Northern Inter-Tribal Health Authority

Empowering Our People

2010 / 2011 Annual Report

Contents

Vision Statement

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

Mission Statement

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

Principles

- NITHA's primary identity is a First Nations health organizations empowered by traditional language, culture, values and knowledge.
- The NITHA Partnership works to promote and protect the inherent Aboriginal and Treaty Right to Health as signatories to Treaty 6.
- NITHA is a bridge between the diversity of our Partners and the external world of different organizations, governments, approaches and best practices.
- The NITHA Partnership has representation at the federal and provincial levels.
- Partner communities are on the inside track of changes and developments.
- Through innovation and experimentation, the NITHA Partnership builds health service models that reflect First Nations' values and our best practices.
- NITHA provides professional support, advice and guidance to its Partners.
- NITHA contributes to capacity development for our northern First Nations health service system.
- NITHA works collaboratively by engaging and empowering.

Northern Inter-Tribal Health Authority

The Northern Inter-Tribal Health Authority Inc. is a First Nations' Partnership organization comprised of Meadow Lake Tribal Council, Lac La Ronge Indian Band, Prince Albert Grand Council and Peter Ballantyne Cree Nation. The four health organizations have more than 20 years of combined experience in the provision of health services in the Health Canada 'transfer environment' and in the delivery of nursing, public health, and primary care treatment services in 33 First Nation communities throughout northern Saskatchewan.

NITHA Partners are "northern", sharing the same geography, attachment to the land and related traditional activities, along with common challenges in accessing and providing health services.

The four Partners established NITHA because of our joint needs for services that were not feasible for each organization to provide alone. The Partnership does not try to direct the development of our Partners' health services but instead, to support and advise.

The Chiefs have the ability to speak with one united voice, thereby being stronger and more powerful in our insistence for health services responsive to the needs of our northern communities.

The Partners want a "First Nations health service" model that is different from the mainstream model. NITHA needs to continue building our services on this evolving First Nations model.

The Partnership

Meadow Lake Tribal Council
8002 Flying Dust Reserve
Meadow Lake, SK
S9X 1T8

Tel: (306) 236-5817
Fax: (306) 236-6485

Lac La Ronge Indian Band
PO Box 1770
La Ronge, SK
S0J 1L0

Tel: (306) 425-3600
Fax: (306) 425-5520

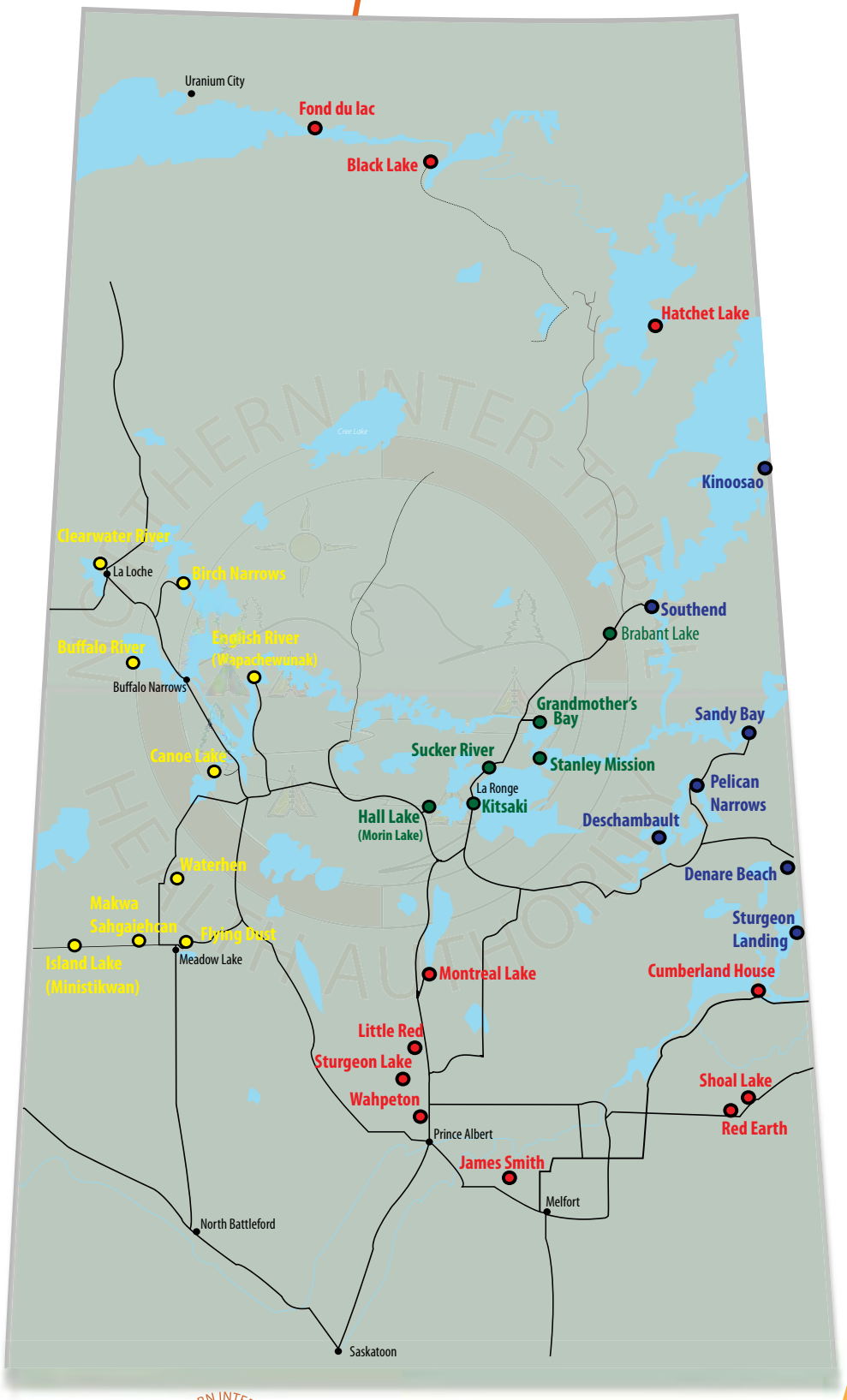
Prince Albert Grand Council
PO Box 1775
Prince Albert, SK
S6V 5T3

Tel: (306) 236-5817
Fax: (306) 236-6485

Peter Ballantyne Cree Nation
PO Box 339
Prince Albert, SK
S6V 5R7

Tel: (306) 953-4425
Fax: (306) 922-4979

Partnership Communities



Legend

NITHA Board of Chiefs

Chief Darrell McCallum
Peter Ballantyne Cree Nation

Tribal Chief Eric Sylvestre
Meadow Lake Tribal Council

Chief Tammy Cook-Searson
Lac La Ronge Indian Band

Grand Chief Ron Michel
Prince Albert Grand Council

NITHA Executive Council

Arnette Weber-Beeds
Peter Ballantyne Cree Nation

Flora Fiddler
Meadow Lake Tribal Council

Mary Carlson
Lac La Ronge Indian Band

Jennifer Conley
Prince Albert Grand Council

Elder Advisory Council

Elder Vitaline Read

Elder Gertie Montgrand

Elder John Morin

Elder Howard Bighead

Elder Kate Hamilton

Elder Mike Daniels

The Role of Elders

Elders provide the Board of Chiefs and the NITHA Executive Council with grounding in First Nations values and approaches to working with each other to serve the Partnership's communities.

The NITHA Board of Chiefs will have one Elder from each Partner present at all meetings. The NITHA Executive Council will have one Elder at all meetings and this role will be alternated amongst the Partners.

Message from the Chair

Tansi.

As chair of the NITHA Board of Chiefs I am proud to present you with the 2010-11 Annual Report for the Northern Inter-Tribal Health Authority. Having served on the Board for three years and now serving in my first year as Board Chair, I continue to fully appreciate the importance of the work of the team at NITHA in supporting and serving the First Nation communities within our Partnership.

Since the formation of NITHA in 1998 the programs and services offered through the NITHA team has increased to respond to the health care needs of our community members. We continue to take a strategic approach with careful planning in deciding how best to use the resources available to NITHA for community well-being.

In 2010-11 the NITHA Board of Chiefs refocused our Vision to reflect our belief that individual health and well-being is a result of access to quality health services and an acceptance of the responsibility for each person to make good decisions for their personal health. Our Vision for the future is that:

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

Even with all of the best efforts of NITHA, we will not be able to move toward this vision unless the Partners and communities do not have adequate resources to provide the necessary health services on the front line. We are well aware that the current level of funding to the communities is not sustainable or adequate.

In June of 2010, the Board of Chiefs travelled to Ottawa to meet MP's and senior government officials to present our concerns and to press for resources that are necessary to sustain health services in NITHA territory. Advocating for sustainable funding will remain a high priority and focal point for the NITHA Board of Chiefs in 2011-12.

Tiniki

Chief Darrell McCallum

Peter Ballantyne Cree Nation

Message from the CEO

The 2010-11 operating year has seen a great deal of change in the foundation documents and organization structure of NITHA. Throughout the year a great deal of time and effort has focused on the establishment of a Governance Manual that includes the new NITHA Vision, Mission and Principles that will guide the supporting work carried out by the NITHA staff.

The new organization structure included in this annual report indicates the establishment of an Elder Council that will become an integral part of the decision making process at NITHA. The Elders of NITHA have always been a part of meetings and decision making on a regular basis. Now we have formalized the Elder Council as part of the NITHA organizational structure and to provide them with the opportunity to meet as an Elder Council to reflect on the operation, programs and services of NITHA. The Elders will continue to be the touchstone for our work and for the way we do our work.

As indicated from the Audited Financial Statements contained in this report, NITHA continues to be in a good financial position as a result of careful budgeting and accountability practices. Support services to our Partners will continue to be sustained only as a result of spending within our means and good accountability practices.

The organizational structure in this report highlights the formation of a Public Health Unit which is a broadening of the mandate of the former Community Health Status and Surveillance Unit. This signals a reinforced commitment by NITHA to 'public health' with a focus on the importance of prevention. This 'public health' focus has led to the recruitment of a newly established Infection Control Advisor and Health Promotion Advisor at NITHA.

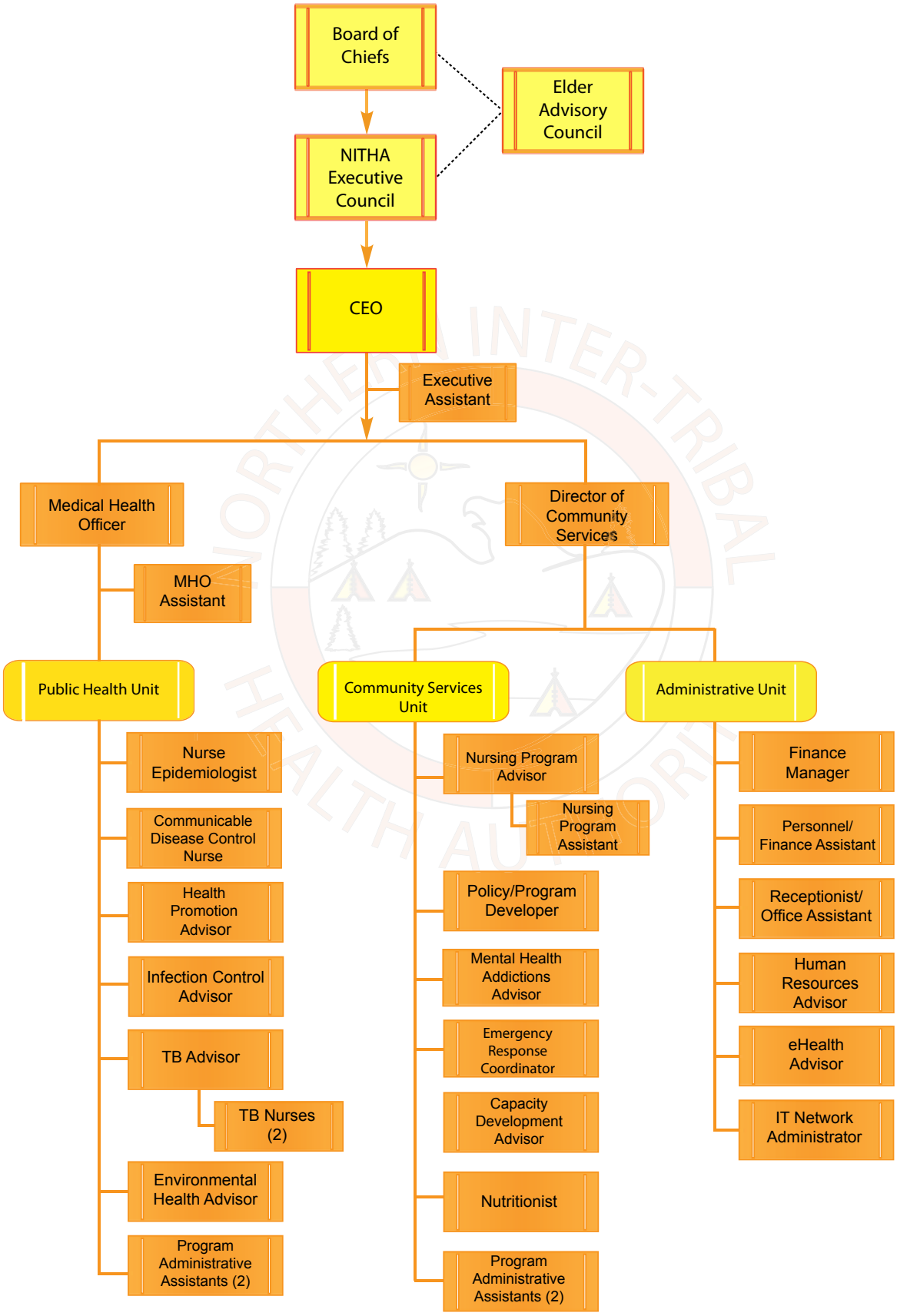
In the 2009-10 year we experienced worldwide pandemic of H1N1 which touched our communities. Although H1N1 is no longer seen as a devastating threat, we have other communicable diseases in our communities that are on the rise. The Public Health Unit will be focusing on this in order to develop strategies that encourage the NITHA communities to work together in the same way they did in prevention around the H1N1 Pandemic.

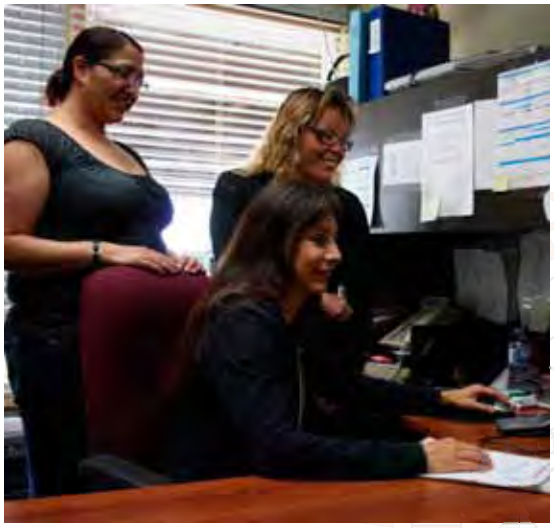
The organization structure also indicates a commitment to strengthen the Community Services Unit (previously Community Health Services Unit) with the establishment of positions for a Nutritionist, an Emergency Response Coordinator, a Nursing Program Advisor and a Director of Community Services. Recruiting for these positions will begin in 2011-12.

Dennis Moore

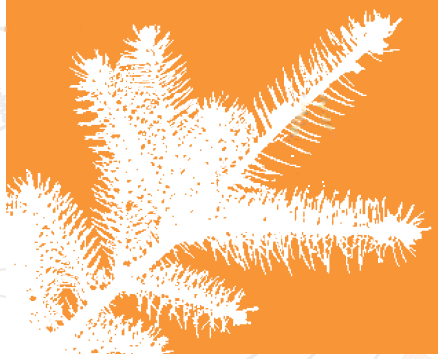
CEO

NITHA Organizational Chart





NITHA



NITHA
Public Health Unit

Program Overview

This year the Community Health Status and Surveillance Unit (CHSSU) took a notable step forward and moved to a Public Health Unit (PHU). The change is not only in name but also brought an increase in staffing to provide broader services to the Partnership. The name CHSSU implied the unit was simply data collection and did not reflect all the work that was being done in the area of interventions and education. From NITHA's inception in 1997, this unit has provided direct services and support to NITHA Partnership communities in the areas of all communicable disease requiring public health follow-up and immunization. The unit has expanded since then to provide environmental health services and emergency preparedness and now has added positions in the areas of health promotion and infection control. The unit has a broad goal of improving the health and wellbeing of the NITHA population through increased health promotion and primary prevention. Ideally, one would like to prevent disease or ill health from occurring rather than having to "fix" once the condition has developed.

This year was a year of outbreaks. The H1N1 outbreak ended and within a short period of time other outbreaks evolved. Syphilis, pertussis and TB were all diseases occurring in larger than normal numbers within some of the Partnership communities.

The PHU was able to recruit an MHO and the Communicable Disease Nurse returned to the unit resulting in a full complement of staff from October to the end of the fiscal year.

There was only one meeting this year due to staffing changes. This group reconvened in March and is back to regular meetings. Membership includes representation from all Partner organizations and independent band. The focus of this meeting was to gather information from the Partnership on priorities for the unit. The information from this meeting contributed to the work plans of the members of the PHU and to the overall direction of the unit.

Communicable Disease Control

One of the mandated roles of the PHU is to support the NITHA Partnership in Communicable Disease Control. Presently NITHA uses a system called iPHIS for electronic data collection. In the future the Ministry of Health will be replacing iPHIS with the public health system, Panorama.

Information is collected on all notifiable diseases and immunization rates. There are many limitations to the collection of this information. This information only reflects those who have sought testing or routine medical care, it depends on whether the health professional provides the testing and therefore represents only those cases and is not a picture of true incidence or prevalence (the number of new cases or existing cases). This is especially important for those diseases in which there may be no symptoms for a long time. HIV, hepatitis C, syphilis and other sexually transmitted infections may go undetected for years.

Nurse Epidemiologist


Shirley Woods

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

This position also provides immunization coordination for the Partnership. Ongoing education in the area of immunization is provided to nurses and others working in the area of immunization. Vaccine management is also provided as vaccines are ordered, shipped and monitored through this unit.

PHU distributes vaccine to all PHU communities and ensures cold chain protocols are followed. In addition PHU measures vaccine wastage and provides feedback and education to communities to reduce vaccine wastage.

Other special projects may also be coordinated by the Nurse Epidemiologist.

Innovation Funding

In February 2009 NITHA became aware of the opportunity to submit proposals for "Innovation Funds" for nursing stations. A proposal was submitted for an ongoing education program as well as personal data assistants or PDAs and a pharmacy scanning system. The latter two were approved and preliminary work was done to begin the process of implementing these 2 components in the nursing stations.

Personal Data Assistants

For both primary care and community/ public health nursing alternate methods of ongoing education are needed. The use of personal data assistants has proven to be a successful means of providing and supporting education and nursing practice. In many emergency rooms in North America PDAs are used by health care practitioners providing quick and easy access to many critical resources.

There are many medical/nursing applications available for the PDAs. There are several pharmacological calculators available as well.

Podcasting is another learning style that PDAs can be used for. This information can then be retained for later reference.

PDAs can also be used for client teaching, providing a color visual aid to help in explaining procedures. Technology can be daunting for some nurses and training and support services are being developed. This continues to be a challenge as there are no dedicated staff to the program and support is not provided as quickly as one would hope.

This project has been well received by nurses in the field. Baseline surveys have been completed by all nurses receiving the ipods.

Pharmacy Electronic Management System

Presently the nurses spend many hours in the pharmacy with a considerable amount of time on inventory management. This electronic system will provide consistent stock inventory at all times and eliminate the existing time consuming manual systems presently used. This system has not been deployed at this time and requires more discussions for a successful implementation plan.

IMMUNIZATION

Immunization continues to be the best protective intervention for the prevention of vaccine-preventable diseases. Due to the increasing numbers of pertussis, the pertussis program in Saskatchewan was expanded. New mothers and household members living in homes with newborns were added to those eligible for pertussis vaccine. Influenza became available to all residents of Saskatchewan requesting it. Due to a shortage of hepatitis B vaccine, for this year only, school children had to receive a 3 dose series rather than the 2 dose nurses have become accustomed to.

There was a product change from the Prevnar 7 to Prevnar 13 which provided 5 additional serotypes to the pneumococcal vaccine that infants receive.

Statistics on all programs are collected at different times of the year depending on logistics. Preschool statistics are collected on a calendar year and this report reflects 2010. Influenza statistics are collected on a fiscal year or flu season. The other statistics are collected on a school year and will reflect the 2009-10 school year. Presently data is

collected manually from all communities. The AHA First Nation communities are using the Saskatchewan Immunization Management System (SIMS) and are able to run electronic reports.

Preschool

The preschool program is the one immunization program that people are most familiar with. Infants begin immunization either shortly after birth, with a Bacille Calmette-Guérin (BCG) for the prevention of certain types of tuberculosis, or at two months of age with Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae B and Pneumococcal (13 serotypes). It is important that children start their immunizations as soon as possible and to stay on schedule as this provides them with the earliest and best protection against serious disease. These are provided in 2 needles at 2, 4, and 6 months.

At one year of age 84% of children in the Partnership have had 3 needles. This is not optimal and efforts to increase these rates are needed. The rates of immunization for this age ranged from 42% to 100% in some communities.

Once a child reaches one year of age they receive 4 injections. These are for Measles, Mumps, German Measles (Rubella) (MMR), Meningococcal, Hepatitis A, and Varicella (chicken pox). At 18 months of age children are eligible to receive a boost of the same immunizations they received in infancy as well as an additional MMR and Hepatitis A.

Immunization rates for the NITHA Partnership ranged from 74-90% for the various vaccinations. Rates for individual communities ranged from 29% to 100%. Again, work needs to be done in those communities with low immunization rates to bring them up to protective levels.

Saskatchewan experienced a higher than usual number of pertussis (whooping cough) cases as did NITHA and unfortunately many were in infants who do experience more serious disease. NITHA had 63 cases of pertussis in 2010. Pertussis is an acute, highly communicable infection of the respiratory tract caused by Bordetella pertussis. The infection usually starts like a cold with a cough that gradually becomes worse, and can last for one to two months or longer. The cough can be characterized by an inspiratory "whoop", apnea, or vomiting.

Although individuals of any age can be infected, pertussis is most severe in young infants. One to three deaths occur each year in Canada, usually in children too young to have begun their primary immunization series or in those who have only been partially immunized. For this reason it is extremely important to start immunizations in children at two months of age. In 2010, 58.6% of infants received immunization during their 2nd month of life. By 7 months, less than half of children (45.5%) had received the required 3 doses.

A "cocooning" program was implemented April 1, 2010 for caregivers of newborn babies. Newborns cannot be immunized and to provide protection to the infants parents and others caring for the newborn were offered pertussis vaccine. If the caregiver is protected then the infant cannot get pertussis.

School Immunization

Immunization against Human Papillomavirus (HPV) was launched in September 2008. The program is for grade 6 girls. Cervical cancer commonly develops after the fourth decade of life and therefore will take at least 20-30 years before one is able to tell whether this vaccine has an impact on decreasing

cervical cancer rates. There are several short-term indicators that can be measured to evaluate the program effectiveness. One of them is analysis of coverage rates with the HPV vaccine. For the grade 6 population there were 273 students eligible with 235 (86%) receiving their first dose. This is a 3 dose series and for this same cohort only 138 (51%) received a third dose.

Grade 6 students also receive meningococcal, varicella (chicken pox if they have not previously had the disease), and hepatitis B vaccine. This year 75% of eligible students received their meningococcal immunization while last year 88% of students received their meningococcal vaccine and the year before year 86.8% received vaccine for prevention of Meningococcal C disease. There were 280 students eligible for varicella vaccine with 126 (45%) receiving it. This is down from last year. Hepatitis B vaccine is a two dose series and 309 (63%) received two doses.

Grade 8 students receive Tdap (Tetanus, Diptheria and acellular pertussis) and for those students not previously having 2 doses of MMR this was recommended as well. There were 414 eligible students with 327 (79%) receiving the Tdap immunization. This is important as Saskatchewan is seeing an increase in pertussis in the most vulnerable populations, those under the age of one. Prior to grade eight the last pertussis immunization is given at 4 years of age. Protection starts to decrease after this time period causing the adolescents to not be protected, which could lead to increased disease in the community, placing infants too young to be immunized at great risk.

Adult Immunization

Immunization is required throughout the lifespan. For most adult immunizations statistics are not collected. Statistics are kept for the Pneumococcal and Influenza vaccines. These are vaccines which are publicly funded.

Pneumococcal 23 vaccine is provided once to individuals with certain medical conditions. There were 169 doses of this vaccine provided in 2009-2010.

In the 2010/11 influenza season vaccine was publicly funded for all residents of Saskatchewan who requested it. Although everyone can benefit from this vaccine it is important that those most at risk continue to receive the vaccine. These are:

- People 65 years of age or older.
- Children 6 to 23 months of age.
- Pregnant women.
- Adults and children with chronic heart or lung disorders.
- Adults and children with chronic conditions (diabetes and other metabolic diseases, cancer, immunodeficiency, renal disease, immunosuppression, anemia and hemoglobinopathy).
- People of any age who are residents of nursing homes and/or special care homes.

- Adults and children with conditions that compromise respiratory function or the management of respiratory secretions are associated with an increased risk of aspiration (e.g.: muscular dystrophy, cerebral palsy, multiple sclerosis, and acquired brain disorders).
- Children and youth from 24 months to 18 years of age who have been treated for a long period of time on acetylsalicylic acid (ASA).
- Individuals directly involved in the destruction of poultry infected with avian influenza (bird flu).
- People working with poultry and/or swine.
- Health care workers.
- Health science students working in hospital, community or other health care facility as part of a practicum experience, and have direct contact with patients.
- Individuals volunteering in health care facilities.

Due to the expanded eligibility for the influenza vaccine, statistics were only collected on those over and under the age of 65. There were 5452 doses provided to individuals under the age of 65 and 636 doses given to those over age 65. The latter number is a little low and increased awareness of the need for this vaccine in high risk groups needs to occur.

Sale Vaccines

NITHA continues to work with the Saskatchewan Association of Health Organizations to purchase those vaccines not publicly funded. Influenza became available to all residents of Saskatchewan who wanted it, reducing the amount of sale vaccine needed. Presently vaccine is purchased for some occupational groups and travellers. These vaccines must be paid for by the individual or organization.

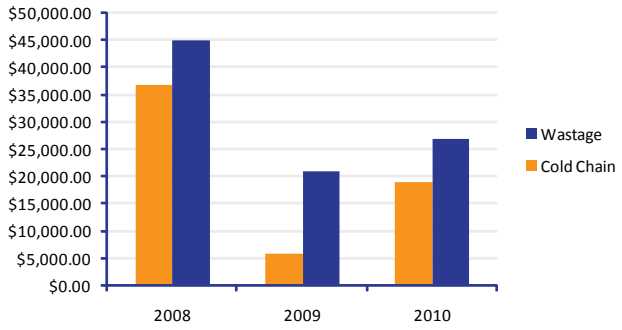
Inoculist Exams

This year 83 inoculist exams were received and processed. Immunization is a special nursing procedure as the procedures involved in immunization may not be taught in the nursing education program. NITHA provides the education and theory while the Partners provide the experience needed to perform the procedures. Safety of the client demands that a Registered Nurse perform these procedures only after successfully completing an education program of theory and practise. After the initial program, registered nurses must write an annual exam to maintain competency. NITHA also provides support to the nurses in the field when they are uncertain about vaccine scheduling or other immunization questions. Ongoing education is provided regarding new or changing immunization programs.

Cold Chain

NITHA continues to work towards minimizing costs related to cold chain breaks (periods of time in which the vaccine is not stored between 2 and 8 degrees Celsius). Each year NITHA coordinates the servicing of all biological refrigerators, purchases new refrigerators as needed and provides battery back-up for those communities without generators as well as repairs of existing equipment. Human errors continue to be a factor in many of the cold chain breaks. In some cases generators are not working or hooked up or temperature logs have not been kept. Additional coolers, warm mark, cold mark monitors and thermometers have been purchased. This is largely due to improper inventory management and vaccine outdating. The proposed Panorama system has an inventory system and this may facilitate better management within the communities. Last year there was $19,342.57 of vaccine wasted and $27,106.29 of cold chain loss within the NITHA communities. The following chart shows the losses in the last 3 years.

NITHA VACCINE REPORT 2010-11



Communicable Disease Control Nurse


Leslie Brooks

The Communicable Disease Control Nurse offers support to the NITHA Partnership by timely reporting of Communicable Diseases in Northern First Nations. The reporting and notification of these diseases is mandated by provincial legislation and is a requirement of the Transfer Agreement. The Public Health Act of 1994 as well as the Communicable Disease Control Regulations that accompany the Act govern reporting and follow up of these Communicable Diseases. Laboratory results are received from the Provincial Lab and entered in iPHIS, an electronic provincial data base. This process allows for reports to be produced electronically and timely.

Direct support to frontline health workers is an essential component of the CDC nurses responsibilities. In the day to day operations of busy health facilities, the importance of timely communicable disease control is sometimes overshadowed by other activities. Our role is to respond to inquiries from field staff whenever they are requested, offer possible interventions when concerns are identified and be the resource for those health workers responsible for the communicable disease program in their respective communities.

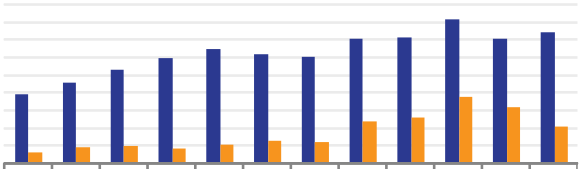
Sexually Transmitted Infections

This year saw a small increase in chlamydia and a decrease in the numbers of gonorrhoea. The overall pattern for the last few years has been fairly constant at a very high rate. Rates continue to be well above provincial and national averages.

Rates are increasing nationally and the reason for this is unknown. This increase may be due to the safer sex message no longer impacting people; the newer HIV drugs that prolong the development of AIDS; the lack of consistent sexual health education; not understanding the long-term consequences of sexually transmitted diseases or the increased use of legal and illicit drugs such as ecstasy, and Viagra. Considerable amount of time is spent tracking and treating cases and contacts. All of the reportable diseases can result in long term consequences, such as infertility. A comprehensive multi professional sexual health initiative is needed to see positive changes in the area of sexually transmitted infections. NITHA hosted a workshop for Partnership communities. Community members and health staff participated in a knowledge sharing session with discussions around activities that could be used in a sexual health strategy.

These high rates of infection also increase the possibility of HIV infection occurring if exposed to the virus. HIV has become more prevalent in the NITHA Partnership and throughout the province. Since 2004, there have been 38 cases of HIV reported in NITHA. This does not include individuals who may have been tested while residing in other jurisdictions. The Saskatchewan rate of HIV is twice the national average with 70% of all new cases in 2009 being of Aboriginal ancestry. In the last two years there have been 20 newly diagnosed case of HIV. NITHA continues to work with the Ministry of Health to develop an HIV strategy and to implement this strategy with the Partnership.

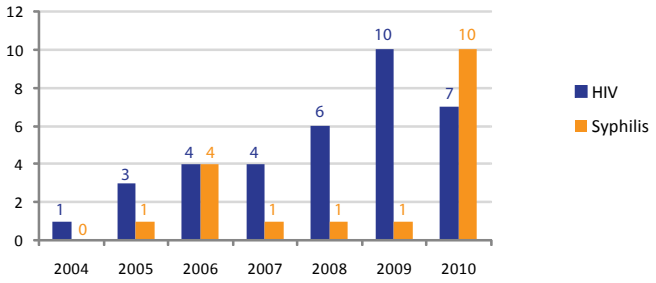
TRENDS OF REPORTED STI'S IN NITHA COMMUNITIES
1998-2010



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Chlamydia	388	453	526	594	645	617	602	703	708	814	703	737
Gonorrhea	55	86	94	79	102	125	114	237	253	376	318	206

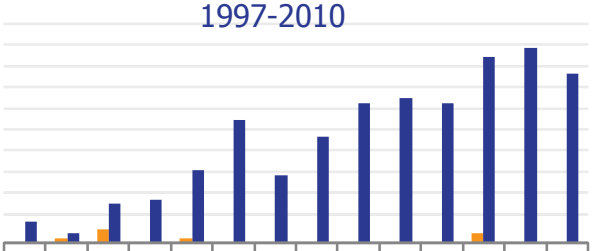
Syphilis is a disease that was rarely seen until the last 5 years. This year there was an outbreak in Saskatchewan which saw increasing numbers in the NITHA Partnership. Follow-up for this disease is long-term to ensure the treatment has worked. This disease can have many effects and may be fatal. If untreated in a pregnant women this disease can also cause severe problems in the developing infant.

2004 - 2011 HIV & Syphilis Cases



The pattern of Hepatitis C continues as it has for the last 3 years. Most cases of Hepatitis C are intravenous drug users or individuals who have used intravenous drugs even once in the past. This disease is serious enough on its own but this is the same risk factor for HIV and if the at risk behavior continues there remains the risk of contracting HIV as well. NITHA Partnership communities saw another 10 cases of HIV this year. This is the same number as last year.

TRENDS OF HEP B & HEP C CASES IN NITHA COMMUNITIES
1997-2010

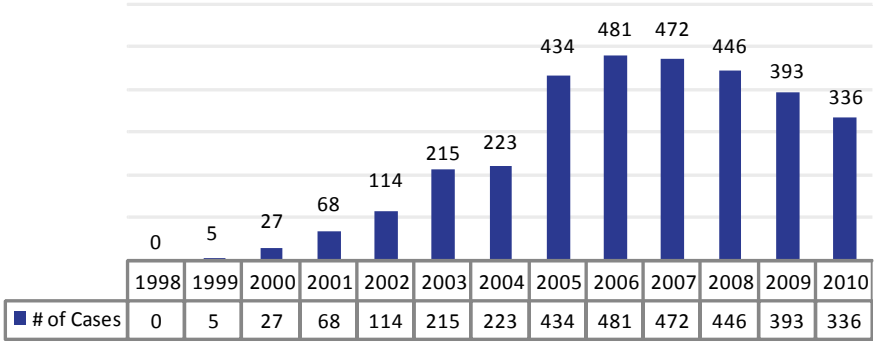


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Hep B	0	1	3	0	1	0	0	0	0	0	0	2	0	0
Hep C	5	2	9	10	17	29	16	25	33	34	33	44	46	40

MRSA

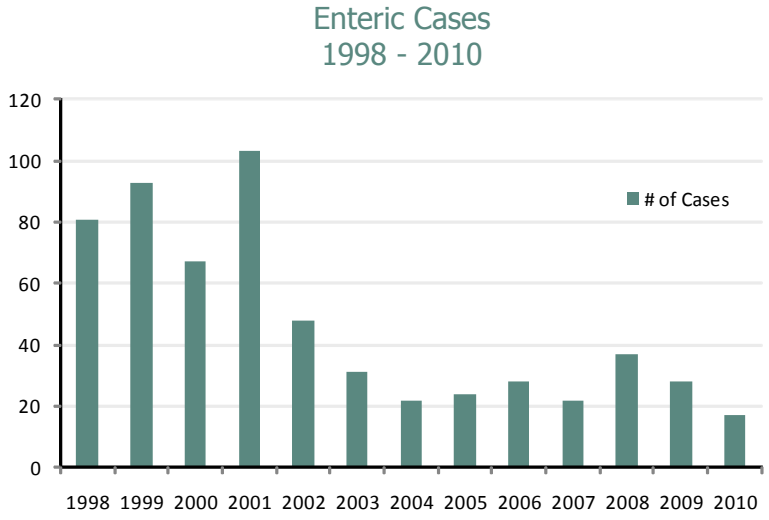
MRSA appears to be on the decrease, but this may be a reflection of testing. Each year there are a number of cases of individuals who test positive, but because they have a previously positive lab report we do not classify as a new case. There is no way to determine whether it is the same infection or a new one so all repeat tests are considered to be ongoing. Some communities do not do much testing as there is a high probability of the test being positive for MRSA and they are treated as such. New cases are followed with health teaching and surveillance information. Overuse and misuse of antibiotics contribute to the spread of MRSA.

TRENDS OF MRSA CASES IN NITHA COMMUNITIES 1998-2010



ENTERIC DISEASES

The trend identified in previous years continued in 2010, with enteric diseases being the least notifiable communicable disease reported NITHA communities. Sixteen enteric cases were reported for 2010 compared with 81 cases in 1998.



Of the 16 enteric diseases reported, Salmonellosis was the predominant communicable disease identified in the NITHA communities. These cases were sporadic with regards to age, location and time the illness occurred.

Enteric Communicable Disease	Number of Reported Cases
Salmonellosis	7
Giardiasis	3
Aeromonas	3
Campylobacteriosis	3
TOTAL	16

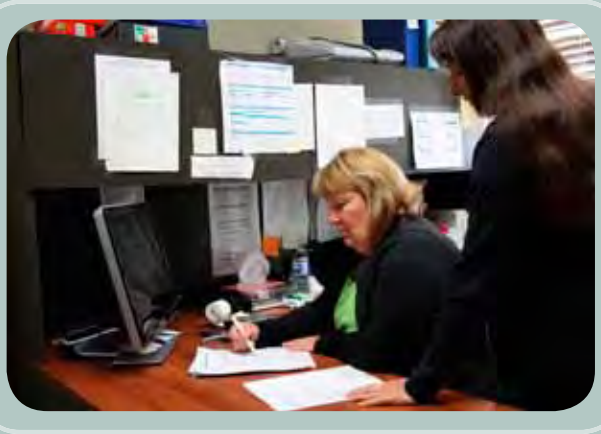
ANIMAL BITES

Rabies is a viral disease that attacks the central nervous system of warm-blooded animals, including humans. Rabies is transmitted through saliva, primarily through bite wounds. It can also be spread when infected saliva comes into contact with a scratch, open wound or the mucous membranes of the mouth, nasal cavity or eyes. The incubation period (from initial exposure to clinical symptoms) may range from two weeks to many months. It can depend on a number of factors, including the strain of rabies and the location of the bite. However, it is important to note that an animal can transmit the disease a few days before showing any clinical signs. Once symptoms appear, rabies is almost always fatal in animals and people.

Human rabies deaths are rare in North America. Prompt treatment following exposure to a bite from an animal suspected of having rabies can prevent human illness.

In Canada the animals that most often transmit rabies are foxes, skunks, bats, and raccoons. Saskatchewan had 21 positive animal rabies cases in 2010: 17 in skunks, 3 in dogs and 1 in a bat.

In our NITHA Partnership 17 bite incidents were reported in 2010 which required follow-up. Of these, 10 were unprovoked animal bites; 4 of which were to the face of the patient.



TB Nurse Advisor


Sheila Hourigan

The NITHA TB program is now well into its second decade of existence and for the first time facing the prospect of significant change in the overall TB Program. Nationally there has been an acceleration of the development of a renewed Canadian TB Strategy and a First Nation and Inuit Health Branch TB Strategy. Drafts of these documents were released to stakeholders in January 2011 and it is expected they will be finalized in the coming fiscal year. These documents recommend the focusing of additional resources on high incidence communities in order to implement aggressive strategies designed to reduce the incidence and transmission of Tuberculosis over both the short and longer term.

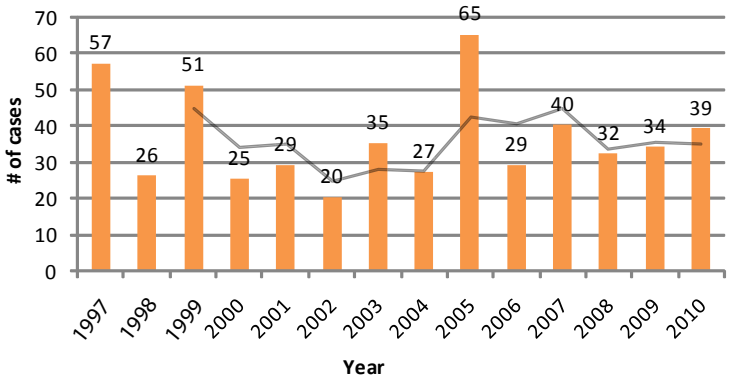
In addition, the Saskatchewan Ministry of Health under the auspices of the Saskatchewan Population Health Council (SPHC) have identified Tuberculosis as a key target in their overall health strategy. NITHA has been invited to be an active participant in the development of a provincial TB strategy through various working and task groups of the SPHC.

In the midst of the coming changes, NITHA has continued to support the Partnership communities in their efforts to control tuberculosis. The TB nurses made a total of 35 visits to 19 communities. In addition, a contracted nurse was used on 2 occasions to tackle a large amount of contact tracing in 1 community over the summer. Another community that began experiencing an outbreak at the end of last year was supported through outbreak resources. Two weeks of nursing per month over several months was provided.

Tuberculosis in NITHA First Nations:

In 2010, there were 39 cases of active Tuberculosis in NITHA communities. This compares to 34 cases in 2009. As in previous years, high incidence communities were the greatest contributor to case numbers with 27 out of 39 cases (70%) in four communities.

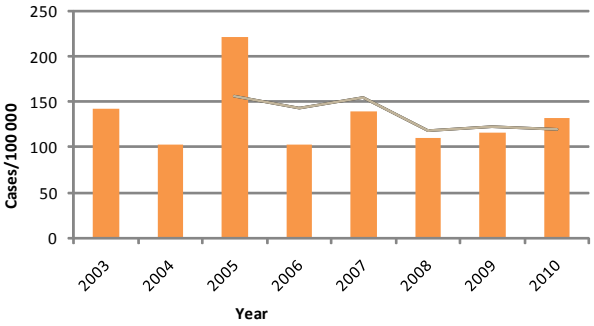
Graph 1 - NITHA TB Cases



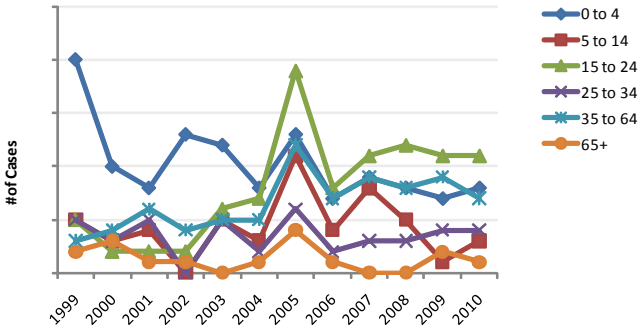
As with case numbers, case rates (which measure the incidence of disease by population), show no evidence of trending downward, as was evident in the late nineties and early 2000's.

*Based on CWIS population figures

Graph 2: NITHA TB Case Rates 1997 - 2010 (Cases/100 000)



Graph 3: Age Distribution NITHA TB Cases 1999 - 2010



The age distribution of 2010 Active Tuberculosis cases is highlighted in Table 1 below.

Table 1 - Age Breakdown of 2010 Active Cases of Tuberculosis

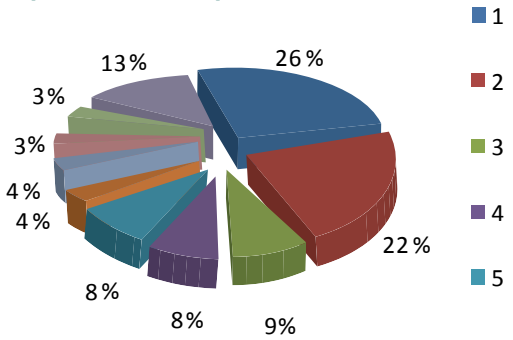
Age	
0-4 yrs	8
5-14 yrs	5
15-24 yrs	11
25-34 yrs	6
35-64 yrs	7
65+ yrs	2
TOTAL	39

The number of cases in the 15-24 year old age group continues to be higher than the other age groups. This contributes significantly to the transmission of TB as individuals of this age are more likely to be infectious at the time of diagnosis. More individuals in this age group who are contacts to tuberculosis are being targeted for the treatment of Latent TB infection (LTBI). This has the potential to decrease disease over time.

In 2010, the sex distribution of active TB Cases was 17 males and 22 females.

Graph 4 below shows that since 2000, 87% of all TB Cases were contained in 9 communities with 2 communities contributing close to half of all NITHA TB cases. Focusing additional resources in these communities has the potential to reduce the burden of disease significantly.

Graph 4: Distribution NITHA TB Cases by community 2000 - 2010



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

Table 2

Type of Disease	Infectious Pulmonary	Non-infectious Pulmonary	Extra Pulmonary	Disseminated
Adult 15 & over	12	15	0	1*
Child 0-14	1	11	0	0

* included in the infectious category as well

There were 13 infectious cases last year which is 33% of all cases. This is a slightly lower percentage than previous years, but is still a long way from what it needs to be if we are to slow the rate of spread of TB in the communities. Early detection is the key to reducing the incidence of infectious disease and though NITHA has implemented a number of strategies to increase early detection, it is clear that more efforts are needed in this area. Perhaps one of the biggest gaps in addressing this is community awareness. This has been identified as important activity for the additional resources that may be focused on the high incidence communities.

A case of MDR TB continues to receive treatment under the care of TB Control.

Professional and Community Education and Support

Community Health Nursing

The NITHA TB nurses oriented 15 nurses to the TB program this year. As well 24 nurses attending the Orientation and Skills training program participated in a pre-sentation on TB diagnosis and treatment. eight nurses attending an orientation to homecare received a presentation on "THINKING TB" in homecare nursing practice. Orientation of community nurses to the program is an important means of supporting the NITHA Partnership communities. In addition to the early detection of disease, particular areas which need to be continually addressed and reinforced, include case management and support to the TB program worker.

FNIH did not support a province wide conference for nurses this year nor were they able to support our request to put on a workshop for our own nurses. A provincial TB day for primary care health providers is being planned for the next fiscal year through FNIH and TB Control. This one day workshop is aimed towards both physicians and nurses working in primary care and other settings.

Telephone consultation continues to be an important means of supporting nurses as they struggle with the day to day challenges presented by the TB program and its clients. Community nurses are frequently assisted by the NITHA TB nurses to undertake various program activities such as screening, contact tracing and education. Contact tracing has been largely the responsibility of the CHN's with support from the NITHA nurses when available. As contact tracing is one of the important means of finding and thereby controlling TB and close to half of cases last year were in contacts (average is 30%) we are looking at shifting our focus to this more important activity and away from school screening. Though the CHN's have always done their best, competing priorities, staff shortages and frequent turnover has made contact tracing challenging. The NITHA TB nurses visited communities to assist with contact tracing on 7 occasions this year. As well, NITHA supported the contact tracing required by a community who had 4 contact traces requested in a short time span and ongoing tracing in the major outbreak community.

TB Program Workers:

Seventeen new TB program workers were trained in NITHA Communities, and 4 received updates. A new service delivery model for TB program workers has been proposed to FNIH. Discussions are ongoing but there has been agreement in principle that high incidence communities need to have TB workers funded in stable part or full time position over a longer term. We are hopeful that once the model is accepted and resourced we will have addressed some of the issues that have long plagued this important part of the program. In addition, having workers performing an expanded scope of duties will be instrumental to the implementation of high incidence community strategy including community awareness.

Training TB workers, which focuses on the Direct Observed Therapy program is the most important way NITHA supports TB workers in the communities. The TB worker workshop was held in early December with 24 workers from NITHA communities and 3 from off reserve communities participating.

Case management issues were supported on a number of occasions both over the telephone and in person. A significant amount of time is spent ensuring that funding is requested to cover workers wages and that they receive timely remuneration for their services. This is instrumental in keeping the program running smoothly and efficiently.

Contact Tracing:

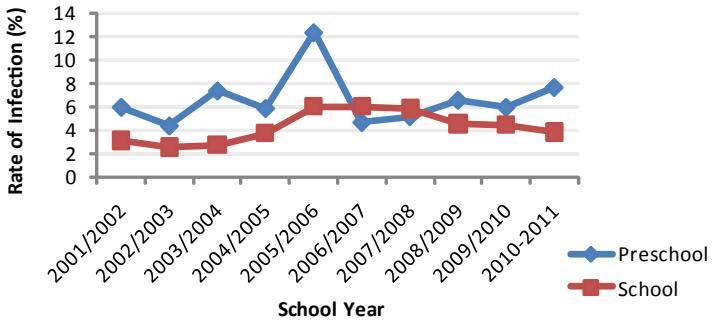
There were 18 contact traces required in NITHA Partner communities in 2010, 13 infectious traces looking for spread and 5 primary traces looking for a source. The NITHA TB program nurses provided assistance at the community level for contact tracing on 7 occasions. On several other occasions a contracted nurse was hired to assist in communities that could not be adequately supported by the NITHA TB Nurses because of their already heavy workload.

Childhood Screening Program:

Twenty four on reserve schools in Partner communities conducted annual tuberculin skin testing of students in kindergarten, grade 2, 4 and 6. 1668 students were tested in all and 64 children had significant tests, for a rate of infection of 3.8%.

The NITHA TB nurses assisted with the school screening in 19 communities. They also assisted with preschool screening on 11 occasions. 380 preschool skin tests were reported to NITHA this year with 29 of them being positive. The prevalence of infection in this age group was 7.6%. Graph 3 below illustrates rates of infection found in groups screened since 2001/2002.

Graph 5: NITHA Preschool/School Infection Rates 2001/2002 - 2010/2011



* preschool TST's reported to NITHA

It has recently been recognized that BCG vaccination may result in positive tuberculin skin tests especially if performed before a certain age and as a result of repeated skin testing. A review of the current childhood screening program will be taking place in the coming year and may result in significant changes to the recommended schedule. Preschool screening coverage levels remained steady at 70%.

All children found to have significant skin tests in the preschool and school tuberculin skin testing programs were offered treatment of Latent TB Infection. Compliance and completion of treatment rates are reported by TB Control in their annual report and remain high in this age group.

Surveillance:

Collecting and analyzing TB data to identify disease and infection trends as well as monitoring program activities are important to ongoing tuberculosis program planning and evaluation. As in previous years surveillance data was used to compile information for outbreak analysis and management. As well, case and contact tracing information was used to examine contact tracing performance, including timelines for completion.

BCG Vaccination:

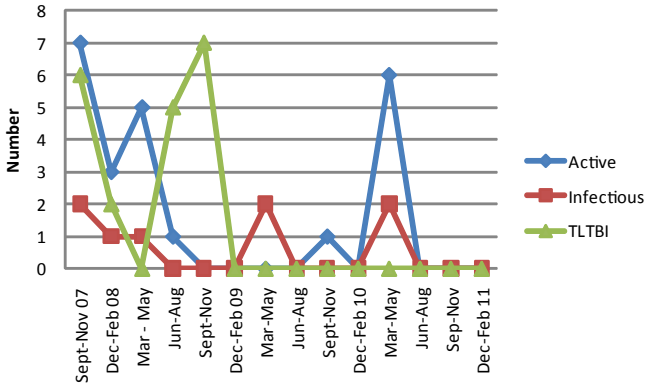
BCG will be discontinued in all Saskatchewan communities effective September 2011. The SPHC TB Working Group was instrumental in moving this decision, which has been a long time coming forward. Communications about this change and the program of enhanced screening and stepped up contact tracing which will be implemented as protective measure for vulnerable children in place of BCG were held with the NITHA Partner Health Directors, the nursing managers and the CHN's.

Outbreak/ High Incidence Community Management

Community A:

An ongoing outbreak in a community that was reported on last year as tackling 4 contact traces at the beginning of this reporting has ceased. No further cases have been identified since the contact tracing was completed in June.

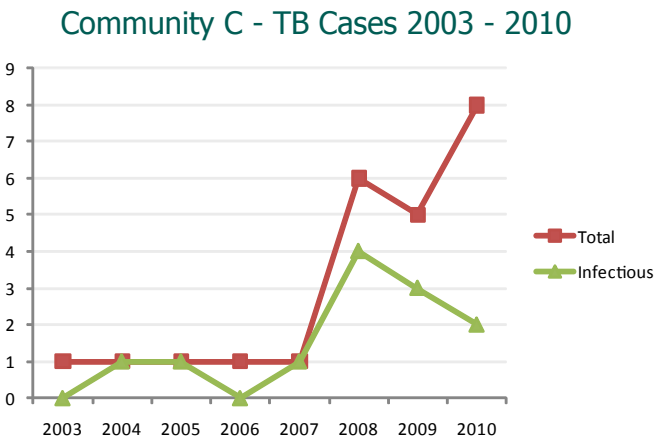
Community A - TB Cases and TLTBI by Quarter



Community B:

There were 9 cases in this community in 2010 including 3 infectious ones. This community continues to experience the highest case numbers of all NITHA communities and though they have an exceptional CHN who is very experienced in managing TB, more needs to be done to address the high incidence. This community, more than any other, stands to benefit the most from the National strategy's high incidence community recommendations.

Community C:



The Outbreak management plan that was developed with this community at the end of last year was implemented over the course of this year. Since the initial proposal was submitted, there were 5 additional cases confirmed for 2010 for a total of 8 cases. 4 cases were in contacts of previously identified smear positive cases, but one case, diagnosed in September, was not a known contact so source tracing had to be done. None of the new cases were themselves smear positive. In the first quarter of 2011 there have been no new cases. A number of adults who were contacts have been and continue to be treated for Latent TB Infection.

A number of educational initiatives were planned and implemented in the community, including the development of a community specific pamphlet, poster campaigns, poster contest and a radio spot that was translated into Dene. The radio spot was run 3 times daily for several months. It was evident by the number of clients presenting themselves at the Health Centre for testing and /or more information, that these community awareness initiatives have had the desired effect.

In January an additional initiative was planned and implemented in collaboration with the Keewatin Yathe Regional Health Authority. It was identified that a number of cases came from a population with addiction issues who frequent an area on the outskirts of the town. The health staff from both jurisdictions implemented an outreach project where they conducted symptom inquires, provided education and collected sputum samples on those coughing. 48 individuals participated despite freezing cold temperatures. All were provided with hot chocolate and cookies as well as being offered a warm pair of socks, gloves or a neck warmer.

Over the course of the project more than 200 people were in contact with the health staff for TB related activities. Another offshoot of the outbreak has been the establishment of a cross-border communication group with a neighbouring province.

Community D

One additional case associated with this outbreak was identified in June 2010. There have been none since.

Conclusion:

While we are hopeful that the renewed concern about the rate of tuberculosis in Canada's First Nation population is propelling a dramatic shift in TB programming, the needed additional resources to implement the strategy have not been secured. The Saskatchewan Ministry of Health's commitment to addressing Tuberculosis in Saskatchewan including Saskatchewan First Nations and the spirit of Partnership they are bringing to the table, adds to our optimism that significant change is around the corner.

Environmental Health

The Environmental Health Program in the NITHA Partnership is a community-based program delivered by Environmental Health Officers (EHO's) working for Meadow Lake Tribal Council, Peter Ballantyne Cree Nation, Lac La Ronge Indian Band and Prince Albert Grand Council. EHO's provide public health inspections/investigations, monitoring, advocacy, expertise and culturally appropriate educational materials to support environmental health services on First Nations Communities. They work closely with community members to identify, prevent and provide recommendations to correct environmental problems which may affect the health of community members.

Chiefs and Councils are responsible for addressing the recommendations provided.

The following are activities that may be undertaken through the Environmental Health Program, as identified based on the needs of the communities:

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

The EHA provides support and assistance through the following activities:

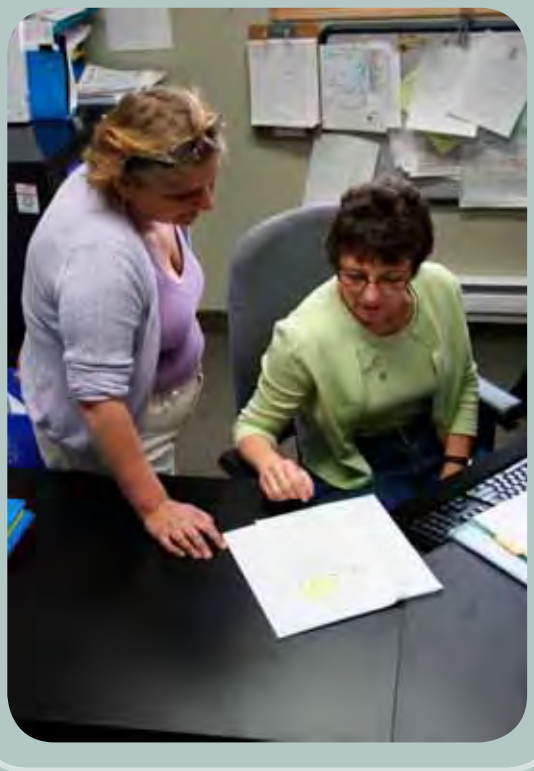
- Providing technical advice to EHO's on request;
- Assisting in the development of environmental health guidelines/standards/by-laws;
- Assisting in the accessing or development of educational/training material;
- Facilitating the networking amongst EHO's - e.g. EHO meetings, training sessions, joint projects, etc;
- Providing information to EHO of technical developments, training opportunities, and developing environmental health concerns;
- Assisting the EHO's in the development of community environmental needs assessments and action plans;
- Assisting in the development and maintenance of networking with Federal, Provincial, and Municipal agencies;
- Working with EHO's in the establishment of goals, objectives and policies for NITHA communities upon request;
- Assist in the development, implementation, and evaluation of training programs for EHO's as required.

Environmental Health Advisor


Brenda Zeigler

This position also provides communicable disease support for community nurses and EHO's for notifiable food, waterborne and zoonotic diseases. This support is essential to ensure that timely reporting and follow-up is conducted as mandated by provincial legislation.

As an important part of public health is to promote and advocate for healthy lifestyles, the EHA assists the EHO's by researching best practices on environmental health issues and preparing or providing promotional and educational material.



The EHA may also provided coverage within the Partnership when EHO's are away or in emergency situations.

The Environmental Health Advisor (EHA) is a member of NITHA's Public Health Unit (PHU). The EHA provides internal and external support to the Environmental Health Program to ensure that our Partner communities are able to respond to environmental issues and protect and promote health in the First Nations people.

The Environmental Health Advisor position within the Public Health Unit (PHU) provides support for the Environmental Health Officers in the development and delivery of Environmental Health Programs within the communities. The EHA participates in a number of meetings, both external and internal. These meetings provide the opportunity for NITHA to identify and discuss issues, provide input in the development of guidelines and/or policies, ascertain the need for EHO training sessions and professional development and ensure effective communication and coordination with all agencies, Partners and staff.

The PHU continues to raise public awareness on West Nile Virus and to motivate communities to implement

preventive activities. NITHA and it's Partner communities were once again invited to participate in the 2010-2011 West Nile Virus Disease Reduction Strategy for Saskatchewan. Funding was available for activities such as Awareness Campaigns, Mosquito Breeding Site Reduction or Training of Staff for Licensing as Pest Control Applicators. Nine communities applied for funding to cover activities initiated to prevent and control West Nile Virus.

On February 25, 2010, NITHA hosted a conference in Prince Albert on HIV, Hepatitis C and Sexual Health Strategies for Communities. During the Group Work Sessions one of the common issues identified was improper disposal of needles in communities. As a result a supply of sharps containers and wall mount brackets were purchased and distributed in April 2010 to all communities to be mounted in suitable public locations (eg: health clinics, band officer, community halls) to make it easier for community members to safely dispose of needles found in the community or used in the home for medical reasons. Informational posters and pamphlets were developed and provided to communities.

The Assembly of First Nations has provided an informal update on the First Nations Biomonitoring Initiative, mentioned in last years NITHA Annual Report. This was a health survey to establish baseline information on human exposure to environmental contaminants for First Nations' communities across Canada (south of 60). This Initiative is a Partnership between HC (Environmental Health Research Division - FNIHB) and the AFN, with data to be owned by the First Nations' communities and the AFN serving as the custodians of the data. A pilot project has just been completed in Manitoba and a full-scale survey is being developed for next fiscal year.

The pilot projects took place in two Manitoba communities. The intent is to continue the next phase in the summer of 2011 in selected First Nations communities across Canada. The Assembly of First Nations is in the process of updating their web site and intend to post information on this initiative soon.

In February of 2011 NITHA was invited by the Ministry of Health to participate on a newly formed Saskatchewan Biomonitoring Study Steering Committee. The Saskatchewan Ministry of Health was offered the opportunity to Partner with AB Health & Wellness in this biomonitoring study. The goal is to gather strategic, baseline data on the prevalence of contaminants in the population residing in areas of future oil-sands development in Northern Saskatchewan. The cost of lab analysis would be absorbed by Alberta. It is proposed to begin this study in the spring/summer of 2011.

Work continues with Partner EHO's, communities and NITHA program staff to develop educational materials on various emerging issues regarding communicable disease, food safety, housing and pest control. Such as the increase in bed bug infestations and their control. Providing information and education on environmental health issues plays an important role in assisting communities in identifying and preventing public health risks that could impact the health of community residents.

Infection Control

The newly established Infection Prevention and Control Program (IPC Program), which was formed in February 2011, is responsible for providing expert IPC support throughout NITHA, working with the Partnership and its Communities to construct and institute standard practices for infection surveillance, prevention, control and outbreak management, and improving knowledge through education and consultation.

The environment in which healthcare is provided, and specifically the communities where people live, are dynamic and continually changing. Healthcare associated infections and various additional illnesses transmitted within the community setting are on the rise. In addition to microbes growing resistant to antibiotics, causing illnesses such as MRSA, a number of re-emerging diseases such as whooping cough are continuing to appear. These are issues reinforcing the importance of effective infection prevention and control (IPC). Residents within the NITHA Partnership need assurance that they are able to receive quality health care.

Infection control is an important element of any workplace which primarily involves the cleaning of hands, wearing of protective clothing and investigation of possible infection problems. Other key infection control activities include sterilizing medical equipment and cleaning and disinfecting healthcare facilities. The purpose of the Infection Control Advisor is to facilitate those activities which aid in the prevention of infections in patients, staff, and visitors of NITHA healthcare facilities. The Advisor's role is to act as a consultant, educator, role model, researcher, and change agent. Particular responsibilities of the Infection Control Advisor include:

- Evaluating cleaning products and procedures
- Developing and reviewing policies and protocol
- Providing consult on infection risk assessment, prevention and control strategies
- Organizing and presenting educational efforts focused on reducing infection risks

Infection Control Advisor


Ewelina Dziak

PROGRAM OBJECTIVES 2011-2012

Through guidance and direction from the Partnership and NITHA Communities, the IPC program plans to complete the following goals within the next year:

1. INFECTION CONTROL PROGRAM DEVELOPMENT

1.1 Develop, implement, and sustain effective and comprehensive Infection Prevention & Control Manual.

1.2 Establish and facilitate a standing committee on Infection Prevention & Control.

2. ENVIRONMENTAL SURVEILLANCE

2.1 Undertake an assessment of the current housekeeping protocol/chemicals at all facilities

2.2 Deliver cleaning standards

2.3 Undertake an assessment of current medical reprocessing protocol

2.4 Develop and support protocol regarding medical reprocessing

3. AWARENESS AND EDUCATION

3.1 Support and deliver education programs with a specific focus on hand hygiene and infection control guidelines

3.2 Develop and implement a formal evaluation system for all IPC education sessions through a feedback questionnaire

4. ADVICE AND SUPPORT

4.1 Provide ongoing advice and support during outbreaks and to IPC standing committee

4.2 Increase visibility of IPC program to communities

Through the achievement of the objectives outlined above, it is expected that considerable progress will be made in the effort to reduce infection levels in the Partnership Communities as well as bring awareness of prevention and control best practices.

Health Promotion

The NITHA Health Promotion program is a new focus for NITHA. The Health Promotion Advisor (HPA) started in this new position at the start of January 2011. The goal of the HPA and the NITHA Health Promotion program is to provide comprehensive support to the Partnership in the area of Health Promotion.

Health Promotion Issues Identified By The Partners As Priorities For NITHA Communities Are:

- Chronic Diseases - The top five are diabetes, hypertension, heart disease, asthma and emphysema, and alcohol related deaths
- Addictions – drug, alcohol and tobacco
- Mental Health issues, including high rates of suicide
- Injuries, including many related to alcohol/drugs use, motor vehicle accidents and dog bites
- Infant mortality
- Obesity including childhood obesity
- Dental issues in children
- FASD
- HIV/STI's

Health Promotion Overview:

Health Promotion is about creating healthy communities and conditions where it is easy for people to make healthy choices. Health Promotion strategies emphasize "upstream" approaches that work to address root causes of poor health by changing the conditions and environments in which people live, work and play.

Health promotion takes into account that the overall health of communities is influenced by many factors beyond access to health services and individual behaviours. Some of these factors include: chronic stress, income, employment, early childhood development, food insecurity, social exclusion, housing and aboriginal status (the effects of colonization).

Three key health promotion strategies are strengthening community action, creating supportive environments and building healthy public policy.

Health Promotion strategies by their very nature are interrelated and complementary to each other and to other initiatives in other programs and disciplines. Effective health promotion strategies are multi-faceted, long term and often require multi-sectorial Partnerships and strategies.

Health Promotions Advisor


Linda Gilmour Kessler

The Health Promotion Advisor's Role Is To:

- Facilitate the development of health promotion strategies.
- Train and mentor Partners and communities in the health promotion skills required to deliver health promotion programs.
- Provide support, guidance, and advice regarding health promotion to the Partnership and communities.
- Develop Partnerships at the local, provincial and federal levels to ensure best practice and to effectively deliver health promotion programs.

The NITHA Health Promotion Advisor, in collaboration with the NITHA Partners will plan, develop, implement and evaluate health promotion strategies to improve the health those living in our NITHA communities.

Future Directions

In the next several years, the Health Promotion Advisor has established several objectives to work on in collaboration with the Partnership and Communities to enhance health promotion in the NITHA Partnership.

These Strategies Include:

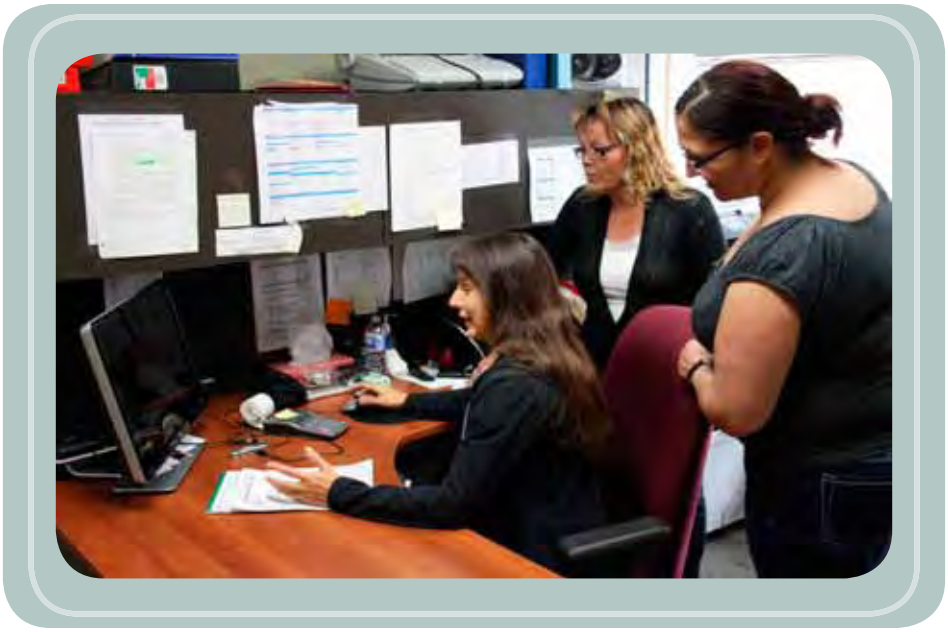
1. Developing a 5 year NITHA-wide Health Promotion strategy to address health promotion issues that are common to the NITHA second level Partners.
   - Initiating a Health Promotion Working Group (HPWG) with representation from NITHA Partners.
   - Providing leadership and support to HPWG to review current activities, statistics, identify common priorities, identify best strategies and develop a 5 year Health Promotion Strategy work plan.
   - Communicating the Health Promotion Strategy to NITHA leadership/NEC committee and obtain formal approval/ commitment from second level Partners.

- Identifying and collate health promotion indicators to inform and evaluate the health promotion strategy

2. Building capacity within second level Partners and NITHA to plan and implement health promotion strategies.
   - Developing a Health Promotion orientation strategy for existing and new staff.
   - Working with and providing guidance and support to NITHA second level Partners and NITHA staff for the Health Promotion component of their health/work plans.
   - Identifying, planning and organizing relevant health promotion training events and resource material development.
   - Facilitating the initiation of and/or support existing Employee Wellness strategies with NITHA staff and second level Partners

3. Developing internal and external Partnerships to develop and implement health promotion strategies.
   - Developing internal Partnerships with second level Partners and NITHA staff.
   - Developing external Partnerships with local, regional, provincial and national organizations and sectors.

There is much to look forward to in working alongside and in support of the NITHA Partners and communities. Many opportunities exist for Health Promotion strategies and initiatives to be enhanced and developed. The focus will be on improving the health outcomes for those living in the NITHA communities.



NITHA
Community Services Unit

The Community Services Unit which was previously known as the Community Health Support Unit provides program support and knowledge in the areas of nursing education / training, capacity development, mental health and addictions, nutrition and emergency preparedness.

The following staff are part of the Community Services Unit: Nursing Program Advisor, Nursing Program Assistant, Policy / Program Developer, Mental Health Addictions Advisor, Emergency Response Coordinator, Capacity Development Advisor, Nutritionist, Program Administrative Assistants (2).

This Unit has been restructured and NITHA is currently going through recruiting and hiring personnel.

This unit provides support to the Partnership through:

- Program development, policy and procedure development, capacity building, training and education;
- Partner & community consultations;
- Advocacy;
- Strengthening and broadening programs;
- Building linkages with various organizations;
- Participation in Partner and community working groups.

Capacity Development Program

PROGRAM OBJECTIVE

The NITHA Executive Council (NEC) three-year strategic priority of Capacity Development included the objectives:

1. Strengthen the capacity of First Nations to deliver quality health service at the community level.
2. strengthen the capacity of First Nations in leadership and management functions.

Suggested activities were:

1. Ensure assessment of and provide recommendations for current capacity development needs and activities across the Partnership.
2. Develop a plan for certifying community health workers on an ongoing basis.
3. Develop a plan for building leadership and management capacity where required across the Partnership.
4. To liaise with outside agencies to facilitate the delivery of certified programs.

The CDA works directly with the NITHA CDWG (made up of the four Partner Health Directors) to plan and develop strategies for implementation activities. The CDA managed the completion of a number of funded initiatives/activities during the year and the achievements follow.

CAREER PATHING (CP) PROJECT

As one of seven *pilot sites* with SAHO the NITHA Partnership brought the project to its completion with funding ending March 31, 2010. The following documents produced during the project were distributed to the Partners.

- Career Pathing Project Brochure
- Career Pathing Project DVD containing interviews with participants in the project
- Career Pathing Project Evaluation Report

Flo Frank of Common Ground Research and Consulting Inc. completed an evaluation of the project and submitted to CDWG on September 27, 2010. The following are the findings of the evaluation.

CP Project Evaluation Report - Summary of Conclusions:

The health sector everywhere across Canada has issues related to human resource management, recruitment, training and retention. Northern and Aboriginal people, however, have additional issues. This pilot helped to build awareness for the need to rethink how things are done and make changes that will be relevant in the Northern Aboriginal context. The pilot showed:

- The need for holistic wellness strategies;
- That system helpers need help too;
- That Health Human Resources (HHR) management systems need to be more

Capacity Development Advisor


Paulette Campbell

culturally & geographically relevant;

- First Nations approaches are needed to address trust and confidence in the system;
- Community-based and holistic approaches showed a strong indication of being relevant and a good foundation upon which other things can be built; and
- This approach is much better than using mainstream disconnected HR and career planning tools and processes. With more time and resources the process could be completed and something more effective developed.

CP Project Evaluation Report - Summary of Recommendations:

The "NITHA Partnership health system of human resource management is well on its way to improvement, and hopefully the following recommendations will help move it further toward that goal." Three essential report recommendations "that would ensure the best benefit could be obtained from the pilot over the long run" were:

- Keep moving while the pilot is fresh in people's minds;
- Seek resources (to build capacity) to continue with the current project's work; and
- Develop a common HR system that will serve each Partner's needs.

An additional 14 recommendations were categorized under the three categories: Strategic Direction, Operational and Advocacy.

HEALTH DIRECTOR/COORDINATOR FRAMEWORK & FLEXIBLE ASSESSMENT

Health Director/Coordinator Framework:

The Partnership proceeded with an occupational analysis process to identify required competencies for the Health Director /Coordinator position and Gail Derbowka of DeMar Consulting Services Inc. was contracted to facilitate the process. The process involved the community Health Directors/Coordinators and their supervisors in a facilitated group discussion. The competencies were documented and validated and written in a format called a Position Competency Profile. The profiles were used to draft a Competency Framework outlining main function areas and related core competencies and competency indicators. The draft was reviewed at the May 3 & 4, 2010 workshop.

Flexible Assessment Tools:

At the May 3 & 4 workshop the participants were introduced to the next steps of the development of Flexible Assessment Tools. As part of this process the participants completed a self-assessment guide identifying their own level of knowledge, skills, and attitudes required to demonstrate competencies outlined in the *Framework*.

At the second workshop October 6 & 7, 2010 the community Health Directors / Coordinators received draft assessment tools for some of the Framework's Core Competencies. The participants reviewed the documents based on the key criteria for effective assessment tools and their applicability for their working context. These *assessment tools* can be used for human resource development approaches, such as:

- Supporting continuous learning strategies;
- Training institutions for curriculum development to support needs;
- Support staff in seeking credit recognition for prior learning; and
- For recruitment, retention and staff orientation.

Assessment of the Workshop and Process:

The following are comments provided by participants in the two workshops:

- *"It can be very useful to measure competency. Adapts to individuality."*
- *"Coming up with better assessment tools that are appropriate to community needs, direction, staff roles and requirements."*
- *"Will apply what I've learned in my everyday work life."*
- *"All this applies in my community and it's very useful to implement new ideas."*

RESEARCH: "SEEKING MODELS OF ABORIGINAL HEALTH HR - SMAHHR"

NITHA was the Community Partner in the research project with IPHRC involving a research team from U of R and U of S for a four-year period ending September 30, 2010 which was lead by the principle investigator Dr. Eber Hampton. Findings of the research activities were documented by the researchers and discussed at the Advisory Committee meeting in the spring 2010. The SMAHHR Gathering took place on August 31 and September 1, 2010 with 47 participants. The session involved:

- An overview of the project by the principle investigator Dr. Eber Hampton, and research officer Larry Sanders;
- Highlights from the research work presented by Larry Sanders and Ron Camp; the Conceptual Framework of the project by Willie Ermine; and
- Distribution of the one-page graphic of the draft Conceptual Framework.

A "talking circle" wherein the "group genius" process of dialogue provided the participants opportunity to reflect on what they had heard, and how they might apply what they heard to their personal lives, families, organizations, and communities was invaluable for the group.

The following are some quotations from participants in the "talking circle":

First Nation Health Board member speaking about the "ethical space " idea: *"….there are two different worlds colliding and not understanding where we are coming from. We need to teach each other about our culture. There is a lack of understanding on the part of our white brothers on where we come from as Indigenous people as we always go back to the land for the things it provides us. Everything is based on what the Creator provides us. I like the model here, but I'd like to take it home to introduce it to our leaders and our communities."*

Tribal Council Representative: *"We do often hear people say in the communities that diabetes is so rampant, or alcohol. We tend to focus only on the negatives in our communities and not the positives. And someone said yesterday that we need to focus on the positives in our communities. I thought about it last night and this model is leading us in the right way, and it's a good thing."*

The SMAHHR Report was submitted to the CDWG at the September 27, 2010 meeting for consideration and to provide follow up direction. The report was distributed to the Gathering Session participants, community Health Directors/ Coordinators and the four Partner Health/ Social Development Directors. Those interested in the report are encouraged to contact their community or organization to obtain copies.

MOVING BEYOND LATERAL VIOLENCE WORKSHOPS

Rod Jeffries of Ancestral Visions delivered "Moving Beyond Lateral Violence and Team Building" workshops in 2009-2010 and again in 2010-2011. The sessions were offered at PAGC, MLTC, LLRIB, and PBCN. Lateral violence has impacted Indigenous peoples throughout the world to the point of where we are harming each other in our communities on a daily basis. The workshop objectives included:

- Discuss the origins of lateral violence;
- Describe how it manifests itself in our communities and workplaces;
- Outline impacts of lateral violence on the community and the workplace;
- Figure out how we can stop the harm it creates in our communities; and
- Learn how we can work together as team members to contribute to positive outcomes.

The following are some quotations from participants in the workshops:

Responses to Key Insights:

"Learning how I can improve and strengthen the team by applying the techniques learned to myself first."

Responses to How did the Workshop Assist:

"Made me look at my past and understand my past actions, how to deal (with) and change my behaviour and try to find balance in my life."

RENEWAL "ABORIGINAL HEALTH HUMAN RESOURCES INITIATIVE" (AHHRI)

On March 31, 2010 the five year AHHRI funding program ended and the Federal Government renewed the program for another five years effective April 1, 2010. The focus of the program is on certified training through Partnership arrangements amongst First Nations, training institutions, provincial organizations and governments, and other community organizations. The CDWG identified their strategy and it formed the basis of the proposal, work plan and funding request which was submitted to FNIH:

1. The Partners and their member communities would forgo submission of proposals for AHHRI funding in lieu of NITHA submitting a proposal for the Partnership based on the NITHA Executive Council priorities.

2. The prioritized certified training areas were identified as:

   a. Mental Health and Addictions

   b. Licensed Practical Nurse

   c. Health Director / Coordinator / Manager

3. The preferred delivery model was identified as:

   a. Being based as close to the community level as possible and in the North;

   b. Using distance deliver modes with student supports to ensure success;

   c. Utilizing Northern resources where possible; and

   d. Incorporating "career pathing" strategies to meet community member needs such as the design of programs and training and the use of Prior Learning Assessment Recognition;

4. The NITHA Partnership, as members of the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS), will work jointly through Northlands College to develop and implement the training Work Plan.

PARTICIPATION ON EXTERNAL ORGANIZATIONS & PARTNERSHIPS

The CDA represents the NITHA Partnership on various northern, institutional and government planning bodies/committees that would benefit the NITHA Partners in the delivery of their services and support the development of capacity of their human resources. The extent of this activity and nature of groups and organizations will vary from year to year based on the priorities of the program area and NITHA Partnership and nature of external activities. The following are the areas of focused participation.

- Northern Labour Market Health Sector Training Subcommittee (NLMHSTS), which includes representatives from the northern health employers, training institutions, post-secondary funders, and provincial and federal agency/ministry representatives. The

role includes planning and seeking funding for the 5-year Northern Health Human Resource (NHHR) Strategy.

- SIIT Community Services Advisory Committee, CDA represents the NITHA Partnership for health human resource and capacity development needs. The group held four meetings in its initial formation year of 2010-2011.

FOCUS FOR 2011-2012 PROGRAM

In consultation/direction with CDWG the following priorities are being pursued:

- Managing implementation of AHHRI Work Plan for certified training;
- Providing certified training for community Mental Health and Addictions workers;
- Training community members to be Licensed Practical Nurses;
- Certified training for community Health Directors / Coordinators / Managers;
- Playing an active role on the NLMHST Subcommittee to acquire funding for and implement the NHHR Strategy through Northlands College;
- Developing funding proposals to meet needs;
- Holding regular CDWG meetings and facilitating 2010-2013 planning process; and
- Representing NITHA Partnership needs on external committees and Partnerships.

CHALLENGES FACED

Over the years we have found that the main challenges in planning, managing, and organizing delivery of program services within the Partnership are ongoing issues. The following is a summary of the issues that were noted in previous reports:

- Communication Practices - Because of the lack of established communication strategies between the Partnership three levels impacts the delivery of services and results in information and decisions not being shared.
- Travel Costs Consume Major Portions of Budgets - Due to the broad region of the Partnership, travel is extensive and expensive, impacting available funds for services. New management strategies are needed to reduce travel costs.
- Community Capacity Issues Impacts Delivery of Services - there is a need to develop community worker skills in order to meet the needs in the communities. Further, these positions need to be supported with appropriate HR management strategies.
- Funding - Funding is required to address HR capacity development issues. Presently it is being supported through special projects and working in Partnership with other organizations such as NLMHST Subcommittee, SAHO, SIIT, FNIH and others.

Home Care

Home Care is based on a holistic health assessment. It is client and family centered and supports individuals to remain in their homes as independently and safely as possible. Home Care provides services across the continuum from prenatal and postnatal care, to children, young adults, elderly and palliative clients. Service Delivery Plans, developed by each community, provide the Vision, Mission, and Philosophy that guide their Home and Community Care program.

Essential elements provided by all NITHA communities include Assessment, Home Care Nursing, Case Management (referrals and linkages), Personal Care, In-Home Respite, access to Medical Equipment & Supplies, Program Management & Supervision, and Data Collection.

Home Care programs and services are well established in all NITHA communities. The demand for home care services continues to increase. This includes an increase in the number of clients receiving services as well as the number and category of staff required to provide the necessary client care. There is also a major increase in the number of home care referrals for high acuity clients as people who previously remained in hospital are being sent home to receive home-based services.

Trends

The acuity of patients being admitted to the Home Care program continues to increase. Patients are discharged from hospital sooner, are sicker when they are discharged, and increasingly require treatments at home that traditionally have been provided in hospital. As on-reserve programs have become well established, patient numbers have also increased. This has a major impact on the use of the limited resources available to the Home and Community Care program.

In preparation for transfer of Home & Community Care into flexible funding agreements, many NITHA communities have begun the process of evaluating their programs and updating their Home & Community Care Service Delivery Plans. This process has provided communities an opportunity not only to review and evaluate the effectiveness of their program, but also to make revisions that reflect the changing needs of home care clients. NITHA provides program support in this process through development of documents and tools, consultation, and assistance with revisions of plans when requested.

Home Care Nurse Advisor


Lynn Oliver

Competency Development

As the services provided by the HCC program become more complex, there is a challenge to provide opportunities for ongoing education and skill development to ensure that all Home Care providers are competent to provide care within their defined role.

In support of nursing and clinical practice and in response to the Partner's needs for competency development and continuing education, NITHA provided the following educational opportunities for Home Care Nurses during 2010 – 2011:

- Home Care Nurse orientation
- IV Therapy Workshop
- eSDRT Home Care Data Collection (4 sessions)
- CNE Footcare Modalities for Nurses
- Diabetes Manager University (three - 3-day workshops)

Nursing Practice / Clinical Practice

In support of collaborative nursing practice, NITHA continues to be involved in discussions involving the RN Scope of Practice and LPN Scope of Practice as they relate to Home Care. The Resource Manual for Home Care Managers, which was completed during the past year, includes job descriptions, skills checklists, and performance review tools for RN's, LPN's, Home Health Aides and Home Care Workers.

The NITHA Home Care Nurse is a member of the SIAST Home Care Aide/ Special Care Aid Sector Partnership Steering Committee. NITHA Partners have identified several critical areas where there is a need to adapt current training methods to better meet the needs of aboriginal students and other students in our area.

Program Support

The number of referrals for home care services following discharge from acute care facilities continues to increase. NITHA has collaborated with the regional health authority in an attempt to address challenges associated with seamless delivery of health services and access to services following discharge. In response to the challenge, NITHA has developed an on-reserve Discharge Planning manual which has been distributed to all acute care units at the Victoria Hospital.

Assessment is the foundation of the

home care program. NITHA facilitated the revision of the First Nations Home Care Assessment Booklet used throughout the region. The document has been completed and is ready for distribution.

NITHA provided program support through home care chart audits and program review to several communities based on request. Policy review meetings have been provided based on request.

Research

Consistent with the Logic Model developed during the program planning stages, the Home & Community Care program has continues to undergo evaluation at all levels.

The results of all program evaluations have indicated that Home Care has been successfully implemented but unmet needs persist. This is mainly due to the challenges associated with an increased demand for services. It is evident from statistics that Home Care services within the NITHA communities increase annually.

Issues and Challenges

Home care programs are challenged with receiving referrals and assessing an increasing number of clients with chronic conditions to determine if these clients require home care services. While home care programs are not intended to replace other health services that provide treatment and support to patients with chronic conditions, home care does provide monitoring, treatment and education to patients who are newly diagnosed with a chronic disease, whose condition is unstable, or patients who have an acute episode of their disease.

Increased use of technology will provide NITHA Partners with ongoing opportunities for video conferencing to meet continuing competency and clinical skill development for all home care staff.

At a national level, quality assurance, improved access to equipment through NIHB, Palliative care and patient safety in home care have been identified as priorities for this year. As well, role clarification, core competencies, and standardization of Scope of Practice for RN's and LPN's working in home care is being addressed. This will include a move towards developing standardization of the knowledge, competency and skills required for all those working in the home care program. NITHA participates in these national agendas through discussion and participation on various working groups.

NITHA
Administrative Unit

The Administrative Unit is responsible for the ongoing daily operations of the organization in the areas of financial management, information technology and management, and human resources. This unit provides the operational foundation for the health program services of the Community Services and Public Health Units.

The following staff are part of the Administrative Unit: a Chief Executive Officer, Executive Assistant, Finance Manager, Personnel / Finance Assistant, Receptionist / Office Assistant, Human Resources Advisor, e-Health Advisor, and an IT Network Administrator.

This unit is responsible for:

- Maintenance of accurate financial records;
- Development of financial policies and procedures;
- Planning and development of electronic health (e-Health) information systems;
- Standardizing Information Technology (IT) hardware and software within the Partnership;
- Development of human resources policies and procedures; and
- Human resource staffing through effective recruitment and retention policies and procedures.

e-Health

e-Health is the modernization of information management practices using information technology tools. The NITHA Leadership has identified e-Health as a strategic priority for health information management and health services delivery support.

An example of an e-Health Solution is the Saskatchewan Immunization Management System (SIMS) which is a web-based electronic database for recording immunizations. Telehealth is another example of an e-Health Solution which can enable remote distance educational or clinical consultations with medical professionals using video conferencing technologies. Presently there are more than twenty-five First Nations Telehealth sites in Northern Saskatchewan.

There are e-Health solutions for general business productivity too such as Microsoft Office for documentation (Word, Excel) and communications (Outlook/e-Mail). e-Health solutions that are presently in development is a Community based Electronic Medical Record (cEMR) and the pan-Canadian electronic public health system called PANORAMA.

The main role of the e-Health Advisor is to support the 4 Partners with their e-Health capacity development. Activities include proposal writing, project management, standards development and strategic planning. Another key role is to liaison and advocate with external governing bodies such as Federation of Saskatchewan Indian Nations (FSIN), Assembly of First Nations (AFN), First Nations & Inuit Health (FNIH) of Health Canada, and the Provincial Ministry of Health (MoH).

Northern First Nations Health Facilities are on "CommunityNet" which is a private health network interconnecting hospitals, clinics, pharmacies and health administration offices throughout Saskatchewan.

e-Health Advisor

Charles Bighead

Achievements

In 2010-2011 NITHA received $404,000 in FNIH funding to conduct an electronic reporting feasibility study and to continue preparation for the pan-Canadian public health surveillance system called PANORAMA.

The purpose of the electronic reporting feasibility study was to determine if the Electronic Medical Record (EMR) system by *Med Access* could meet First Nations specific information management needs, including Health Canada reporting. The study began by first conducting a detailed information management needs assessment with health managers and program leads throughout the Partnership. This assessment went beyond identifying Health Canada Reporting needs and included the needs for program management, client care management and general "data collection" for program planning and advocacy purposes. After the needs assessment was completed a gap analysis on Med Access' EMR was performed to identify where system upgrades would be required to meet First Nations specific information management needs.

The feasibility report concluded the EMR by Med Access could meet all of the NITHA Partnership's Information Management needs with [doable] system upgrades. The report also included implementation and sustainability costing of the system for all the NITHA Partnership Communities.

Panorama funding was secured to support NITHA staff involved with preparing the north for Panorama and sustaining the "CommunityNet" service. CommunityNet is similar to an Internet service but with improved speed, reliability, and security which are crucial network attributes for future web-based applications such as Panorama and the Electronic Health Record.

This was the last year to complete the AHTF project titled "Readying the NITHA Communities for Integrated e-Health". The two objectives of the project were to migrate First Nations electronic data networks to CommunityNet, and to implement a First Nations privacy and security program.

The first objective, migrating First Nations electronic data networks to CommunityNet prepared Northern First Nations for future integrated e-Health systems. Many clinics

were wired for data networking and all were interconnected and secured with Cisco network equipment and the CommunityNet service.

The second objective was to implement a First Nations privacy and security program

to advance the governing processes for managing First Nations data in an integrated data sharing environment. This entails privacy & security policy development, implementation of a First Nations data trustee model, and staff training and awareness.

Challenges

Insufficient funding is the single biggest challenge to developing First Nations e-Health systems. This has been a long standing issue which impacts the Partners abilities to provide timely IT support services for the communities as well as to move forward e-Health initiatives such as an integrated (and comprehensive) Community based EMR. In June, the e-Health Advisor participated in an FSIN sponsored MOU consultation session where he advised that development of e-Health Systems for First Nations is a risky proposition without committed and sustained funded. Fortunately, Health Canada does have their Health Infostructure Strategic Action Plan (HISAP) which is being promoted as the means for modernizing First Nations e-Health systems, although it may be some time before significant funding is available to implement HISAP.

Personnel changes at First Nations Inuit Health (FNIH) and the Ministry of Health has also been a challenge to moving forward First Nations e-Health Systems. Personnel changes has the general effect of halting e-Health initiatives including the MOU on First Nations e-Health Initiatives Steering Committee meetings.

Internally one of the biggest challenges to moving forward e-Health systems is education and awareness amongst First Nations about data and processes which are intended to protect First Nations information in a health information sharing environment. NITHA has been promoting the concept of a "First Nations Data Trustee" that would be recognized by other trustees such as the Regional Health Authorities (RHA). In this model, trustees are responsible for the protection and confidentiality of personal health information entrusted to them. These same trustees could also enter into "Data Sharing Agreements" to enable an environment of client information sharing for improved health care while ensuring the use of health information is limited to a need-to-know basis.

Aside from the issues around First Nations data, it was very challenging to move forward First Nations privacy & security capacity development. Firstly, much more community engagement is necessary before leadership can move privacy forward. Also the Leadership is often quite busy with other competing and urgent issues. The NITHA Privacy Officer who was staffed to support the Partnership's privacy & security capacity development resigned, therefore the developmental worked was

halted. Because of the timing and short term funding for the position, it was not practical to recruit for a replacement.

Direction for next year

In the New Year, NITHA will conduct an e-Health "Readiness Assessment" which will provide the Leadership with current state assessment information and developmental requirements for e-Health systems amongst the Partnership.

NITHA will continue supporting the Partners whom are interested in implementing the Saskatchewan Immunization Management System (SIMS). Considering Panorama will not be available for approximately 2-yrs, SIMS would be a good bridge application for a number of reasons; the immunization data entered into SIMS could be transferred to Panorama and the lessons learned and the organizational development activities will be applicable to Panorama.

NITHA will continue advocating for e-Health funding to move forward e-Health initiatives such as the Community based Electronic Medical Record. There are a number of avenues to do so such as aligning with Health Canada's Health Infostructure Strategic Action Plan (HISAP), continuation of the MOU on e-Health Initiatives Steering Committee Meeting, participation in regional and national First Nations working groups, and accessing available pockets of funds through proposal writing.

Finance

Overview

The accompanying financial statements are the responsibility of management and are reviewed and approved by the NITHA Executive Council and the NITHA Board of Chiefs. The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the requirements of Health Canada for funding purposes.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that NITHA's assets are safeguarded and that financial records are relevant and reliable.

Throughout the year, the NITHA management team meets with the NITHA Executive Council to discuss and review financial matters. The quarterly financial statements are presented to the NITHA Executive Council on a quarterly basis and a motion is passed once the financial statements are accepted.

The auditor is appointed by the NITHA Board of Chiefs. The appointed auditor conducts an independent audit of the financial statements. The auditors' examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and other procedures, which allow the auditor to report on the fairness of the financial statements.

2010-2011 Health Transfer Funding

This marks NITHA's 5th year of the current transfer agreement with Health Canada.

In 2010-2011 NITHA received $2,649,506 under this agreement which included a 3% increase from prior year and also additional one-time funds for evaluation and other Environmental Health program costs as follows;

3rd level Transfer Services	$2,352,713
Funding Increase	50,867
Evaluation	51,745
EHO Programs	194,181
Total Transfer Funds	**$2,649,506**

Originally, the transfer agreement was to expire September 30th, 2011. Health Canada has agreed to extend the term of NITHA's transfer agreement to March 31st, 2013. The funding for each of the next 2 years is $2,413,929 each year. NITHA views this additional time as time to proactively prepare for negotiations and advocate for increased health funding to provide supportive health services as a First Nations driven health organization.

Originally the 4 Partners came together under a Third Level Structure to support and enhance northern health service delivery to First Nations. In alignment with the Partners vision *'Partner communities will achieve improved quality health and well-being, with community members empowered to be responsible for their health'*, NITHA will continue to advocate for improved health services for communities as we enter health transfer negotiations for continued Third Level services for the Partnership.

Finance Manager

Christine Tienkamp

2010 2011 Challenges and Successes

HR Challenges

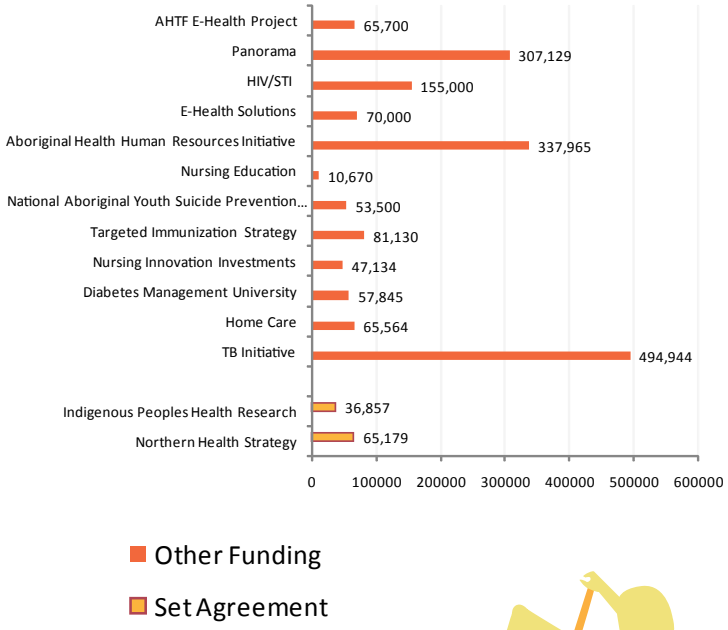
Recruitment for vacant positions continues to be a challenge in the current market. These vacancies result in surpluses in the program area personnel costs and related employment costs.

The NITHA Executive Council and the Board of Chiefs continually monitor the appropriated surplus allocations and proactively make recommendations as they continually plan strategically for the future of the organization. Many of these allocations result from areas that have been underfunded in the past or simply not fully implemented due to vacant positions. The Board of Chiefs in consultation with the NITHA Executive Council have proactively set aside funds in specific areas that ensure program needs and objectives are met as NITHA faces the challenges of having to spend Health Canada contribution agreement dollars by March 31st of the applicable fiscal year.

Program Successes

As identified in detail in the respective program areas of this annual report, funding was received from Health Canada under a Set Agreement where a number of health services were supported. This includes programs such as;

- TB program and outbreak services
- Home and Community Care
- HIV/Aids Strategy
- Nursing Innovation
- Nursing Education
- Targeted Immunization
- Panorama/e-Health Solutions



NITHA Bursary and Scholarship Fund

NITHA has appropriated the interest earned on its' investments to a scholarship fund. In the 2010-2011 fiscal year NITHA developed the NITHA Bursary and Scholarship fund guidelines. The Board of Chiefs will ratify the guidelines in 2011. The details of the fund will available on the NITHA web site, under the Finance page in late July. It will include the bursary and scholarship fund details, guidelines and application forms.

Asset Management

NITHA implemented a new Asset Management module into its' accpac computerized accounting system. Previously, asset inventories were managed using a manual system. The module increases efficiencies, providing better reporting capabilities for its' assets.

Finance Policies and Procedures

The NITHA Finance Policies and Procedures were reviewed and recommended for board approval by the NITHA Executive Council in 2010-2011. The new policies and procedures manual was reviewed in detail and includes improvements such as the addition of a comprehensive investment policy, improved signing authority policies and ties to the recently adopted governance policy document.

The final document will be brought to the NITHA Board of Chiefs in June 2011 for ratification.

Looking forward

Objectives for 2011-2012

With a newly adopted organizational chart in place, HR will continue to be at the forefront going into 2011-2012. Job descriptions will continue to be developed and subsequently recruited for. This will result in implementing programs and services that were otherwise under implemented due to HR deficiencies.

Going forward, the new organizational chart will ensure that third level programs and services are delivered to the Partner communities to achieve improved health and well-being, in alignment with the NITHA strategic plan.

Audited Financial Statements

The 2010-2011 audited financial statements unveil the financial portrait of the year's programs and services provided to its' members. NITHA reported an operating surplus directly related to vacant full time staff positions.

For the fourth year, Deloitte and Touche LLP has carried out the audit as the appointed auditors for Northern Inter-Tribal Health Authority Inc. Deloitte presented an unqualified audit, meaning that the financial statements were presented fairly in all material reports. Deloitte presented the audited statements to NITHA's Executive Council and Board of Chiefs. The Board of Chiefs ratified the audited statements in June 2011.

Included in the financial audit are:

- The auditor's opinion of the fairness of the financial statements
- Statement of Revenue, Expenditures and Fund Balances, sometimes referred to as the Income Statement
- Statement of Financial Position, sometimes referred to as the Balance Sheet
- Statement of cash Flows
- Notes to the Financial Statements

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

FINANCIAL STATEMENTS

March 31, 2011

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

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

INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of Northern Inter-Tribal Health Authority Inc., which comprise the statement of financial position as at March 31, 2011, and the statements of revenue, expenditures and fund balances and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of Northern Inter-Tribal Health Authority Inc. as at March 31, 2011, and its financial performance and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte + Touche LLP

Chartered Accountants

June 16, 2011
Prince Albert, Saskatchewan

Member of
Deloitte Touche Tohmatsu

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF REVENUE, EXPENDITURES AND FUND BALANCES
year ended March 31. 2011

	Operating Fund (Schedule 1)	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2011**	Total 2010
REVENUE						
Health Canada - transfer agreements	$ 2,649,505	$ -	$ -	$ -	$ **2,649,505**	$ 2,265,304
Health Canada - set agreements	1,746,581	-	-	-	**1,746,581**	2,532,160
Health Canada - flow through funding	35,500	-	-	-	**35,500**	367,350
Mamawetan Churchill River Regional Health Authority	29,679	-	-	-	**29,679**	78,067
SAHO	-	-	-	-	-	113,326
Province of Saskatchewan	-	-	-	-	-	49,500
University of Regina	36,857	-	-	-	**36,857**	28,683
University of Saskatchewan	-	-	-	-	-	7,139
Other	-	-	-	-	-	10,000
Administration fees (Note 10)	163,186	-	-	-	**163,186**	137,686
Expense recoveries	6,326	-	-	-	**6,326**	11,635
Gain on sale of capital assets	-	-	-	59,654	**59,654**	-
Interest	38,743	-	-	-	**38,743**	16,793
Other	3,688	-	-	-	**3,688**	-
Transfer from deferred revenue	545,587	-	-	-	**545,587**	708,790
Transfer to deferred revenue	-	-	-	-	-	(555,587)
	5,255,652	-	-	59,654	**5,315,306**	5,770,846
EXPENDITURES						
Health Canada programs	3,774,531	-	-	-	**3,774,531**	4,053,379
Other programs	152,056	-	-	-	**152,056**	614,347
Expenses funded by appropriated surplus	-	509,849	-	-	**509,849**	422,935
Amortization of capital assets	-	-	-	367,884	**367,884**	322,458
	3,926,587	509,849	-	367,884	**4,804,320**	5,413,119
NET SURPLUS (DEFICIT)	1,329,065	(509,849)	-	(308,230)	**510,986**	357,727
FUND BALANCES, BEGINNING OF YEAR	384,782	3,266,686	318,231	809,952	**4,779,651**	4,421,924
TRANSFER TO SURPLUS APPROPRIATED FOR SCHOLARSHIPS	(38,743)	-	-	-	**(38,743)**	(16,793)
TRANSFER TO CAPITAL FUND	(271,818)	-	-	-	**(271,818)**	(482,182)
TRANSFER (TO) FROM OPERATING FUND	-	(18,915)	38,743	271,818	**291,646**	2,067,016
TRANSFER FROM (TO) APPROPRIATED SURPLUS	18,915	-	-	-	**18,915**	(1,568,041)
FUND BALANCES, END OF YEAR	$ 1,422,201	$ 2,737,922	$ 356,974	$ 773,540	$ **5,290,637**	$ 4,779,651

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF FINANCIAL POSITION
as at March 31. 2011

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2011**	Total 2010
CURRENT ASSETS						
Cash	$ 1,102,308	$ -	$ -	$ -	**$ 1,102,308**	$ 360,937
Short term investments	1,085,736	2,737,922	356,974	-	**4,180,632**	4,145,423
Accounts receivable (Note 5)	385,929	-	-	-	**385,929**	1,182,083
Prepaid expenses	5,130	-	-	-	**5,130**	5,097
	2,579,103	2,737,922	356,974	-	**5,673,999**	5,693,540
CAPITAL ASSETS (Note 6)	-	-	-	773,540	**773,540**	809,952
	$ 2,579,103	$ 2,737,922	$ 356,974	$ 773,540	**$ 6,447,539**	$ 6,503,492
CURRENT LIABILITIES						
Accounts payable and accrued charges	$ 1,146,902	$ -	$ -	$ -	**$ 1,146,902**	$ 1,148,509
Deferred revenue (Note 7)	10,000	-	-	-	**10,000**	575,332
	1,156,902	-	-	-	**1,156,902**	1,723,841
FUND BALANCES						
Unappropriated surplus	1,422,201	-	-	-	**1,422,201**	384,782
Appropriated surplus (Note 8)	-	2,737,922	-	-	**2,737,922**	3,266,686
Surplus appropriated for scholarships (Note 9)	-	-	356,974	-	**356,974**	318,231
Equity in capital assets		-	-	773,540	**773,540**	809,952
	1,422,201	2,737,922	356,974	773,540	**5,290,637**	4,779,651
	$ 2,579,103	$ 2,737,922	$ 356,974	$ 773,540	**$ 6,447,539**	$ 6,503,492

SIGNED ON BEHALF OF THE BOARD:

Chair

Board Member

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF CASH FLOWS
year ended March 31. 2011

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	2011	2010
OPERATING ACTIVITIES						
Net surplus (deficit)	$ 1,329,065	$ (509,849)	$ -	$ (308,230)	$ 510,986	$ 357,727
Adjust items not affecting cash						
Gain on sale of capital assets	-	-	-	(59,654)	(59,654)	-
Amortization of capital assets	-	-	-	367,884	367,884	322,458
	1,329,065	(509,849)	-	-	819,216	680,185
Changes in non-cash working capital						
Accounts receivable	796,154	-	-	-	796,154	209,620
Prepaid expenses	(33)	-	-	-	(33)	(782)
Accounts payable and accrued charges	(1,607)	-	-	-	(1,607)	207,675
Deferred revenue	(565,332)	-	-	-	(565,332)	(153,203)
	1,558,247	(509,849)	-	-	1,048,398	943,495
INVESTING ACTIVITIES						
Purchase of capital assets	-	-	-	(331,472)	(331,472)	(482,182)
Proceeds from disposal of capital assets	-	-	-	59,654	59,654	-
	-	-	-	(271,818)	(271,818)	(482,182)
NET INCREASE (DECREASE) IN CASH	1,558,247	(509,849)	-	(271,818)	776,580	461,313
CASH, BEGINNING OF YEAR	921,443	3,266,686	318,231	-	4,506,360	4,045,047
TRANSFER TO SURPLUS APPROPRIATED FOR SCHOLARSHIPS	(38,743)	-	-	-	(38,743)	(16,793)
TRANSFER TO CAPITAL FUND	(271,818)	-	-	-	(271,818)	(482,182)
TRANSFER (TO) FROM OPERATING FUND	-	(18,915)	38,743	271,818	291,646	2,067,016
TRANSFER (TO) FROM APPROPRIATED SURPLUS	18,915	-	-	-	18,915	(1,568,041)
CASH, END OF YEAR	$ 2,188,044	$ 2,737,922	$ 356,974	$ -	$ 5,282,940	$ 4,506,360
CASH REPRESENTED BY:						
Cash	$ 1,102,308	$ -	$ -	$ -	$ 1,102,308	$ 360,937
Short term investments	1,085,736	2,737,922	356,974	-	4,180,632	4,145,423
	$ 2,188,044	$ 2,737,922	$ 356,974	$ -	$ 5,282,940	$ 4,506,360

1. DESCRIPTION OF BUSINESS

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

2. SIGNIFICANT ACCOUNTING POLICIES

The financial statements have been prepared in accordance with Canadian generally accepted accounting principles ("GAAP") and reflect the following significant accounting policies:

Use of Estimates

The preparation of the financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from these estimates.

Fund Accounting

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

i) The Operating Fund accounts for the Corporation's administrative and program delivery activities.

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

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

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

Short-term Investments

Investments are carried at fair value.

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Capital Assets

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

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

Impairment of Long-lived Assets

Long-lived assets are tested for recoverability whenever events or changes in circumstances indicate that their carrying amount may not be recoverable. An impairment loss is recognized when their carrying value exceeds the total undiscounted cash flows expected from their use and eventual disposition. The amount of the impairment loss is determined as the excess of the carrying value of the asset over its fair value.

Revenue Recognition

Revenue received from funding agencies which pertains to future operations is recorded as deferred revenue and recognized as revenue in future years as the related expenditures are incurred.

Financial Instruments

The Corporation has elected to use the exemption provided by the Canadian Institute of Chartered Accountants ("CICA") permitting not-for-profit organizations not to apply Sections 3862 and 3863 of the CICA Handbook which would otherwise have applied to the financial statements of the Corporation for the year ended March 31, 2011. The Corporation applies the requirements of Section 3861 of the CICA Handbook.

Financial assets and financial liabilities are initially recognized at fair value and their subsequent measurement is dependent on their classification as described below. Their classification depends on the purpose for which the financial instruments were acquired or issued, their characteristics and the Corporation's designation of such instruments. Settlement date accounting is used.

Classification

Cash	Held-for-trading
Short term investments	Available-for-sale
Accounts receivable	Loans and receivables
Accounts payable and accrued charges	Other liabilities

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Financial Instruments (continued)

Held-for-trading

Held-for-trading financial assets are financial assets typically acquired for resale prior to maturity or that are designated as held-for-trading. They are measured at fair value at the statement of financial position date. Fair value fluctuations including interest earned, interest accrued, gains and losses realized on disposal and unrealized gains and losses are included in other income.

Available-for-sale

Available-for-sale financial assets are those non-derivative financial assets that are designated as available-for-sale, or that are not classified as loans and receivables, held-to-maturity or held-for-trading investments. Except as mentioned below, available-for-sale financial assets are carried at fair value with unrealized gains and losses included in fund balances until realized when the cumulative gain or loss is transferred to other income.

Available-for-sale financial assets that do not have quoted market prices in an active market are recorded at cost.

Interest on interest-bearing available-for-sale financial assets is calculated using the effective interest method.

Loans and receivables

Loans and receivables are accounted for at amortized cost using the effective interest method.

Other liabilities

Other liabilities are recorded at amortized cost using the effective interest method and include all financial liabilities, other than derivative instruments.

Credit concentration

Financial instruments that potentially subject the Corporation to concentrations of credit risk consist primarily of accounts receivable from Health Canada which represents 90% of total accounts receivable. The Corporation believes that there is minimal risk associated with the collection of these amounts. The balance of accounts receivable is distributed among the remainder of the Corporation's funders, including third party health associations.

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Financial Instruments (continued)

Interest rate risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in the interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk.

The Corporation is exposed to price risk with respect to its investments in guaranteed investment certificates and mutual funds. The exposure to price risk is not considered significant.

3. CHANGES IN ACCOUNTING POLICIES

Future Accounting Policies

The Accounting Standards Board has approved a new framework that is based on existing Canadian GAAP and incorporates the 4400 series of standards which relate to situations unique to the not-for-profit sector. The new standards became available December 1, 2010 as Part III of the CICA Handbook - Accounting and are effective January 1, 2012. Early adoption is permitted. Also, the not-for-profit organizations were given the option of adopting International Financial Reporting Standards, an alternative that may be attractive to some organizations depending on their individual circumstances. The new reporting options were created to recognize the diverse nature of the organizations and will provide useful financial statements for the members, boards, contributors, lenders, clients and other users of their financial statements.

The Corporation is currently evaluating the impact of the adoption of these new Standards on its financial statements.

4. ECONOMIC DEPENDENCE

The Corporation receives the major portion of its revenues pursuant to various funding agreements with the First Nations and Inuit Health Branch of Health Canada. The most significant agreement undertaken was a 5-year health transfer agreement, which expires September 30, 2011. An extension of the current transfer agreement was granted, which now expires March 31, 2013.

5. ACCOUNTS RECEIVABLE

	2011	2010
Health Canada	$ **349,082**	$ 1,057,307
Government of Saskatchewan - AEEL	**-**	19,500
Indigenous Peoples' Health Research Centre	**-**	28,683
Mamawetan Churchill River Regional Health Authority	**24,789**	12,871
Other	**12,058**	27,249
Saskatchewan Association of Health Organizations (SAHO)	**-**	36,473
	$ **385,929**	$ 1,182,083

6. CAPITAL ASSETS

	Cost	Accumulated Amortization	Net Book Value 2011	Net Book Value 2010
Computers	$ 998,483	$ 551,730	$ **446,753**	$ 456,033
Equipment and furniture	276,702	174,972	**101,730**	123,096
Leasehold improvements	405,082	347,119	**57,963**	66,642
Vehicles	275,550	108,456	**167,094**	164,181
	$ 1,955,817	$ 1,182,277	$ **773,540**	$ 809,952

7. DEFERRED REVENUE

	2011	2010
Aboriginal Health Transition Fund	$ **-**	$ 495,568
Community Health	**-**	19,744
Glaxosmith Kline Project	**10,000**	10,000
IPHRC	**-**	1,500
Recognized Prior Learning	**-**	48,520
	$ **10,000**	$ 575,332

8. APPROPRIATED SURPLUS

The Corporation maintains an Appropriated Surplus Fund to fund program initiatives. The Board of Directors of the Corporation authorized the transfer of balances to and from the Appropriated Surplus Fund during the 2011 fiscal year. Funds have been allocated within the Appropriated Surplus Fund for future expenditures as follows:

	Opening Balance	Transfers In (Out)	Expenditures	Ending Balance
Capacity development iniatives	$ 190,421	$ -	$ 123,288	$ 67,133
Capital projects	1,030,750	-	-	1,030,750
E Health solutions	1,100,000	-	300,000	800,000
Human resource iniatives	80,917	-	17,463	63,454
Nursing support	310,800	-	-	310,800
Special projects	351,596	-	(7,483)	359,079
Strategic planning and long-term planning	202,202	(18,915)	76,581	106,706
	$ 3,266,686	$ (18,915)	$ 509,849	$ 2,737,922

9. SURPLUS APPROPRIATED FOR SCHOLARSHIPS

The Directors of the Corporation established a policy that any interest earned by the Corporation be appropriated to fund scholarships for students entering post secondary education in a medical field. The transfer from the Operating Fund recorded in each year represents the interest earned in that fiscal year as follows:

	Amount
2003	$ 5,555
2004	22,140
2005	17,180
2006	22,658
2007	34,843
2008	116,065
2009	82,997
2010	16,793
2011	38,743
	$ 356,974

10. ADMINISTRATION FEES

The Corporation charged the following administration fees to program activities as follows:

	Schedule	2011	2010
TB Initiative	5	$ 42,986	$ 44,925
Communicable Disease Control / CDHE	7	-	17,093
Diabetes	8	5,259	-
Nursing Innovation Investments	9	4,278	16,590
Targeted Immunization Strategy	10	-	1,990
National Aboriginal Youth Suicide Prevention Strategy	11	5,350	2,875
Nursing Education - CHPC / NEPD	12	1,400	-
E Health Solutions	14	6,057	3,329
HIV / STI Conference	15	14,059	5,088
Panorama	16	28,227	14,047
Aboriginal Health Transition - e-Health	17	51,024	23,802
Northern Health Strategy	18	1,441	3,763
Indigenous Peoples	19	304	-
Recognized Prior Learning	22	2,801	-
Other administrative amounts recorded in the current year		-	4,184
		$ 163,186	$ 137,686

11. FLOW THROUGH FUNDING

The Corporation disbursed funding as follows:

	2011	2010
Northern Health Strategy		
Aboriginal Human Resource	$ -	$ 150,000
Aboriginal Health Transition Fund	35,500	322,800
Maternal Child Health Regional Initiative Funding	-	44,550
	$ 35,500	$ 517,350

12. CAPITAL MANAGEMENT

The Corporation's objectives when managing capital are to maintain sufficient Operating Fund, Appropriated Surplus Fund, Surplus Appropriated for Scholarships Fund and Capital Fund balances to achieve the purposes of the funds and to ensure compliance with internal and external restrictions placed on those funds.

In the management of capital, the Corporation includes fund balances in the definition of capital. As at March 31, 2011, the Corporation has $5,290,637 (2010 - $4,779,651) in capital.

Capital management objectives, policies and procedures are unchanged since the preceding year.

13. RELATED PARTY TRANSACTIONS

The Corporation works as a Third Level Structure in a partnership arrangement between the Prince Albert Grand Council, the Meadow Lake Tribal Council, the Peter Ballantyne Cree Nation, and the Lac La Ronge Indian Band to support and enhance existing northern health service delivery in First Nations.

At March 31, 2011, there was $573 (2010- $465) of receivables and $197,327 (2010 – $263,173) of payables with the Corporation's partners listed above. These transactions were made in the normal course of business and have been recorded at the exchanged amounts.

14. COMPARATIVE FIGURES

Certain prior year figures have been reclassified to conform to the current year's presentation.

Schedule 1

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
SUMMARY OF OPERATING FUND REVENUE, EXPENDITURES AND SURPLUS FROM PROGRAMS PRIOR TO INTERFUND TRANSFERS
year ended March 31, 2011

	Schedule	Health Canada Transfer	Health Canada Set	Other Revenue	Administration Fees (Note 10)	Transfer (To) From Deferred Revenue	Total Revenue	Expenditures	**Surplus (Deficit) 2011**	Surplus (Deficit) 2010
TRANSFER AGREEMENTS										
Public Health Unit	2	$ 1,011,243	$ -	$ 6,326	$ -	$ -	$ 1,017,569	$ 512,273	$ **505,296**	$ (142,688)
Administration	3	1,205,759	-	42,431	163,186	-	1,411,376	1,002,319	**409,057**	712,877
Community Health Support Unit	4	432,503	-	-	-	-	432,503	199,594	**232,909**	191,351
SET AGREEMENTS										
TB Initiative	5	-	494,944	-	-	-	494,944	492,262	**2,682**	(9,731)
Home Care	6	-	65,564	-	-	-	65,564	101,853	**(36,289)**	(17,388)
Communicable Disease Control / CDHE	7	-	-	-	-	-	-	-	-	13,234
Diabetes	8	-	57,845	-	-	-	57,845	57,845	-	-
Nursing Innovation Investments	9	-	47,134	-	-	-	47,134	47,134	-	118,701
Targeted Immunization Strategy	10	-	81,130	-	-	-	81,130	70,630	**10,500**	30,000
NAYSPS	11	-	53,500	-	-	-	53,500	53,500	-	-
Nursing Education	12	-	10,670	-	-	-	10,670	10,670	-	-
Aboriginal Human Resource	13	-	337,965	-	-	-	337,965	337,965	-	-
E-Health Solutions	14	-	70,000	-	-	-	70,000	70,000	-	113,786
HIV/STI	15	-	155,000	-	-	-	155,000	155,000	-	-
Panorama	16	-	307,129	-	-	-	307,129	304,723	**2,406**	4,581
AHTF E-Health Project	17	-	65,700	-	-	495,567	561,267	358,763	**202,504**	82,099
		2,649,505	1,746,581	48,757	$ 163,186	495,567	5,103,596	3,774,531	**1,329,065**	1,096,822
OTHER AGREEMENTS										
Northern Health Strategy	18	-	-	65,179	-	-	65,179	65,179	-	(615)
Indigenous Peoples	19	-	-	36,857	-	1,500	38,357	38,357	-	-
Nursing Students CH Practicum	21	-	-	-	-	-	-	-	-	6,913
Recognized Prior Learning	22	-	-	-	-	48,520	48,520	48,520	-	-
		-	-	102,036	-	50,020	152,056	152,056	-	6,298
TOTAL		$ 2,649,505	$ 1,746,581	$ 150,793	$ 163,186	$ 545,587	$ 5,255,652	$ 3,926,587	$ **1,329,065**	$ 1,103,120

Schedule 2

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PUBLIC HEALTH UNIT (Formerly C.H.S.S.U)
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada - transfer agreement	$ 1,011,243	$ 631,000
Expense recoveries	6,326	8,140
	1,017,569	639,140
EXPENDITURES		
Meetings and workshops	1,481	662
Personnel	472,438	548,857
West Nile Virus Reductions Program	10,132	5,860
Program costs	-	200,000
Telephone and supplies	13,901	12,336
Travel and vehicle	14,321	14,113
	512,273	781,828
SURPLUS (DEFICIT)	$ 505,296	$ (142,688)

Schedule 3

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ADMINISTRATION
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada - transfer agreement	$ 1,205,759	$ 1,280,666
Administration fees	163,186	137,686
Expense recoveries	-	3,473
Interest	38,743	16,793
Other Revenue	3,688	-
	1,411,376	1,438,618
EXPENDITURES		
Bank charges	3,719	2,519
Equipment lease and maintenance	18,366	18,005
Facility Costs	97,596	79,182
Meetings and workshops	84,957	38,072
Personnel	598,908	389,430
Professional fees	58,535	45,320
Telephone and supplies	110,573	119,753
Travel and vehicle	29,665	33,460
	1,002,319	725,741
SURPLUS	409,057	712,877
NET TRANSFER TO CAPITAL FUND	(113,381)	(118,598)
	$ 295,676	$ 594,279

Schedule 4

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNITY HEALTH SUPPORT UNIT
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada - transfer agreement	$ 432,503	$ 580,947
EXPENDITURES		
Meetings and workshops	10	414
Personnel	174,743	356,583
Professional fees	12,000	12,000
Program costs	12,841	14,925
Travel and vehicle	-	5,674
	199,594	389,596
SURPLUS	$ 232,909	$ 191,351

Schedule 5

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TB INITIATIVE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 494,944	$ 435,790
EXPENDITURES		
Administration Fees	42,986	44,924
Equipment lease and maintenance	285	285
Facility Costs	1,384	1,384
Meetings and workshops	322	908
Personnel	299,611	312,356
Program Incentives	16,500	11,252
Program costs	15,715	18,418
Outbreak Services	78,394	20,119
Telephone and supplies	9,473	8,755
Travel and vehicle	27,592	27,120
	492,262	445,521
SURPLUS (DEFICIT)	2,682	(9,731)
NET TRANSFER TO CAPITAL FUND	(2,682)	(1,183)
	$ -	$ (10,914)

Schedule 6

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HOME CARE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 65,564	$ 65,882
Expense recoveries	-	22
	65,564	65,904
EXPENDITURES		
Meetings and workshops	659	796
Personnel	96,982	77,511
Program costs	1,103	952
Telephone and supplies	-	147
Travel and vehicle	3,109	3,886
	101,853	83,292
DEFICIT	$ (36,289)	$ (17,388)

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNICABLE DISEASE CONROL / CDHE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ -	$ 222,620
EXPENDITURES		
Administration fees	-	17,093
Meetings and workshops	-	699
Personnel	-	77,153
Program costs	-	105,167
Telephone and supplies	-	7,919
Travel and vehicle	-	1,355
	-	209,386
SURPLUS	-	13,234
NET TRANSFER TO CAPITAL FUND	-	(13,234)
	$ -	$ -

Schedule 8

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
DIABETES
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 57,845	$ -
EXPENDITURES		
Administration fees	5,259	-
Meetings and workshops	48,971	-
Personnel	3,615	-
	57,845	-
SURPLUS	$ -	$ -

Schedule 9

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING INNOVATION INVESTMENTS
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 47,134	$ 166,000
EXPENDITURES		
Administration fees	4,278	16,590
Personnel	5,333	-
Professional fees	-	1,530
Telephone and supplies	37,523	29,179
	47,134	47,299
SURPLUS	-	118,701
NET TRANSFER TO CAPITAL FUND	-	(118,701)
	$ -	$ -

Schedule 10

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TARGETED IMMUNIZATION STRATEGY
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 81,130	$ 80,500
EXPENDITURES		
Administration fees	-	1,990
Equipment lease and maintenance	55,818	32,000
Program costs	8,325	15,780
Telephone and supplies	6,487	693
Travel and vehicle	-	37
	70,630	50,500
SURPLUS	10,500	30,000
NET TRANSFER TO CAPITAL FUND	(10,500)	(30,000)
	$ -	$ -

Schedule 11

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NATIONAL ABORIGINAL YOUTH SUICIDE PREVENTION STRATEGY
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	**$ 53,500**	$ 53,500
EXPENDITURES		
Administration fees	**5,350**	2,875
Meetings and workshops	**-**	500
Professional fees	**48,150**	48,839
Program costs	**-**	1,286
	53,500	53,500
SURPLUS	**$ -**	$ -

Schedule 12

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING EDUCATION - CHPC / NEPD
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 10,670	$ 22,854
EXPENDITURES		
Administration fees	1,400	-
Personnel	3,288	2,968
Program costs	971	588
Telephone and supplies	2,269	18,651
Travel and vehicle	2,742	647
	10,670	22,854
SURPLUS	$ -	$ -

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ABORIGINAL HUMAN RESOURCE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 337,965	$ 615,268
Transfer from deferred revenue	-	109,907
	337,965	725,175
EXPENDITURES		
Career pathing workshop	-	409,885
Communications	-	26,454
Meetings and workshops	803	135,978
Personnel	37,087	-
NHS HR Project	-	150,000
Northlands AHHRI Project	297,985	-
Telephone and supplies	-	2,407
Travel and vehicle	2,090	451
	337,965	725,175
SURPLUS	$ -	$ -

Schedule 14

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
E-HEALTH SOLUTIONS
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 70,000	$ 230,146
EXPENDITURES		
Administration fees	6,057	3,329
Meetings and workshops	-	436
Professional fees	-	112,595
Program costs	63,943	-
	70,000	116,360
SURPLUS	-	113,786
NET TRANSFER TO CAPITAL FUND	-	(113,786)
	$ -	$ -

Schedule 15

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HIV/STI CONFERENCE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 155,000	$ 55,600
EXPENDITURES		
Administration fees	14,059	5,088
Personnel	5,784	2,399
Program costs	135,107	31,974
Telephone and supplies	-	15,727
Travel and vehicle	50	412
	155,000	55,600
SURPLUS	$ -	$ -

Schedule 16

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PANORAMA
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 307,129	$ 159,000
EXPENDITURES		
Administration fees	28,227	14,047
Meetings and workshops	230	-
Personnel	152,996	130,577
Program costs	118,802	-
Telephone and supplies	-	9,795
Travel and vehicle	4,468	-
	304,723	154,419
SURPLUS	2,406	4,581
NET TRANSFER TO CAPITAL FUND	(2,406)	(4,581)
	$ -	$ -

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
AHTF E-HEALTH PROJECT
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ 65,700	$ 197,691
Transfer to deferred revenue	-	(495,567)
Transfer from deferred revenue	495,567	572,283
	561,267	274,407
EXPENDITURES		
Administration fees	51,024	23,802
Meetings and workshops	128	1,497
Personnel	25,184	58,871
Professional fees	151,910	89,267
Program costs	115,669	2,683
Telephone and supplies	12,697	10,468
Travel and vehicle	2,151	5,720
	358,763	192,308
SURPLUS	202,504	82,099
NET TRANSFER TO CAPITAL FUND	(202,504)	(82,099)
	$ -	$ -

Schedule 18

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NORTHERN HEALTH STRATEGY
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Mamawetan Churchill River Regional Health Authority -service fee	$ **29,679**	$ 78,067
Health Canada - Flow through funding	**35,500**	367,350
	65,179	445,417
EXPENDITURES		
Administration fees	**1,441**	3,763
Flow through funding - Health Canada (Note 11)	**35,500**	381,426
Meetings and workshops	**1,454**	5,077
Personnel	**26,048**	51,144
Professional fees	**-**	3,000
Telephone and supplies	**-**	256
Travel and vehicle	**736**	1,366
	65,179	446,032
DEFICIT	$ **-**	$ (615)

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
INDIGENOUS PEOPLES
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Indigenous Peoples Health Research -University of Regina	$ 36,857	$ 28,683
Transfer to deferred revenue	-	(1,500)
Transfer from deferred revenue	1,500	-
	38,357	27,183
EXPENDITURES		
Administration fees	304	-
Meetings and workshops	1,539	2,701
Program costs	-	5,572
Telephone and supplies	3,784	2,105
Travel and vehicle	32,730	16,805
	38,357	27,183
SURPLUS	$ -	$ -

Schedule 20

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
CAREER PATHING PILOT PROJECT
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Health Canada	$ -	$ 113,326
EXPENDITURES		
Meetings and workshops	-	1,333
Personnel	-	92,007
Professional fees	-	202
Program costs	-	4,985
Telephone and supplies	-	1,343
Travel and vehicle	-	13,456
	-	113,326
SURPLUS	$ -	$ -

Schedule 21

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING STUDENTS CH PRACTICUM
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
University of Saskatchewan - College of Nursing	$ -	$ 7,139
EXPENDITURES		
Meetings and workshops	-	226
SURPLUS	$ -	$ 6,913

Schedule 22

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
RECOGNIZED PRIOR LEARNING
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Province of Saskatchewan	$ -	$ 49,500
Transfer to deferred revenue	-	(48,520)
Transfer from deferred revenue	**48,520**	26,600
	48,520	27,580
EXPENDITURES		
Administration fees	**2,801**	-
Meetings and workshops	**28,557**	3,140
Professional fees	**15,601**	16,454
Telephone and supplies	**1,161**	31
Travel and vehicle	**400**	7,955
	48,520	27,580
SURPLUS	$ -	$ -

Schedule 23

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
GLAXOSMITH KLINE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2011

	2011	2010
REVENUE		
Glaxosmith Kline Grant	$ -	$ 10,000
Transfer to deferred revenue	-	(10,000)
	-	-
EXPENDITURES	-	-
SURPLUS	$ -	$ -

NITHA

Dennis Moore
Chief Executive Officer

Heather Gunville
Executive Assistant

Christine Tienkamp
Finance Manager

Charles Bighead
e-Health Advisor

Ramona Caisse
Program Administrative Assistant

Rosanne Page
Program Administrative Assistant Temp

Deanna Brown
Program Administrative Assistant

Maxine Ballantyne
Receptionist/Office Assistant Temp

Paulette Campbell
Capacity Development Advisor

Eric Xue
IT Network Administrator

Lynn Oliver
Home Care Advisor

Staff Directory

Shirley Woods
Nurse Epidemiologist

Leslie Brooks
Communicable Disease Control Nurse

Linda Gilmour Kessler
Health Promotion Advisor

Ewelina Dziak
Infection Control Advisor

Sheila Hourigan
TB Advisor

Vi Petrinka
TB Nurse

Eileen Oliveri
TB Nurse

Brenda Ziegler
Environmental Health Advisor

Linda Rogozinski
Program Administrative Assistant

Cindy Sewap
Program Administrative Assistant

Northern Inter-Tribal Health Authority

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

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

Tel: (306) 953-0670

Fax: (306) 922-0593

NORTHERN INTER-TRIBAL HEALTH AUTHORITY

www.nitha.com