Infostructure equipment, systems and applications to improve the quality of, and access to, health care programs and services for First Nations, community health workers, program managers and administrators, and First Nation community members themselves.

Exceptions
Not applicable.